

- 5) Defines “serious emotional disturbances of a child” as meeting both of the following (HSC §1374.72(e), IC §10144.5(e)):
 - a) The child has one or more mental disorders as identified in the most recent Diagnostic and Statistical Manual of Mental Disorders (other than a primary substance use disorder or developmental disorder) that result in inappropriate behavior to the child’s age according to expected developmental norms; and
 - b) The child meets the criteria specified in Welfare and Institutions Code (WIC) §5600.3(a)(2) as follows:
 - The child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either the child is at risk of removal from home or has already been removed from the home, or the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; and/or
 - The child displays psychotic features, risk of suicide, and/or risk of violence due to a mental disorder; and/or
 - The child has been assessed and determined to have an emotional disturbance, as defined in specified sections of the Education code or Federal regulations.
- 6) Exempts certain Medi-Cal plans from the above requirements. Also exempts accident only, specified disease, hospital indemnity, Medicare supplement, dental only or vision only insurance policies from the requirements. (HSC §1374.72(f), IC §10144.5(g))
- 7) Allows a plan to comply with the above requirements by providing coverage for all or part of the required mental health services through a separate specialized health care service plan or mental health plan. (HSC §1374.72(g)(1), IC §10144.5(f)(1))
- 8) Requires a plan or insurer to provide the required mental health coverage in its entire service area and in emergency situations as required in law and regulations. However, if they provide benefits through preferred provider contract arrangements, they may require enrollees who live or work in geographic areas to secure all or part of their mental health services within those geographic areas. (HSC §1374.72(g)(2), IC §10144.5(f)(2))
- 9) Permits a health care service plan or disability insurer to utilize specified tools such as case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing. (HSC §1374.72(g)(3), IC §10144.5(f)(3))

- 10) The Pall Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), known as MHPAEA, is a federal law that requires group health plans that offer mental health or substance use disorder benefits to ensure financial requirements (i.e. copays and deductibles) and treatment limitations (i.e. visit limits) for mental health or substance use disorders are not more restrictive than the requirements on all other covered medical benefits. The federal MHPAEA applies to insurance plans with more than 50 employees.

This Bill:

- 1) States that any provision in a health care service plan that reserves discretionary authority to the plan to determine eligibility for benefits/coverage, to interpret terms of the contract, or provide standards of interpretation or review that are inconsistent with California law is void and unenforceable. This applies to plans offered, issued, delivered, amended, or renewed on or after January 1, 2021. (HSC §1367.045(a))
- 2) Defines “discretionary authority” as a contract provision that confers discretion on a health plan or other claims administrator to determine entitlement to benefits or interpret contract language that could lead to a deferential standard of review by a reviewing court. (HSC §1367.045(b))
- 3) States that a health care service plan is not prohibited from including a provision in a contract that informs an enrollee that the plan applies the terms of its contracts for making decisions, including determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures and processes, as long as the provision could not give rise to a deferential standard of review by a reviewing court. (HSC §1367.045(c))
- 4) Requires every health care service plan contract or disability insurance policy issued, amended or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage, to also provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions. (Health and Safety Code (HSC) §1374.72(a)(1), Insurance Code (IC) §10144.5(a)(1))
- 5) States that “mental health and substance use disorders” means 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 listed in the most recent version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. (HSC §1374.72(a)(2), IC §10144.5(a)(2))

- 6) States that “medically necessary treatment of a mental health or substance use disorder” means a service or product prescribed, ordered or provided by a treating physician or other health care provider for the patient’s specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms - including minimizing its progression – in a manner that is all of the following (HSC §1374.72((a)(3), IC §10144.5(a)(3)):
 - a) In accordance with generally accepted standards of mental health and substance use disorder care;
 - b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and
 - c) Not primarily for the economic benefit of the health care service plan or disability insurance policy and its subscribers/insureds or for the convenience of the patient, treating physician, or other health care provider.

- 7) Defines a “health care provider” as any of the following (HSC §1374.72(a)(4), IC §10144.5(a)(4)):
 - a) A person licensed under Division 2 of the Business and Professions Code. (This includes LMFTs and AMFTs, LEPs, LCSWs and ASWs, and LPCCs and APCCs.)
 - b) An AMFT or marriage and family therapist trainee functioning pursuant to BPC §4980.43.3.
 - c) A qualified autism service provider or professional certified by a national entity pursuant to HSC §1374.73 and IC §10144.51.
 - d) An associate clinical social worker functioning pursuant to BPC §4996.23.2.
 - e) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to BPC §4999.46.3.

