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EXPANSION OF ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES (S.B. 855)

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On January 1, 2021, Senate Bill 855 took effect and requires health plans and disability insurers regulated by California to expand access to mental health and substance use disorder ("MH/SUD") services. For MH/SUD providers and their patients, S.B. 855 represents a significant and welcome strengthening of California's mental health parity law. Unlike under prior law, commercial health plans and disability insurers in California must now cover *all* mental health and SUD conditions at the same cost as physical health conditions. This legislation was motivated primarily to address insufficient coverage of MH/SUD conditions in existing health plans and health insurance policies.

This article presents a brief background to the passage of S.B. 855, a summary of each of its most significant provisions, and key takeaways from the author's perspective.

BACKGROUND TO SB 855

Mental health parity means health insurance coverage of mental health disorders on terms and conditions that are no less favorable than medical and surgical benefits. To take a simple example: if a health insurance plan covers medications, then it must cover medications not only for treatment of physical ailments but also medication to treat mental disorders. Another example: a health plan cannot make it more expensive to use mental health benefits by imposing out-of-pocket financial responsibility that is greater or more onerous than for medical and surgical benefits.

Generally speaking, the driving force behind mental health parity has been a gradual societal recognition that mental health disorders are a disease of the brain rather than a moral failing on the part of the person suffering from the condition. There is less stigmatization around drug and alcohol addiction; and it too is being recognized as a health condition that requires treatment to improve and hopefully overcome. Mental health parity legislation is part of an overall effort to shift the conversation about drug addiction away from being a criminal justice issue and instead towards being a public health crisis.

The legislative findings set forth in S.B. 855 expressly recognize the negative public health consequences when MH/SUD services are not adequately covered by insurance. According to the Legislature, 1 in 5 adults in the United States experiences a mental health disorder and 1 in 13 individuals 12 years of age or older experience a substance use disorder.[1] The Legislature also found that when these conditions go without treatment, the conditions worsen, people end up on Medicaid, in the criminal justice system, on the streets homeless and all too often in an early and tragic death.[2] Given the cost of health care, it is not surprising that many will forgo treatment if they have no insurance coverage.

S.B. 855 is not the first of its kind. In fact, S.B. 855 rewrites and expands on the California Mental Health Parity Act that was enacted in 1999 (the "1999 MHPA"). The 1999 MHPA required coverage of medically necessary treatment of nine listed severe mental illnesses, as well as serious emotional disturbances in children.

The law applied to health care service plans regulated by the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act, as well as disability health insurers regulated by the Department of Insurance. However, the 1999 MHPA was limited to the nine listed mental illnesses, which over twenty years later is considered incomplete, out of date and not encompassing the interaction between mental health and substance use disorders.

The 2008 federal parity law known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA") was significantly more robust than California's 1999 MHPA, and specifically applied to substance use disorders. Most significantly, the MHPAEA applies to plans governed by the federal ERISA law and therefore has wide ranging effect given that many Americans get their health insurance through their employers. Just a few years later, the 2010 federal Affordable Care Act ("ACA") made mental health and addiction coverage one of the essential health benefits that must be included in plans sold through an ACA marketplace.

A significant limitation with all of these laws, however, was the lack of a definition for medical necessity. The plans and insurance companies have always been free to develop their own criteria for determining medical necessity. Not surprisingly, many insureds and MH/SUD providers have faulted the insurance companies for making determinations of medical necessity that are overly restrictive and designed to cover as little treatment as possible. In *Wit v. United Behavioral Health,* a class action filed in 2014 in the Northern District of California on behalf of United Health policyholders, it was alleged that United Behavioral Health imposed overly restrictive medical necessity criteria for mental health and substance use disorders in violation of the MHPAEA.[3] In March 2019, following a bench trial, the court ruled that United created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care.[4] According to the court, United did this to mitigate against the cost of complying with the requirements of the federal parity law.

The *Wit* case is notable in no small measure because the legislative findings for S.B. 855 specifically referenced the court's factual findings regarding generally accepted standards of MH/SUD treatment.[5] Indeed, the California Legislature pointed out that the court in *Wit* found that all parties' expert witnesses considered the "prime examples of level of care criteria that are fully consistent with generally accepted standards" to be the American Society of Addiction Medicine (ASAM) criteria for SUD and Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Child and Adolescent Service Intensity Instrument (CASII), and Early Childhood Service Intensity Instrument (ECSII) criteria for mental health disorders.[6] These criteria will be the standards against which medical necessity determinations will be judged in the coming enforcement of S.B. 855 by the Department of Managed Health Care, the Department of Insurance, and the courts.

