manatt

Mental Health Parity and Implementation of SB 855 in California

Joseph Laska and Jessamyn Vedro
Manatt, Phelps & Phillips, LLP

April 7, 2021

Overview and History

SB 855: Coverage of mental health or substance use disorders

- Applies to all California health plans and disability insurance policies issued, amended, or renewed on or after January 1, 2021
- Adds provisions to both the Health & Safety Code (§§ 1367.045, 1374.72, 1374.721) and the Insurance Code (§§ 10144.5, 10144.52)
- **Notable provisions**:
  - **Expands state coverage requirements** and restrictions for mental (MH) and substance use disorder (SUD) services
  - **Requires parity of coverage for all MH/SUD disorders** listed in the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders
  - **Requires** health plans and insurers to adopt a **standardized definition of "medical necessity"** for MH/SUD treatments
  - **Mandates** use of certain **clinical level-of-care guidelines**

Key Provisions

SB 855: Key Provisions

Uniform "Medical Necessity" Definition

- Modeled on rulings in ***Wit v. United Behavioral Health***, No. 14-cv-02346-JCS (N.D. Cal.)
- **"Medically Necessary"** MH/SUD services must be:
  - "In accordance with the **generally accepted standards** of mental health and substance use disorder care"
    - "generally recognized by health care providers practicing in relevant clinical specialties"
    - found in peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and FDA-approved drug labeling

SB 855: Key Provisions

Uniform “Medical Necessity” Definition

- **“Medically Necessary”** services must be:
  - “clinically appropriate in terms of type, frequency, extent, site, and duration,” and
  - “Not primarily for economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider”

manatt

SB 855: Key Provisions

Uniform "Medical Necessity" Definition

- Plans and insurers must use "criteria and guidelines set forth in the **most recent versions of treatment criteria** developed by the **nonprofit professional association** for the relevant clinical specialty"
- If no applicable criteria, plans may apply other criteria consistent with "generally accepted standards"
- **DMHC All Plan Letter (issued Jan. 5, 2021)**: Identifies clinical criteria and guidelines health plans regulated by DMHC must apply to determine medical necessity of MH/SUD services
  - "Safe Harbor" compliance

Uniform "Medical Necessity" Definition

- **DMHC All Plan Letter (issued Jan. 5, 2021)**
  - **Attachment A**: List of criteria and clinical guidelines that must be applied "to any and all relevant initial denials or modifications" for relevant services as of January 1, 2021
    - **Substance Use Disorder (any age):** American Society of Addiction Medicine, ASAM Criteria, 3rd Edition (2013)
    - **Mental Health Disorders (age 18 years or older):** American Association of Community Psychiatrists, Level of Care Utilization System (LOCUS), Version 20
    - **Mental Health Disorders (ages 6 to 17 years):** American Association of Community Psychiatrists, Child and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or American Academy of Child and Adolescent Psychiatry, Child and Adolescent Service Intensity Instrument (CASII) 2019
    - **Mental Health Disorders (ages 0 to 5 years):** American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII)
    - **Gender Dysphoria:** World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7

SB 855: Key Provisions

Uniform “Medical Necessity” Definition

- **DMHC All Plan Letter (issued Jan. 5, 2021)**
  - Contracted clinical review
    - Plans may contract with entities that offer clinical criteria services only to the extent plans demonstrate compliance with Attachment A
    - No “different, additional, conflicting, or more restrictive” criteria
    - Amendments to contracts/scopes of work must be filed with DMHC
    - Plans must verify compliance and notify DMHC if using utilization criteria outside the scope of sources in Health & Safety Code § 1374.721(b)

Other Relevant Provisions

- **“Discretionary Clauses” prohibited**
  - Primarily pertains to ERISA plans
  - Preempted?
- **“Arrange Coverage” requirement**
  - Must arrange for out-of-network options “within geographic and timely access standards”
  - “The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider”

Other Relevant Provisions

- **No "short-term or acute treatment" limitations**
  - Does not specify whether it prohibits a plan or insurer from limiting an **individual member's treatment** to short-term or acute treatment, or whether it invalidates plan terms that restrict coverage to short-term treatment on a **blanket basis**
- **No rescission of authorization for MH/SUD services after services are provided**
  - Must pay for authorized MH/SUD treatment, even if coverage is rescinded, canceled, or modified
  - Must pay for authorized MH/SUD treatment, even if authorization was in error

SB 855: Key Provisions

Other Relevant Provisions

- **New disclosure and internal compliance requirements include:**
  - ☑ Formal education programs
  - ☑ Tracking
  - ☑ Evaluation
  - ☑ Disclosure of clinical review criteria
  - ☑ Interrater reliability testing
  - ☑ Remediation functions

→ **DMHC All Plan Letter – requires formal education programs by nonprofit clinical specialty associations listed in Attachment A**

SB 855: Key Provisions

Enforcement

- **Health & Safety Code**
  - DMHC may assess administrative penalties for violations of new Health & Safety Code Section 1374.721
- **Insurance Code**
  - Under new Insurance Code Sections 10144.5(j) and 10144.52(i), the commissioner may assess a penalty for violation of either section, up to $5,000 per violation or $10,000 if the violation is “willful”
- **No private right of action**, but potential for litigation under California’s Unfair Competition Law, Bus. & Prof. Code §§ 17200 et seq.

All Plan Letter - DMHC Compliance Deadlines

- Deadlines for filings demonstrating compliance with medical necessity definition and coverage requirements have passed in February/March
- Ongoing rolling deadline for updating Plan documents, which must describe changes relevant to SB 855
- Initial interrater reliability reports due July 1, 2021

Wit v. United Behavioral Health

Wit v. United Behavioral Health

Overview

- ERISA class action re: propriety of guidelines used by United Behavioral Health ("UBH") for adjudicating claims for outpatient and residential inpatient behavioral health treatment
- *Wit* findings of fact were integral to criteria established in SB 855

Wit v. United Behavioral Health (cont'd)

Timeline

- **March 5, 2019: Trial Court Findings of Fact and Conclusions of Law**
  - Following a ten-day bench trial, the *Wit* court issued a 106-page ruling addressing certain specific level of care guidelines
- **November 3, 2020: Remedies and Reprocessing Order**
  - Declaratory judgment and permanent injunction
  - Reprocessing order
    - Unprecedented order requiring UBH to reprocess over 67,000 benefits determinations consistent with the remedies order
    - Both reprocessed denials and approvals must be supported by "specific and detailed findings"
    - Certification and report to the court detailing numbers of denials and reversals and payment data

Wit v. United Behavioral Health (cont'd)

Timeline

- **Ninth Circuit Appeal**
  - December 28, 2020:
    - UBH moves the trial court to stay reprocessing remedy pending appeal
    - Trial court denies stay
    - UBH appeals denial of stay
  - February 1, 2021: Trial court issues final judgment
  - February 12, 2021: Ninth Circuit grants motion to stay reprocessing order pending appeal
- **Ninth Circuit Appeal**
  - Reversal or modification of the *Wit* court's findings could have wide-ranging effects in other actions challenging behavioral health coverage guidelines

Key Takeaways

Key Takeaways

- SB 855 represents a significant expansion of state coverage requirements
- *Wit* appeal may have implications for interpretation of new laws
- Litigation will likely ensue relating to various provisions, including “arrange coverage” provision and medical necessity standards
- Plans/insurers may need to adjust coverage terms and internal procedures to comply with the new law
- Plans/insurers should follow *Wit* and other litigation matters that may shed light on how state regulators will interpret and enforce the new laws
- Will SB 855 serve as a template for new laws in other states?

Questions?