- 8) Prohibits a health care service plan or disability insurer from limiting benefits or coverage for mental health and substance use disorders to short term or acute treatment. (HSC §1374.72(a)(6), IC §10144.5(a)(6))

- 9) Requires all medical necessity determinations by the health care service plan or disability insurer concerning the following for enrollees/insureds diagnosed with mental health and substance use disorders to be conducted in accordance with the requirements specified in HSC 1374.721 and 10144.52. (HSC §1374.72(a)(7), IC: §10144.5(a)(7))
 - a) Service intensity;

- b) Level of care placement;
 - c) Continued stay; and
 - d) Transfer or discharge of enrollees/insureds
- 10) Prohibits a health care service plan or disability insurer that authorizes a specific type of treatment from rescinding or modifying the authorization after care is rendered for any reason. (HSC §1374.72(a)(8), IC §10144.5(a)(8))
 - 11) Requires the covered benefits to include basic health care services, intermediate services (including residential treatment, partial hospitalization, and intensive outpatient treatment), and prescription drugs (if the plan includes coverage for prescription drugs). (HSC §1374.72(b), IC §10144.5(b))
 - 12) Requires the terms and conditions for benefits that must be applied equally include maximum annual and lifetime benefits, copayments and coinsurance, individual and family deductibles, and out-of-pocket maximums. (HSC §1374.72(c), IC §10144.5(c))
 - 13) Requires the health care service plan or disability insurer to arrange coverage of out-of-network services if the medically necessary services are not available in-network within geographic and timely access standards. The enrollee or insured shall pay no more than the same cost-sharing that they would pay for the same services received in-network. (HSC §1374.72(d), IC §10144.5(d))
 - 14) Exempts certain Medi-Cal plans from the above requirements. Also exempts accident only, specified disease, hospital indemnity, Medicare supplement, dental only or vision only insurance policies from the requirements. (HSC §1374.72(e), IC §10144.5(e))
 - 15) Allows a plan or insurer to comply with the above requirements by providing coverage for all or part of the required mental health and substance use disorder services through a separate specialized health care service plan or health insurance policy or mental health plan or policy. (HSC §1374.72(f)(1), IC §10144.5(f)(1))
 - 16) Requires a plan or disability insurer to provide the required mental health and substance use disorder coverage in its entire service area and in emergency situations as required in law and regulations. However, if they provide benefits through preferred provider contract arrangements, they may require enrollees who live or work in geographic areas to secure all or part of their mental health services within those geographic areas, if the appropriate mental health or substance use disorder services are available in those geographic areas within timeliness standards. (HSC §1374.72(f)(2), IC §10144.5(f)(2))

- 17) Permits a health care service plan or disability insurer to utilize specified tools such as case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing. (HSC §1374.72(f)(3), IC §10144.5(f)(3))
- 18) Prohibits a health care service plan or disability insurer from limiting benefits or coverage for medically necessary services on the basis that it should or could be covered by a public entitlement program. (HSC §1374.72(h), IC §10144.5(h))
- 19) Requires health care service plans and disability insurers that provide hospital, medical, or surgical coverage to base medical necessity determinations or utilization review criteria for mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. (HSC §1374.721(a), IC §10144.52(a)):
- 20) Sets specific standards and requirements for conducting utilization review. (HSC §1374.721(b)-(e), IC §10144.52(b)-(e)):
- 21) Defines “generally accepted standards of mental health and substance use disorder care” as standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine, counseling, and behavioral health treatment. (HSC §1374.721(f), IC §10144.52(f))

Comments:

- 1) **Author’s Intent.** The author’s office provided the following statement for the Legislature’s analysis of this bill:

“California should require insurers to cover all medically necessary mental health and addiction treatment. It is unacceptable that insured individuals cannot access the health services they desperately need. Currently, California law only requires commercial health plans to cover all medically necessary treatment for a limited number of mental health (but no substance use) disorders. By updating the California Mental Health Parity Act, we can treat mental health and substance use disorders early on – combating overdose deaths, suicides, and saving lives. It is time to update the California Mental Health Parity Act to cover all mental health and substance use disorders. Additionally, for covered mental health and substance use services, insurers should be required to evaluate medical necessity (e.g., the appropriate level of care) using criteria that are fully consistent with generally accepted standards of mental health and addiction care.”

- 2) **Previous Position.** At its June 5, 2020 meeting, the Board voted to take a “support” position on a previous version of this bill.

Separate from its “support” position, the Board also directed staff to ask the author’s office to consider amendments related to the definition of a “health care provider.”

