CAPITOL OFFICE
1021 O STREET, SUITE 8620
SACRAMENTO, CA 95814
TEL (916) 651-4011
FAX (916) 651-4911

DISTRICT OFFICE
455 GOLDEN GATE AVENUE
SUITE 14800
SAN FRANCISCO, CA 94102
TEL (415) 557-1300
FAX (415) 557-1252

SENATOR.WIENER@SENATE.CA.GOV

California State Senate

SENATOR
SCOTT WIENER
威善高
ELEVENTH SENATE DISTRICT

MENTAL HEALTH CAUCUS
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Oversight Hearing
Compliance with California's Mental Health Parity Law (SB 855)
October 18, 2023 – 10 AM
1021 O Street, Room 1200

This oversight hearing of the Select Committee on Mental Health and Addiction will focus on Senate Bill 855, which requires insurers to cover "medically necessary treatment" for all mental health and substance use disorders. It defines medically necessary treatment clearly and requires the medical necessity determinations be consistent with generally accepted standards of care. It also prohibits limiting benefits or coverage to short-term or acute treatment. SB 855 requires plans, for level of care determinations, to use treatment criteria developed by the non-profit, clinical professional association of the relevant clinical specialty. It requires plans to meet requirements relating to the implementation and usage of these criteria.

Background

Wit, et al. v. United Behavioral Health.

In *Wit v. United Behavioral Health* (UBH), 11 plaintiffs sued UBH on behalf of more than 50,000 individuals whose claims were denied based on UBH review criteria. It was filed under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs group health insurance policies issued by private employers, alleging that UBH violated its obligations under this federal law. ERISA requires plan administrators to function in a fiduciary capacity when overseeing employee benefit plans, including insurance coverage for MH/SUD treatment. In this case, the court held that UBH breached its fiduciary duties by developing and employing flawed medical necessity criteria for behavioral health services. In his 106-page decision, the Judge described the UBH's guidelines as "unreasonable and an abuse of discretion" and having been "infected" by financial incentives meant to restrict access to care. The judge ruled that UBH wrote its guidelines for treatment much more narrowly than common medical standards, covering only enough care to stabilize patients "while ignoring the effective treatment of members' underlying conditions." According to the NY Times, the case represents the latest development in the contentious debate over how health insurance companies cover MH/SUDs, as compared to medical conditions like diabetes, multiple sclerosis and asthma. In spite of the passage of the federal Act, patients have long complained about the difficulty of getting care covered, especially when they are in no immediate danger.

As described by the federal court in *Wit*, the eight generally accepted standards of mental health and substance use disorder care require all of the following: (1) effective treatment of underlying conditions,

rather than mere amelioration of current symptoms, such as suicidality or psychosis; (2) treatment of co-occurring behavioral health disorders or medical conditions in a coordinated manner; (3) treatment at the least intensive and restrictive level of care that is safe and effective and meets the needs of the patient's condition; a lower level or less intensive care is appropriate only if it safe and just as effective as treatment at a higher level or service intensity; (4) erring on the side of caution, by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care, or when the recommended level of care is not available; (5) treatment to maintain functioning or prevent deterioration; (6) treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits; (7) accounting for the unique needs of children and adolescents when making level of care decisions; and (8) applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.

The ERISA class action challenged the guidelines used by United Behavioral Health (UBH) for adjudicating claims for outpatient and residential inpatient behavioral health treatment. The court ruled for plaintiffs and ordered UBH to "reprocess" 50K+ claims. The court's findings of fact in *Wit* were integral to criteria and standards established in SB 855. The Ninth Circuit just issued its third opinion superseding the two prior ones and making new law on ERISA class action procedure.

Key takeaways from the third opinion, which was published August 22, 2023 state that "reprocessing" is not available to get around individualized questions of whether class members are entitled to benefits; there is uncertainty on exhaustion and whether and when mandatory exhaustion requirements can be excused; and finally, the breach of fiduciary duty claim was remanded, which means there will be more litigation to come.

In response to *Wit* and to stop health plans from making overly restrictive medical necessity determinations, Senator Wiener introduced Senate Bill (SB) 855 in January 2020. The bill was enacted in September 2020. Although a subsequent federal case reversed *Wit*, the SB 855 statutes remain effective. SB 855 amended California's mental health parity statute, requiring commercial health plans and insurers in all markets to cover treatment for all medically necessary mental health and substance use disorder conditions.

