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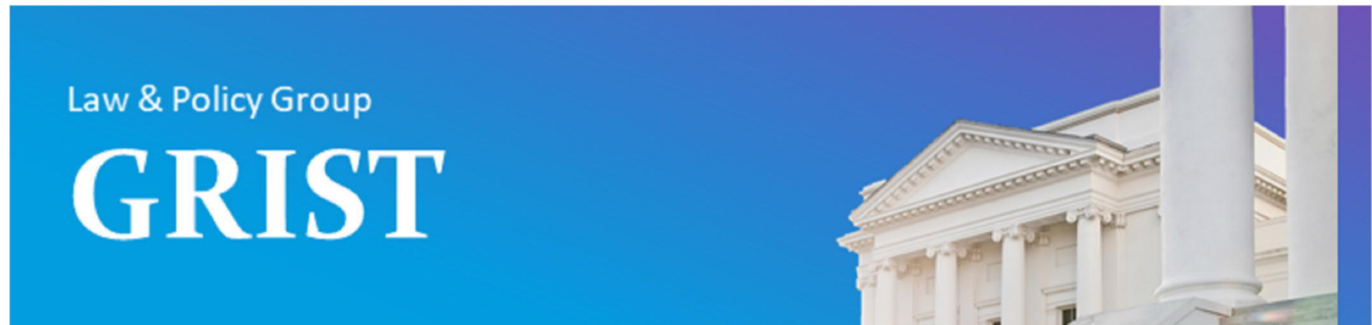

California broadens its mental health parity law

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California's mental health and substance use disorder insurance requirements expanded effective Jan. 1, 2021, under legislation (SB 855, 2020 Ch. 151) meant to update and align the state law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). The changes also respond to recent litigation involving improper denial of mental health claims.

Key court ruling

In a 2019 ruling, a California federal court held that a mental health benefit administrator applied overly narrow guidelines in violation of ERISA claims review and fiduciary standards when determining whether requested services like residential treatment conformed to generally accepted standards of care (*Wit v. United Behavioral Health*, No. 14-cv-02346-JCS (N.D. Cal., Feb. 28, 2019)). The court later issued an order requiring the administrator for insured and self-insured plans to correct ERISA violations by reprocessing more than 67,000 denied claims.

Replacing old standards

Partly in response to the *Wit* case, the California legislation replaces the state's previous requirements that limited the mental health condition parity obligations. The law used to require coverage to diagnose and treat defined severe mental illnesses in a person of any age or serious emotional disturbances in a child. Benefits had to include outpatient services, inpatient hospital services, partial hospital services and prescription drugs when the plan includes drug coverage. Parity requirements applied only to terms and conditions relating to patient financial responsibilities.

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The revised requirements significantly broaden mandated coverage standards. For example, the law now prohibits insurers from limiting coverage for mental health and substance use disorders to short-term or acute treatment.

Regulatory guidance

Under guidance from the departments of Managed Health Care and Insurance, health insurance policies and contracts issued or renewed in California on or after Jan. 1, 2021, must provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions that apply to medical conditions.

Insured plans now must cover medically necessary prevention, diagnosis, and treatment of all mental health conditions and substance use disorders listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) or the *International Statistical Classification of Diseases* (ICD-10). The regulatory guidance also defines medical necessity for purposes of the coverage mandate, prohibits limiting coverage to short-term or acute treatment, and requires adherence to network adequacy standards.

Safe harbor guidelines

The new law limits how insurers can define medical necessity for utilization reviews of mental health claims. Insurers cannot use their own clinical guidelines to make claim decisions and instead must use the latest independent guidelines developed by a nonprofit entity.

Agency guidance requires carriers to submit to the state the nonprofit guidelines used for claim decisions, and the state provides a list of guidelines that, if used, will operate as a safe harbor for showing compliance. For instance, use of the World Professional Association for Transgender Health (WPATH) clinical guidelines for gender dysphoria treatment is listed as a safe harbor. The state will consider insurers using this guideline for utilization review of relevant claims as complying with the new law. Insurers using guidelines not on the safe harbor list must demonstrate how use of the alternate guidelines complies with the new law.

Plan sponsor impact

The change in the California law could affect insured health coverage that employers purchase in the state for their employees but won't have a direct impact on self-insured plans. However, the broader implications of the *Wit* ruling and increased state enforcement of MHPAEA standards could have consequences for self-insured plans. For example, some carriers that also provide third-party administrative services to self-insured plans might change their utilization-review criteria to comply with this state insurance law. Plan sponsors may want to review the implications of these developments with their insurers and plan administrators.

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Related resources

Non-Mercer resources

- All Plan Letter 21-002 (CA Department of Managed Health Care, Jan. 5, 2021)
- Insurance notice (CA Commissioner of Insurance, Dec. 10, 2020)
- Equal treatment: A review of mental health parity enforcement in California (CA Health Care Foundation, Sept. 11, 2020)

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- Mental health parity compliance gets a boost in 2021 spending act (Jan. 25, 2021)
- Mental health parity FAQs address nonquantitative limits, disclosures (Dec. 17, 2019)

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