3) Definition of “Health Care Provider.” In the previously considered version of the bill, HSC section 1374.72(a)(4) and IC section 10144.5(a)(4) specifically included associate marriage and family therapists and marriage and family therapist trainees in the definition of a “health care provider” for purposes of the bill. Separate from its “support” position, the Board requested the following:

- That associate social workers and associate professional clinical counselors also be included in the definition for consistency, if associate marriage and family therapists are to be included.
- That marriage and family therapist trainees be removed from the definition of a “health care provider” for purposes of the bill. The Board had concerns about trainees, who are still in school and have not graduated from their master’s degree program yet, being considered full-fledged health care providers.

Staff spoke with the author’s office and the Senate Health Committee staff member who included the definition. The committee staff member explained that the definition being used is the same as that already used for the definition of health care provider for purposes of telehealth used in BPC Section 2290.5(a)(3) **(Attachment A)**. She has concerns about removing MFT trainees from the language, citing that when the 2290.5 definition was developed for telehealth, MFT trainees needed to be included because some autism service providers are MFT trainees, and if they weren’t included that would potentially cause unintended limitations for autism providers.

4) Submitted Amendments. The author’s office asked staff to provide suggested amendments and noted that they were needed before the next Board meeting on August 14th, due to legislative deadlines. Staff provided the author the following amendments to the definition of a “health care provider”, with the caveat that the Board would reconsider the trainee issue on August 14th. These have been included in the current version of the bill that the Board is considering today:

- Add the following to HSC §1374.72(a)(4):
[\(D\) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.](#)
[\(E\) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.](#)
- Add the following to IC §10144.5(a)(4):
[\(D\) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.](#)

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

5) Previous Legislation. AB 88 (Chapter 534, Statutes of 1999) required health plans and insurers to provide coverage for the diagnosis and medically necessary treatment of severe mental illness (for persons of any age), and for serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions.

Support and Opposition:

Support

The Kennedy Forum (sponsor)

Steinberg Institute (sponsor)

Ricardo Lara, California Insurance Commissioner
Alkermes, Inc.

American Foundation for Suicide Prevention

Anaheim Lighthouse

APLA Health

Association of Regional Center Agencies

Autism Speaks

Board of Behavioral Sciences

Cal Voices (formerly NorCal MHA)

California Academy of Child and Adolescent Psychiatry

California Academy of Physician Assistants

California Access Coalition

California Alliance of Child and Family Services

California Association of Alcohol and Drug Program Executives, Inc.

California Association of Local Behavioral Health Boards and Commissions.

California Association of Marriage and Family Therapists

California Association of Public Hospitals & Health Systems

California Association of Veteran Service Agencies

California Children's Hospital Association

California Children's Trust

California Consortium of Addiction Programs and Professionals

California Council of Community Behavioral Health Agencies

California Judges Association

California LGBTQ Health and Human Services Network

California Narcotic Officers' Association

California Pan - Ethnic Health Network

California Psychiatric Association

California Psychological Association

California Society of Addiction Medicine

California State Association of Counties

California State Council of Service Employees International Union (SEIU California)

California State PTA
Center for Autism and Related Disorders
Children Now
City of San Jose
Congress of California Seniors
County Behavioral Health Directors Association
Crestwood Behavioral Health Inc.
Depression and Bipolar Support Alliance California
Disability Rights California
Drug Policy Alliance
Equality California
Friends Committee on Legislation of California
Glide
Hathaway-Sycamores
Health Access California
Helpline Youth Counseling, Inc.
Latino Coalition for A Healthy California
Legal Action Center
Los Angeles County Chief Executive Office
Mental Health & Autism Insurance Project
Mental Health America of California
Mental Health America of Los Angeles
Mental Health and Autism Insurance Project
Mental Health Services Oversight and Accountability Commission
Momentum United
National Alliance on Mental Illness (NAMI) California
NAMI Solano County
NAMI Yolo County
National Association of Social Workers, California Chapter
National Center for Youth Law
National Health Law Program
Orange County Recovery Collaboration
Planned Parenthood Affiliates of California
Shatterproof
Sutter Health
Western Center on Law & Poverty

Oppose

Advocates for Responsible Treatment
America's Health Insurance Plans
California Chamber of Commerce

History:

2020

08/06/20 Read second time and amended. Re-referred to Com. on APPR.

08/05/20 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (August 4).

07/27/20 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

06/29/20 Referred to Com. on HEALTH.

06/25/20 In Assembly. Read first time. Held at Desk.

06/25/20 Read third time. Passed. (Ayes 30. Noes 5.) Ordered to the Assembly.

06/22/20 Read second time. Ordered to third reading.

