SB 22 (Beall) – Health Care Coverage: Mental Health Parity

Introduced December 3, 2012, Amended May 28, 2013

This bill requires health plans and health insurers (collectively referred to as carriers) to submit annual reports to the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) certifying their compliance with state and federal mental health parity laws.

Existing law:

1. Requires carriers that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. Requires these benefits to include outpatient services, inpatient hospital services, partial hospital services, prescription drugs, if the carrier contract includes coverage for prescription drugs.

2. Lists the conditions that are defined as having a "severe mental illnesses."

3. Requires the terms and conditions applied to the benefits required to be applied equally to all benefits under the carrier contract.

4. Requires, under the federal Patient Protection and Affordable Care Act (ACA), the Secretary of the federal Department of Health and Human Services to define the essential health benefits.

5. Requires, under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), group carriers that cover mental health or substance use disorders (MH/SUD) to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

6. Provides for the regulation of health insurers by CDI under the Insurance Code and provides for the regulation of health plans by DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

This bill:

1. Requires on or after July 1, 2014, carriers to submit consolidated annual reports to DMHC and CDI certifying compliance with MHPAEA, its implementing regulations, and all federal guidance.

2. Requires the annual report to be a public record made available upon request and to be published on DMHC's and CDI's Web sites.

3. Permits DMHC and CDI to hold public hearings on the reports at its discretion.

4. Requires the annual report to provide an analysis of the plan's or contractor's compliance with MHPAEA using all of the elements set forth in those provisions of law, as well as the mental health parity standards (P-MHP 1, P-MHP 2, and P-MHP 3) of the American Accreditation HealthCare Commission (now known as URAC) Health Plan Accreditation Guide, Version 7, or any subsequent versions.

5. Requires, as a part of the annual report, carriers to conduct:
   A. A survey of enrollees to collect responses pertaining to enrollee experiences with mental health and substance use care; and
   B. A survey of providers to collect responses pertaining to provider experiences with providing mental health and substance use care.
      1. Requires carriers to use the compliance criteria set forth in the URAC mental health parity standards to structure the surveys.
      2. Prohibits the annual reports from including any information that may individually identify enrollees including, but not limited to, medical record numbers, names, and addresses.
      3. Exempts Medi-Cal contracts from the provisions of this bill.

Background:

State and federal mental health parity law. There are three separate provisions of law on carrier coverage of mental health. Under current state law, as enacted by AB 88 (Thomson, Chapter 534, Statutes of 1999) carriers are required to cover the diagnosis and medically necessary treatment of "severe mental illness" of a person of any age, and of "serious emotional disturbances" of a child. Coverage is required to be at parity - under the same terms and conditions applied to other medical conditions. California's current mental health parity law applies to the large group, small group, and individual (non-group) markets.

Under the federal MHPAEA of 2008, carriers providing group coverage that cover MH/SUD must provide coverage that is no more restrictive than coverage for other medical/surgical benefits. MHPAEA does not require a carrier to provide MH/SUD benefits. Rather, if a carrier provides medical/surgical and MH/SUD benefits, it must comply with MHPAEA's parity requirements. The federal law applies to all group carriers, but small groups with 50 or fewer employees are exempt. The federal Department of Labor, Department of Health and Human Services, and the United States Treasury collectively promulgated interim final regulations on February 2, 2010 to implement the provisions of MHPAEA. Final regulations are anticipated by the end of this year to provide further guidance to clarify certain requirements to assist the marketplace with the implementation of and compliance with MHPAEA.

The ACA explicitly includes MH/SUD services, including behavioral health treatment, as one of the 10 categories of service that must be covered as essential health benefits. The ACA further mandates that MH/SUD benchmark coverage be provided at parity with other medical and surgical benefits offered by carriers, pursuant to MHPAEA.

URAC. URAC, a nonprofit independent health care accreditation agency, recently released accreditation standards that have incorporated MHAPEA and the interim federal regulations that govern the statute. According to the author's office, the inclusion of the federal parity law and its regulations in these accreditation standards provides an additional level of oversight on MHPAEA compliance for carriers.

State Oversight of Compliance. The two state agencies that have primary oversight of carrier compliance with state and federal mental health parity laws and their implementing regulations are DMHC and CDI. At least once every three years, DMHC conducts a Routine Medical Survey of a plan which includes a review of the plans policies and procedures and the overall performance of the plan in providing health care benefits and meeting the health needs of its enrollees. Similarly, CDI routinely conducts Market Conduct Examinations. Individuals covered by carriers in California are also entitled to an Independent Medical Review (IMR) if a carrier denies health care services or payment for health care services based on medical necessity. DMHC and CDI administer the IMR program to enable consumers to request an impartial appraisal of medical decisions within certain guidelines specified in law. An IMR can only be requested if the carrier's decision involves the medical necessity of a treatment, an experimental or investigational therapy for certain medical conditions, or a claims denial for emergency or urgent medical services.

