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CLIENT ALERT

States Strengthen Mental Health Parity Protections

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Mental health parity compliance remains a focus of both state and federal regulators. As federal compliance guidance continues to evolve, states are taking more direct action to delineate specific compliance programs for health plans. California and Pennsylvania each recently enacted mental health parity legislation to increase compliance requirements—and burdens—for health plans and issuers.

California

California enacted legislation that both mandates more expansive mental health coverage and removes a "lever" available to health plans to manage their members' mental health care. Signed in late September along with a few other bills focused on mental health care, SB 855 expands the requirements under California's mental health parity law.

Medical Necessity and Clinical Criteria

The new law introduces a more prescriptive approach to medical management and clinical criteria used by managed care plans and health insurance issuers for mental health and substance use disorder benefits. Specifically, it requires plans to tie medical necessity determinations to generally accepted standards of mental health and substance use disorder care, defined in the law to mean "standards of care and clinical practice that are generally recognized by health care providers practicing in the relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment . . . ." The definition further appears to magnify the role of provider associations by incorporating "clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies" as appropriate sources for such generally accepted standards. Although this new definition is generally consistent with typical health plan criteria, it prohibits internal standards or criteria—which may be established, informed, and measured using the plan's proprietary data—in favor of more general, academic standards. Plans that apply their own standards rather than those adopted from an outside organization will no longer be able to do so beginning in 2021.

This law limits the discretion of managed care organizations and health insurance issuers to select clinical criteria and medical management standards when seeking to improve outcomes and control costs for their members.

Benefit Mandate

For plan years beginning on or after January 1, 2021, the new law also mandates coverage of diagnosis and treatment of all mental health conditions and substance use disorders more broadly across managed care and health insurance markets. California's mental health parity law has long included a benefit mandate for diagnosis and treatment of severe mental illnesses—an enumerated list of nine specific disorders—and for serious emotional disturbances for children, and such benefits must be in parity with medical/surgical requirements. In addition, in the non-grandfathered small group and individual markets,

California essential health benefits provisions require coverage of mental disorders listed under the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The scope of the new law more broadly captures all medically necessary treatment of mental health or substance use disorders, including for the large group market. Medically necessary treatment is defined to include "service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms . . . ." Mental health or substance use disorders is defined expansively to mean a condition or disorder "that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders." These two comprehensive resources include all diagnosable mental health conditions and substance use disorders, expanding the list of covered conditions from nine "severe" mental illnesses to the known universe of conditions.

This expanded benefit mandate has been issued with very little notice to health plans and insurance issuers, whose 2021 benefits were defined and rates were established months before the enactment of the new law. Although many plans already may have covered the full range of required items and services, some may not have.

Compliance and Enforcement

The new parity law will be enforced using both new and existing authorities. Both the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) are empowered to assess administrative penalties for violations under their regulated plans. In addition, existing law subjects DMHC-regulated plans to criminal liability for any willful violation of the Act, and the new law includes criminal penalties for willful violations of DOI-regulated plans. While there is no private right of action included in the new law, it is likely that private litigants will seek to enforce its provisions through other statutory schemes, such as California Business and Professions Code Section 17200, *et seq*.

Pennsylvania

With the enactment of two new pieces of legislation on October 29, Pennsylvania increased the regulatory burdens on health plans to demonstrate compliance with federal mental health parity requirements. These laws do not substantively expand the rights of patients to be covered for mental health or substance use disorder services; instead, they require more elaborate demonstrations of compliance with the laws that have already applied—similar to regulations recently finalized by New York.

Acts 89 and 92, introduced as House Bills 1439 and 1696, respectively, will require issuers offering comprehensive health insurance coverage to certify compliance with federal mental health parity law, affirmatively perform and document baseline and subsequent parity analyses for *each* quantitative and non-quantitative treatment limitation, and prepare disclosures consistent with federal law to be provided to the insurance department and to insured members.

The analyses required by the new legislation will include new, burdensome requirements for issuers to add to their current compliance processes and procedures. Issuers must identify each quantitative and non-quantitative treatment limitation, describe the process used develop it, identify and define each factor used to determine that the limitation is applicable to benefits, and analyze each such factor to ensure that their applicability to mental health and substance use disorder benefits are comparable to their applicability to medical/surgical benefits. Each of these elements must be documented by the issuer. These

specific, detailed elements do not include deemer or waiver provisions for issuers whose compliance processes already include safeguards to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the 2008 federal law that the Pennsylvania law references.

For the new disclosure and documentation requirements, the new law notes that an issuer "may designate the information and documentation . . . as a trade secret or confidential proprietary information." Beyond that, the law provides no meaningful assurances that the detailed medical management practices involved in the required analyses would be kept confidential.

Pennsylvania has cast these enactments as furthering the purposes of the "Reach Out PA: Your Mental Health Matters" anti-stigma campaign. But it is not clear whether or how these burdens on insurers could impact stigma associated with mental health and substance use disorder services.

Issuers will have time to implement these laws, which take effect for plan years beginning on or after December 31, 2021.

These Pennsylvania laws follow on the heels of targeted mental health parity enforcement actions and may be a harbinger of further compliance focus on parity. The Department of Insurance found parity-related violations in market conduct examination reports issued in 2018 and 2019 for several Pennsylvania health insurers. The Mental Health Parity and Addiction Equity Act (B) Working Group of the National Association of Insurance Commissioners (NAIC), chaired by Pennsylvania's Katie Dzurec, recently released draft templates for measuring and evaluating parity compliance of treatment limitations. These templates received some public comments contrasting the simplicity of the proposed reporting requirements against the complexity of mental health and substance use disorder benefit administration.

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The new laws in California and Pennsylvania, and the trend they suggest in the context of actions in other states and efforts by the NAIC, suggest that state health insurance regulators' interest in mental health parity continues to intensify, and the challenges with compliance are likely to continue to grow.

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