06/18/20 Read second time and amended. Ordered to second reading.

06/18/20 From committee: Do pass as amended. (Ayes 5. Noes 2.) (June 18).

06/11/20 Set for hearing June 18.

06/09/20 June 9 hearing: Placed on APPR. suspense file.

06/03/20 Set for hearing June 9.

06/02/20 Hearing rescheduled due to Capitol closure.

05/26/20 Set for hearing June 1.

05/19/20 Read second time and amended. Re-referred to Com. on APPR.

05/18/20 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 7. Noes 2.) (May 13).

05/12/20 Referral to Com. on JUD. rescinded due to the shortened 2020 Legislative Calendar.

05/11/20 Set for hearing May 13.

05/05/20 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

01/22/20 Referred to Coms. on HEALTH and JUD.

01/15/20 From printer. May be acted upon on or after February 14.

01/14/20 Introduced. Read first time. To Com. on RLS. for assignment. To print.

Attachment

Attachment A: BPC §2290.5(a)(3): Definition of a "Health Care Provider" for Purposes of Telehealth link here:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC

AMENDED IN ASSEMBLY AUGUST 6, 2020

AMENDED IN ASSEMBLY JULY 27, 2020

AMENDED IN SENATE JUNE 18, 2020

AMENDED IN SENATE MAY 19, 2020

AMENDED IN SENATE MAY 5, 2020

SENATE BILL

No. 855

Introduced by Senator Wiener

(Principal coauthor: Senator Beall)

(Principal coauthors: Assembly Members Aguiar-Curry and Chiu)

(Coauthors: Senators Galgiani, Glazer, Hill, and Hurtado)

(Coauthors: Assembly Members Arambula, Maienschein, and Wicks)

January 14, 2020

An act to add Sections 1367.045 and 1374.721 to, and to repeal and add Section 1374.72 of, the Health and Safety Code, and to add Section 10144.52 to, and to repeal and add Section 10144.5 of, the Insurance Code, relating to health coverage.

legislative counsel's digest

SB 855, as amended, Wiener. Health coverage: mental health or substance use disorders.

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 and makes a willful violation of the act a crime. Existing law also provides for the regulation of disability insurers by the Department of Insurance.

Existing law, known as the California Mental Health Parity Act, requires every health care service plan contract or disability insurance

policy issued, amended, or renewed on or after July 1, 2000, that provides 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, as specified. Existing law requires those benefits to include, among other things, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the plan contract or policy includes coverage for prescription drugs.

This bill would revise and recast those provisions, and would instead require a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. The bill would prohibit a health care service plan or disability insurer from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment. The bill would revise the covered benefits to include basic health care services, as defined, intermediate services, and prescription drugs.

This bill would require a health care service plan or disability insurer that provides hospital, medical, or surgical coverage to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care. The bill would require the health care service plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits and would prohibit the plan or insurer from applying different, additional, or conflicting criteria than the criteria and guidelines in the specified sources. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. The bill would make any provision in a health care service plan issued, delivered, amended, or renewed on or after January 1, 2021, that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, interprets the terms of

the contract. This provision shall not be of interpretation or restriction that are inconsistent with California law, void and unenforceable, as specified. The bill would declare that its provisions are severable.

Because a willful violation of these requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) The California Mental Health Parity Act (Section 1374.72
4 of the Health and Safety Code and Section 10144.5 of the Insurance
5 Code) was enacted in 1999 to require coverage of all diagnosis
6 and medically necessary treatment of nine listed severe mental
7 illnesses, as well as serious emotional disturbances of a child.
8 However, this list of nine severe mental illnesses is not only
9 incomplete and out-of-date, but also fails to encompass the range
10 of mental health and substance use disorders whose complex
11 interactions are contributing to overdose deaths from opioids and
12 methamphetamines, the increase in suicides, and other so-called
13 deaths of despair.

14 (b) Following the California Mental Health Parity Act, the
15 federal Paul Wellstone and Pete Domenici Mental Health Parity
16 and Addiction Equity Act of 2008 put in place even more robust
17 mental health parity protections, which also applied to substance
18 use disorders, making the most important provision of the
19 California Mental Health Parity Act its coverage requirement for
20 medically necessary treatment for severe mental illnesses and
21 serious emotional disturbances of a child.

22 (c) The federal Affordable Care Act (ACA) includes mental
23 health and addiction coverage as one of the 10 essential health
24 benefits, but it does not contain a definition for medical necessity,

1 and despite the ACA, needed mental health and addiction coverage
2 can be denied through overly restrictive medical necessity
3 determinations.