AMENDED IN SENATE APRIL 2, 2013

AMENDED IN SENATE FEBRUARY 26, 2013

SENATE BILL No. 22

Introduced by Senator Beall
(Coauthors: Senators Correa, De León, DeSaulnier, and Yee)
(Coauthors: Assembly Members Ammiano and Chesbro)

December 3, 2012

An act to add Section 1374.18 to the Health and Safety Code, and to add Section 10144.53 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 22, as amended, Beall. Health care coverage: mental health parity.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts or health insurance policies issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.

Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all

medical and surgical benefits. Existing state law requires individual and small group health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2014, to comply with MHPAEA.

This bill would, on or after July 1, 2014, require every health care service plan, contractor of a health service plan, and health insurer to submit an annual report to the Department of Managed Health Care or the Department of Insurance, as appropriate, certifying compliance with specified state laws and the MHPAEA, except as provided. The bill would require the reports to be a public record made available upon request and to be published on the respective department's Internet Web site. The bill would require a plan, contractor, and health insurer to provide an analysis of the entity's compliance with the law using certain mental health parity standards and to conduct surveys of enrollees, insureds, and providers as part of the report, as specified. *The bill would prohibit the inclusion of any information that may individually identify enrollees or insureds in the reports submitted to the respective departments pursuant to the provisions described above.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.18 is added to the Health and Safety Code, to read:

1374.18. (a) On and after July 1, 2014, every health care service plan and contractor of a health care service plan shall submit an annual report to the department certifying compliance with Section ~~1274.72~~ *1374.72* and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), hereafter referred to as the MHPAEA, its implementing regulations, and all related federal guidance. The annual report shall be a public record made available upon request and shall be published on the department's Internet Web site. The department may hold public hearings on the reports at its own discretion or at the request of any person.

(b) The report shall provide an analysis of the plan's or contractor's compliance with Section ~~1274.72~~ *1374.72* and the MHPAEA using all of the elements set forth in those provisions of law, as well as in standards P-MHP 1, P-MHP 2, and P-MHP

3 of the American Accreditation HealthCare Commission (URAC) Health Plan Accreditation Guide, Version 7, or any subsequent versions.

(c) (1) As part of the report, a plan or contractor shall conduct both of the following:

(A) A survey of enrollees to collect responses pertaining to enrollee experiences with mental health and substance use care.

(B) A survey of providers to collect responses pertaining to provider experiences with providing mental health and substance use care.

(2) The plan or contractor shall use the compliance criteria set forth in the URAC *mental health parity* standards described in subdivision (b) to structure the surveys.

(d) A report submitted to the department pursuant to this section shall not include any information that may individually identify enrollees, including, but not limited to, medical record numbers, names, and addresses.

~~(d)~~

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of *Part 3 of* Division 9 ~~of Part 3~~ of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

SEC. 2. Section 10144.53 is added to the Insurance Code, to read:

10144.53. (a) On and after July 1, 2014, every health insurer shall submit an annual report to the Department of Insurance certifying that its health insurance policies comply with Section 10144.5 and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), hereafter referred to as the MHPAEA, its implementing regulations, and all related federal guidance. The annual report shall be a public record made available upon request and shall be published on the department's Internet Web site. The department may hold public hearings on the reports at its own discretion or at the request of any person.

(b) The report shall provide an analysis of the insurer's compliance with Section 10144.5 and the MHPAEA using all of the elements set forth in those provisions of law, as well as in

standards P-MHP 1, P-MHP 2, and P-MHP 3 of the American Accreditation HealthCare Commission (URAC) Health Plan Accreditation Guide, Version 7, or any subsequent versions.

(c) (1) As part of the report, an insurer shall conduct both of the following:

(A) A survey of insureds to collect responses pertaining to insured's experiences with mental health and substance use care.

(B) A survey of providers to collect responses pertaining to provider ~~experience~~ *experiences* with providing mental health and substance use care.

(2) The insurer shall use the compliance criteria set forth in the URAC mental health parity standards described in subdivision (b) to structure the surveys.

(d) A report submitted to the department pursuant to this section shall not include any information that may individually identify insureds, including, but not limited to, medical record numbers, names, and addresses.

~~(d)~~

(e) This section shall not apply to policies or health benefit plans issued pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of *Part 3 of* Division 9 ~~of Part 3~~ of the Welfare and Institutions Code, between the State Department of Health Care Services and an insurance policy or health benefit plan for enrolled Medi-Cal beneficiaries.

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