KEY PROVISIONS OF S.B. 855

S.B. 855 applies to California health plans that are regulated by the Department of Managed Health Care pursuant to the California Health & Safety Code and disability insurance policies that are regulated by the Department of Insurance pursuant to the California Insurance Code.[7] S.B. 855 does not appear to have any applicability to Medicare Advantage plans, Medi-Cal managed care plans, other government-sponsored plans, self-funded ERISA plans, or health insurance policies issued and regulated outside of California.

Coverage Expansion

The most immediate impact of S.B. 855 is that it expands coverage to all MH/SUD conditions under the same terms and conditions applied to other medical conditions. The law specifically defines "mental health and substance use disorders" to mean "a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders."[8] Consequently, all substance use disorders, depression, eating disorders, generalized anxiety disorders, and many others are now included within the scope of California's mental health parity law, which was not the case with the 1999 MHPA.

S.B. 855 clarifies that treatment of these covered MH/SUD conditions must be covered in the full spectrum of level of care setting when medically necessary, including inpatient residential treatment, partial hospitalization, intensive outpatient treatment, therapy sessions, and medication for managing covered conditions.[9] In addition, health plans and insurers are not permitted to limit benefits or coverage to "short-term or acute treatment."[10] While it remains to be seen whether plans and insurers will seek to limit the applicability of this prohibition to treatment on an individual case-by-case basis, the likely effect is that any plan term that purports to restrict coverage to short-term treatment will be invalidated. This is significant, because one of the main complaints from patients and providers is that plans and insurers often will not authorize more than a few weeks of inpatient residential care, thereby forcing a premature "step down" to an outpatient level of care when the patient is not ready.

Medical Necessity Criteria

As mentioned above, a major loophole in both the 1999 MHPA as well as the existing federal parity legislation is the absence of a medical necessity definition. Insurers and their administrators have consequently sought to deny or limit coverage of MH/SUD treatment by developing their own restrictive definitions of medical necessity.

S.B. 855 attempts to close that loophole by requiring uniformity in the determination of medical necessity for mental health and substance use disorder services. The law expressly defines "medically necessary treatment of a mental health or substance use disorder" as a "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" provided that three criteria are met.[11] First, the service must be in accordance with the generally accepted standards of care for MH/SUD disorders. Second, the service must be clinically appropriate in terms of type, frequency, extent, site, and duration. Third, the service must not be primarily for the economic benefit of the plan and subscribers, or for the convenience of the patient, treating physician or other health care provider.[12]

This definition may appear to leave insurance companies a fair amount of latitude to argue about what constitutes generally accepted standards of care. However, the enforcement of S.B. 855 will likely prove to be in favor of MH/SUD providers. Not only does S.B. 855 provide this definition of medical necessity, it defines "generally accepted standards of mental health and substance use disorder care" by reference to care and practice "generally recognized by health care providers practicing in the relevant clinical specialties."[13] This is significant. Disputes involving medical necessity criteria for MH/SUD services are common, and frequently arise in the context of post-payment audits from which the insurer demands a refund on the ground that the insurer's internal medical necessity criteria were not met. Going forward, for plans and policies subject to S.B. 855, the insurers will not be able to recoup money in this fashion unless they can show, at a minimum, that their criteria are consistent with published guidelines by nonprofit clinical associations. As a practical matter, plans and insurers are adopting ASAM criteria for SUD services and LOCUS for mental health disorders.[14]

Standard of Review

S.B. 855 prohibits and renders "void and unenforceable" language in health plan contracts that confer discretion on the plan or the plan's administrators to make benefits and coverage determinations that lead to a deferential standard of review by a reviewing court.[15] This is significant because courts have generally given deference to the decisions of plan administrators when reviewing coverage determinations. S.B. 855 appears to mandate that courts apply a de novo standard of review when interpreting health plan provisions to determine whether a coverage decision was correctly made. This will likely make it easier to bring claims alleging that plan administrators made a coverage determination that breached the plan.

Notably, this provision only appears in the Health & Safety Code; there is no corresponding provision in the Insurance Code, and therefore does not appear to apply to disability policies regulated by the Department of Insurance. Presumably the California Legislature was concerned that applying such a provision to fully insured ERISA plans would trigger

an ERISA preemption fight, because the doctrine of deferential standard of review is well-entrenched in ERISA jurisprudence.[16]

Out-of-Network Coverage

S.B. 855 also provides that where medically necessary services for MH/SUD are not available within the plan's existing network, then the plan or insurer must arrange to provide "services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards."[17] At the same time, they also must ensure that the enrollee's cost-sharing obligations, such as deductibles, are no higher for the out-of-network services than what the enrollee would pay for the same covered services received from an in-network provider.[18]

Simply put, if a plan enrollee or insured cannot access an in-network MH/SUD provider in his or her geographic area, then it will be incumbent upon the plan or insurer to allow for out-of-network services in the geographic area, or locate them outside the geographic area, without it costing the enrollee or insured more out of pocket. This is contrary to how plans normally work, as generally deductibles and coinsurance are higher when out-of-network services are accessed.