These statutes established specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines when making medical necessity and level of care placement decisions for mental health or substance use disorder treatment. The purpose of SB 855 was to update mental health coverage standards, expand substance use disorder coverage requirements to health plans in the large group market, and provide enrollees with stronger mechanisms to use against health plans that do not provide timely and appropriate coverage.

Public Records Request

On February 1st 2023, a Public Records Act Request was sent to DMHC to provide the statistical information concerning DMHC's administration of the Independent Medical Review ("IMR") program and reports its aggregate data by year. The requested information was 1) The average time between DMHC's initial receipt of an enrollee's IMR application and DMHC's initial review of the application 2) The average time between DMHC's initial receipt of an IMR application and DMHC's determination that the application affirmatively qualifies for IMR and 3) The average time between DMHC's receipt of a

complete IMR application and DMHC's notification to the enrollee of MAXIMUS's clinical determination, amongst other request information.

DMHC responded to this PRA on March 6, 2023 saying that DMHC Help Center's case management system, Spotlight, is unable to generate data on the average time between DMHC's initial receipt of an enrollee's IMR application and DMHC's initial review of the application in an accurate and systematic manner, therefore this data cannot be produced. Spotlight is also unable to generate the requested IMR data by in-network vs. out-of-network services. The data is measured and being reported in calendar days. They concluded with this minimal information, that the CPRA request was fulfilled and closed the file.

Attached to the DMHC CPRA Request included charts with both the Standard and Expedited Mental Health and Medical IMR Data from January 1, 2016 through December 31, 2022. A standard IMR In 2022 took 19.4 calendar days for DMHC to receive; a standard mental health IMR, the initial request took 24.3 days to complete compared to a standard medical IMR which only takes 18.3 days. While expedited data shows that these requests are received in a timelier manner, mental health IMRs still fall behind. In 2022, an expedited IMR took 11.4 days for DMHC to receive. An expedited medical IMR takes 10.4 days to receive, but even an expedited mental health IMR falls behind at 15.4 days.

DMHC's Open Pending Regulations

The Department is now initiating this rulemaking action to implement, interpret, and make specific the medical necessity and utilization review requirements under SB 855 by repealing Rule 1300.74.72 adopt proposed Rules 1300.74.72, 1300.74.72.01, and 1300.74.721 in title 28 of the California Code of Regulations (CCR).

Overview of Proposed Regulation

The former Rule 1300.74.72 contains an outdated definition of "mental health disorders" and "omits substance use disorders." This Rule also does not have the most updated definition of medically necessary treatment of mental health conditions that is required by the statute and contained in the Rule being proposed by the Department.

Rules as proposed to be adopted

Proposed Rule 1300.74.72 specifies that plans shall cover medically necessary MH/SUD services which means that every health plan that provides hospital, medical, or surgical benefits shall also provide coverage for medically necessary MH/SUD under the same terms and conditions as applied to other medical conditions. The proposed Rule sets out the health plans' obligation to provide information regarding coverage of MH/SUD benefits in their Evidence of Coverage. This rule would also provide guidance for health plans regarding their obligation to arrange for out-of-network medically necessary MH/SUD services if medically necessary services are not available in-network.

Rule 1300.74.72.01 defines the scope of MH/SUD that health plans are required to cover.

Network coverage for MH/SUD services

The proposed Rule clarifies how a health plan shall arrange for in-network and out-of-network MH/SUD services. This is beneficial to enrollees because a health plan has clear requirements regarding what

actions the health plan shall take to arrange in-network or out-of-network MH/SUD services and the timeline for the health plan action regarding the MH/SUD service request. This will ensure that there will be minimal delay in enrollees receiving medically necessary MH/SUD services.

SB 855 represents a crucial change to MH/SUD coverage in the state of California. The proposed Rule adds essential clarification to SB 855. Most notably, a health plan will have to either utilize the specific tool developed by the non-profit association (NPA) to conduct utilization review or integrate the NPA criteria into internal utilization review procedures and have those procedures certified by the relevant NPA. In specifying that a health plan shall either use a tool developed by the NPAs or have their internal utilization review procedure vetted and approved by the NPAs that developed the criteria, the Department has ensured correct application of the NPA criteria for MH/SUD service decisions. In turn, this will limit the health plans' ability to restrict MH/SUD services and ensure that enrollees have access to medically necessary services.