OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Memorandum

To: Interested Persons

From: Jane Beyer, Senior Health Policy Advisor

Date: May 6, 2022

Subject: Behavioral Health Emergency Services Under E2SHB 1688 (Chap. 263, Laws of 2022)

In anticipation of upcoming implementation of the "988" suicide prevention line in July 2022, the Washington state legislature enacted E2SHB 1477 (Chap. 302, Laws of 2021). The law establishes the design for a more effective behavioral health crisis response system in Washington state.

E2SHB 1688 was passed by the Washington state legislature in the 2022 legislative session. The bill relates to protecting consumers from charges for out-of-network health care services by addressing coverage of emergency services and aligning the Washington state Balance Billing Protection Act and the federal No Surprises Act (NSA). Sections 2 and 3 of this legislation amend current law, including provisions related to coverage of emergency services, to clarify the role of behavioral health crisis services providers in meeting the needs of individuals enrolled in fully insured individual and group health plans when they experience a behavioral health emergency.

RCW 48.43.005 defines an emergency medical condition to encompass "a medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress…" according to a prudent layperson standard, which is consistent with Centers for Medicare & Medicaid Services' interpretation of the EMTALA statute.[1] Section 2 of the act amends RCW 48.43.005 to include "behavioral health emergency services providers" as providers of emergency services. Under the act, "behavioral health emergency services providers" include facilities licensed to provide behavioral health crisis services, such as evaluation and treatment facilities, crisis triage

[1] See 86 Fed. Reg. at p. 36879 (July 13, 2021)

Contact: Jane Beyer | 360-725-7043 | Jane.Beyer@oic.wa.gov

facilities, medical withdrawal management services facilities, and mobile rapid response crisis team services.[2] These behavioral health emergency services providers are equivalent to the full range of emergency and crisis services for medical and surgical conditions including hospital emergency rooms, ambulance (mobile outreach), and urgent care centers.

Hospital emergency rooms often lack the staff and capacity to immediately address a behavioral health crisis, while behavioral health emergency services providers are designed and licensed for this purpose. The impact of E2SHB 1688 is to incorporate these essential, behavioral health-specific providers and services as part of the full range of behavioral health emergency and crisis care, just as the full range of medical/surgical emergency care is covered.

Furthermore, this clarification in E2SHB 1688 regarding emergency behavioral health services providers brings Washington state law into alignment with provisions of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the NSA. Under MHPAEA, treatment limitations that are not expressed numerically (unlike the way copays, coinsurance, deductibles are numerically expressed), are termed nonquantitative treatment limitations (NQTLs). The NQTL rule under MHPAEA requires that NQTLs imposed on mental health and substance use benefits must be comparable to and no more stringently applied than NQTLs imposed on medical and surgical benefits.[3] In addition, MHPAEA specifically prohibits any separate treatment limitations that are applicable only with respect to behavioral health benefits.[4]

Health plans in Washington state already cover the full range of emergency medical care, ambulance services (mobile), and urgent care. Typically, emergency care and ambulance services are classified in the emergency care class of benefits. Some carriers classify urgent care services in the emergency care benefits class; others in the outpatient benefits class. The MHPAEA Final Rules provide: "In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use benefits."[5] Thus, a carrier is required to classify services in benefit classifications consistently and according to the same standards for medical/surgical and mental health/substance use disorder benefits.

[2] See Sec. 2(48) for additional detail regarding these settings.
[3] 45 CFR 146.136(c)(4)(i)
[4] 45 CFR 146.136(c)(4)
[5] 78 Fed. Reg. 68240, 68288 (Nov. 13, 2013).

Given the act's definition of "emergency medical condition" under the "prudent layperson standard,"[6] a health plan enrollee is able to seek and obtain any type of emergency or urgent care for a medical/surgical condition at a hospital emergency room, via ambulance (mobile) or urgent care center; or for a behavioral health condition, at a facility licensed to provide behavioral health crisis services, such as evaluation and treatment facilities, crisis triage facilities, medical withdrawal management services facilities and mobile rapid response crisis team services. Of note, health plans often incentivize enrollees to obtain medical care at urgent care centers by having lower cost-sharing for use of urgent care than for use of hospital emergency departments. Under Washington state's mental health parity law,[7] if a health plan covers medical services, then it also must provide coverage for mental health services, which are defined by state statute to include mental health and substance use disorders.[8]

Under MHPAEA Final Rules, restrictions or exclusions based on "facility-type" that limit the scope of coverage for services is expressly listed as an NQTL.[9]

The MHPAEA Final Rules provide an example of a non-comparable facility-type restriction or exclusion that violates the NQTL rule under MHPAEA. In Example 9, a plan automatically excluded coverage for inpatient substance use treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For medical/surgical conditions, the plan provided coverage for inpatient treatment outside of a hospital upon authorization that the inpatient treatment was medically appropriate. The Final Rules conclude that the plan's exclusion of substance use disorder inpatient treatment in any setting outside of a hospital violated MHPAEA, as it was not comparable to the coverage of medical/surgical inpatient treatment outside of a hospital, so long as it was authorized.[10]

In addition, any separate NQTL (such as facility-type exclusion or restriction) that applies only to behavioral health benefits within any particular classification of benefits does not comply

---

[6] "'Emergency medical condition' means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part." RCW 48.43.005 (15)

[7] See RCW 48.21.580, 48.21.241, 48.44.341 and 48.46.291

[8] Id.

[9] 78 fed. Reg. 68240, 68292 (Nov. 13, 2013)

[10] Example 9 (78 Fed.Reg. 68240, 68293 (November 13, 2013))

with MHPAEA.[11] The 2020 MHPAEA Self-Compliance Tool provides an example of a plan that classifies medical skilled nursing facilities and behavioral residential treatment facilities as inpatient benefits and covers room and board for all medical/surgical inpatient care. The plan imposed a restriction on behavioral health residential care, which was an impermissible limitation only on behavioral health benefits and therefore violated MHPAEA.[12] Thus, any restriction on coverage for behavioral health emergency and crisis services where there exists coverage for medical emergency and urgent care services would be in violation of MHPAEA.

E2SHB 1688 thereby brings coverage into compliance with MHPAEA by including the full range of behavioral health emergency and urgent services, in the same manner that the full range of medical emergency and urgent care services are covered.

In addition to bringing Washington state law into compliance with MHPAEA, the clarifications set forth in E2SHB 1688 also bring Washington state law into alignment with the NSA. Under the NSA, a freestanding emergency department is defined as a health care facility that is geographically separate and distinct from a hospital, is separately licensed from a hospital by the state, and provides services for an emergency medical, mental health and/or substance use condition.[13] Such freestanding emergency departments must be covered without regard to network status.[14] It is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by the state to provide emergency services, even if the facility is not licensed under the term "independent freestanding emergency department".[15] Several facilities licensed by Washington state are included in the definition of behavioral health emergency services providers.[16] These providers are licensed to provide behavioral health crisis services, which are analogous to emergency services, given that their function is to assess, stabilize, and initiate treatment of individuals experiencing a behavioral health emergency condition.

[11] 2020 MHPAEA Self-Compliance Tool, p. 22.
[12] Id.
[13] 45 CFR §149.30; 45 CFR §149.110(c)
[14] 45 CFR §149.110(b)
[15] See 86 Fed. Reg. at p. 36879 (July 13, 2021)
[16] RCW 48.43.005(48), as amended by E2SHB 1688