S.B. 855 does not clarify who gets to determine whether medically necessary treatment is available in-network in the patient's geographic area, nor does it mention the rights of out-of-network providers to be reimbursed for their services. Out-of-network providers may be incentivized to show that the MH/SUD services they rendered were not available to the patient within the plan's network. On the other hand, plans and insurers may attempt to limit reimbursement of out-of-network providers under these circumstances to the amounts that they would have paid to in-network providers. In the absence of guidance from the enforcement agencies around the issue of out-of-network coverage, litigation is likely to ensue.

Pre-Authorized Services

S.B. 855 also clarifies that health plans and insurers are prohibited from refusing to pay for medically necessary services that have been pre-authorized through utilization review.[19] This is true even if the plan or insurer has determined that treatment was authorized in error, including because it turns out that the patient was not eligible for benefits or the policy had lapsed for nonpayment of premium.

The rationale here is that the insurer is in the better position to make the correct decision about coverage and eligibility, and therefore the insurer should bear the cost of its mistake, not the healthcare provider. This principle is derived from a series of important court decisions, most notably *City of Hope Medical Center v. Superior Court,* (1992) 8 Cal.App.4th 633 (holding that hospital had no duty to repay insurer for uncovered experimental treatment where the provider was not at fault, had disclosed all material facts, and had changed its position in reliance on the insurer's actions).

This provision of S.B. 855 essentially mirrors already existing statutes applicable to health care plans and disability insurers.[20] Nonetheless, from the perspective of MH/SUD providers who have trouble getting paid for services for which they received prior authorization, this is a welcome reiteration of the law. Importantly, however, this requirement only applies where the services were rendered "in good faith" and "pursuant to" the authorization.[21] Thus, false or fraudulent claims will not be protected by this provision, nor will claims for services that were procured illegally such as through kickback arrangements.

LITIGATION AND LEGISLATIVE INITIATIVES IN THE WAKE OF S.B. 855'S ENACTMENT

Despite receiving bipartisan support in both houses, S.B. 855 was unsurprisingly opposed by health insurers and health plan associations. According to the California Association of Health Plans, S.B. 855 as drafted "will undermine clinically appropriate care, is missing important consumer protections, and will increase the cost of care for consumers."[22] With the passage of S.B. 855, the expectation is that plans and insurers will make the necessary changes to policies and practices to conform to the law's requirements. S.B. 855 mandates that plans and insurers engage in numerous internal measures to ensure and certify compliance with the law's requirements, including sponsoring education programs for staff and contractors regarding claims review, utilization management, and medical necessity determinations under the

standards required by S.B. 855.[23] Plans and insurers that refuse to make the necessary changes and fail to comply with S.B. 855 risk administrative penalties.[24]

Nonetheless, enforcement battles involving S.B. 855 are anticipated. Plans and insurers may decide to go to court to challenge the enforceability of certain aspects of S.B. 855. For example, insurers may try to argue that fully insured ERISA plans cannot be required to comply with certain requirements, such as the definition of medical necessity, because of the doctrine of federal preemption. And as mentioned above, litigation will likely ensue over the requirement that plans and insurers "arrange coverage" for out-of-network providers in certain circumstances, particularly around the issue of reimbursing out-of-network providers. The prohibition on plans and insurers limiting services to short-term and acute treatments also invites litigation given the current lack of specificity in the law on this topic.

In addition, because S.B. 855 is expressly built upon, in part, the trial court's findings in the *Wit* case, plans and insurers will be paying close attention to the outcome of the appeal of that decision, which, as of this writing, has been fully briefed and argued in the Ninth Circuit Court of Appeal.[25] A reversal of some or all of the trial court's decision could influence how S.B. 855 is interpreted and enforced by the regulatory agencies as well as by the courts.

For their part, MH/SUD providers and their patients will almost certainly invoke S.B. 855 at every opportunity when contesting adverse coverage determinations and denials based on lack of medical necessity. Although S.B. 855 does not provide for a private right of action, there are several paths available to providers and their patients to bring civil actions relating to wrongful denials and underpayments of MH/SUD services. California's unfair competition law (Business and Professions Code section 17200) may prove useful in seeking injunctive and declaratory relief. In addition, S.B. 855 specifically states that plans and insurers shall not enforce terms, in writing or in operation, that undermine, alter or conflict with any of the law's requirements.[26] Therefore, even if a provider or a patient could not point to a specific term of the insurance policy that was not being followed, the requirements of S.B. 855 would be implied in the policy and therefore any terms or operational practices that were inconsistent with S.B. 855 would arguably give rise to a claim for breach.[27]

As a result of S.B. 855, California now has the strongest mental health parity law in the country. But because the law is limited in scope and applicability to certain health plans and insurance products regulated by California agencies, the federal parity statutes remain the primary fallback for enforcing coverage of MH/SUD services. It remains to be seen whether S.B. 855 will inspire a significant expansion of federal mental health parity legislation. Given the relatively bipartisan support for covering MH/SUD services, there is a good chance that it will.

Indeed, it should not go unnoticed that Section 203 of the federal 2021 Consolidated Appropriations Act (CAA) that was signed into law on December 27, 2020 require that group health plans perform and document comparative analyses of the plans' design and application of what are known in the federal MHPAEA as "nonquantitative treatment limitations" or NQTLs.[28] NQTLs are limits that health plans place on benefits that are not tied to specific monetary or visit limits, such preauthorization for certain services, clinical criteria, etc. While Section 203 of the CAA did not match the ambition of S.B. 855 in terms of requiring uniform medical necessity determinations, it nonetheless is a small but notable step in the direction of further ensuring that group health plans are complying with the MHPAEA. It may also be an indication that more change is on the way at the federal level, which means that the implementation and enforcement of S.B. 855 will garner national attention.

CONCLUSION

By significantly expanding the legal obligations of health plans and insurers to cover MH/SUD treatment, S.B. 855 represents an important legislative step towards securing the rights of behavioral health providers and Californians who need their services. The momentum that led to the passage of S.B. 855 is expected to continue, both in California and nationally, in the coming years.

ENDNOTES

1 Stats. 2020, c. 151 (S.B. 855), § 1(d), eff. Jan. 1, 2021.
2 Id., § 1(f), (h).
3 Wit, et al. v. United Behavioral Health, Case No. 14-cv-02346-JCS (N.D. Cal.)
4 Wit, et al. v. United Behavioral Health, 2019 WL 1033730, Case No. 14-cv-02346-JCS (N.D. Cal. March 5, 2019).
5 The Legislature found: "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.
(8) Applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care."

Stats. 2020, c. 151 (S.B. 855), § 1(l), eff. Jan. 1, 2021.
6 Id. § 1(m).
7 S.B. 855 added Health & Safety Code sections 1367.045, 1374.72 and 1374.721; and Insurance Code sections 10144.5 and 10144.52.
8 Health & Safety Code § 1374.72(a)(2); Insurance Code § 10144.5(a)(2).
9 Health & Safety Code § 1374.72(b); Insurance Code § 10144.5(b).
10 Health & Safety Code § 1374.72(a)(6); Insurance Code § 10144.5(a)(6).
11 Health & Safety Code § 1374.72(a)(3)(A); Insurance Code § 10144.5(a)(3)(A).
12 Id.
13 Health & Safety Code §§ 1374.72(a)(2), 1374.721(f)(1); Insurance Code §§ 10144.5(a)(2), 10144.52(f)(1).
14 In fact, on January 5, 2021, the Department of Managed Health Care issued an "All Plan Letter" in which it listed ASAM, LOCUS and other nonprofit association criteria and guidelines that must be applied "to any and all relevant initial denials or modifications" for services as of January 1, 2021. The All Plan Letter is available at: https://www.dmhc.ca.gov/Portals/0/Docs/DO/APL21-002-SB-855MH-SUDCoverage.pdf
15 Health & Safety Code § 1367.045(a).
16 See, e.g., Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 675-76 (9th Cir. 2011).
17 Health & Safety Code § 1374.72(d); Insurance Code § 10144.5(d).
18 Id.
19 Health & Safety Code § 1374.72(a)(8); Insurance Code § 10144.5(a)(8).
20 Health & Safety Code § 1371.8; Insurance Code § 796.04.
21 Health & Safety Code § 1374.72(a)(8); Insurance Code § 10144.5(a)(8).
22 CAHP Implementation Guideline for SB 855, available at: https://www.calhealthplans.org/wp-content/uploads/2020/11/SB-855.pdf
23 Health & Safety Code § 1374.721(e); Insurance Code § 10144.52(e).
24 Health & Safety Code § 1374.721(i); Insurance Code §§ 10144.5(j), 10144.52(i).
25 Wit, et al. v. United Behavioral Health, Case No. 20-17363 (9th Cir.)
26 Health & Safety Code § 1374.72(i); Insurance Code § 10144.5(i).
27 As is well known in the industry, a provider can pursue a breach claim against the plan if the plan member has assigned the plan and its benefits to the provider.
28 Pub. L. No. 116-260, December 27, 2020, 134 Stat. 1182, § 203.

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