4 (d) With one in five adults in the United States experiencing a
5 mental health disorder and 1 in 13 individuals 12 years of age or
6 older experiencing a substance use disorder, it is critical for the
7 California Mental Health Parity Act to be expanded to apply to all
8 mental health and substance use disorders, as defined by
9 preeminent national and international bodies.

10 (e) The conditions currently listed in the California Mental
11 Health Parity Act, including autism, are all included in the broader
12 definition of mental health and substance use disorders.

13 (f) When medically necessary mental health and substance use
14 disorder care is not covered, individuals with mental health and
15 substance use disorders often have their conditions worsen, ending
16 up on Medicaid, in the criminal justice system, or on the streets,
17 resulting in harm to individuals and communities, and higher costs
18 to taxpayers.

19 (g) In 2016, approximately 6,000,000 veterans in the United
20 States had private health care coverage, making it critical to ensure
21 that the veterans' private health plans cover all medically necessary
22 treatment for the invisible wounds of war.

23 (h) Expansion of the California Mental Health Parity Act will
24 help address the following manifestations of the ongoing mental
25 health and addiction crises in California:

26 (1) Between 2012 and 2017, California's rate of fatal overdoses
27 for all opioids increased 22 percent, while fatal overdose rates
28 increased 85 percent for heroin and 425 percent for fentanyl.

29 (2) Suicide rates in California increased by 14.8 percent between
30 1999 and 2016, with the suicide rate from 1991 to 2017, inclusive,
31 for children 10 to 14 years of age, inclusive, increasing by 225
32 percent.

33 (3) Thirty-seven percent of students with a mental health
34 condition 14 years of age and older drop out of school, and mental
35 illness has the highest dropout rate of any disability group.

36 (4) The correlation between untreated mental illness, substance
37 use disorders, and incarceration is substantial, as three in four
38 individuals in jail have been diagnosed with both a mental illness
39 and a substance use disorder.

1 (g) ~~Untreated mental health and substance use disorders are an~~
2 enormous problem with incarcerated youth, with 70 percent of
3 youth arrested each year having a mental health disorder.

4 (6) As many as one-third of the 130,000 individuals who are
5 homeless living on the streets in California have a mental health
6 condition.

7 (i) In two court decisions, *Harlick v. Blue Shield of California*,
8 686 F.3d 699 (9th Cir. 2011), cert. denied, 133 S.Ct. 1492 (2013),
9 and *Rea v. Blue Shield of California*, 226 Cal.App.4th 1209, 1227
10 (2014), the California Mental Health Parity Act was interpreted
11 to require coverage of medically necessary residential treatment.

12 (j) Coverage of intermediate levels of care such as residential
13 treatment, which are essential components of the level of care
14 continuum called for by nonprofit, and clinical specialty
15 associations such as the American Society of Addiction Medicine
16 (ASAM), are often denied through overly restrictive medical
17 necessity determinations.

18 (k) In March 2019, the United States District Court of the
19 Northern District of California ruled in *Wit v. United Behavioral*
20 *Health*, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that
21 United Behavioral Health created flawed level of care placement
22 criteria that were inconsistent with generally accepted standards
23 of mental health and substance use disorder care in order to
24 “mitigate” the requirements of the federal Mental Health Parity
25 and Addiction Equity Act of 2008.

26 (l) As described by the federal court in *Wit*, the eight generally
27 accepted standards of mental health and substance use disorder
28 care require all of the following:

29 (1) Effective treatment of underlying conditions, rather than
30 mere amelioration of current symptoms, such as suicidality or
31 psychosis.

32 (2) Treatment of ~~co-occurring~~ *co-occurring* behavioral health
33 disorders or medical conditions in a coordinated manner.

34 (3) Treatment at the least intensive and restrictive level of care
35 that is safe and ~~effective~~; *effective and meets the needs of the*
36 *patient’s condition*; a lower level or less intensive care is
37 appropriate only if it safe and just as effective as treatment at a
38 higher level or service intensity.

1 (4) Erring on the side of caution, by placing patients in higher
2 levels of care when there is ambiguity as to the appropriate level
3 of care, or when the recommended level of care is not available.

4 (5) Treatment to maintain functioning or prevent deterioration.

5 (6) Treatment of mental health and substance use disorders for
6 an appropriate duration based on individual patient needs rather
7 than on specific time limits.

8 (7) Accounting for the unique needs of children and adolescents
9 when making level of care decisions.

10 (8) Applying multidimensional assessments of patient needs
11 when making determinations regarding the appropriate level of
12 care.

13 (m) The court in Wit found that all parties' expert witnesses
14 regarded the ASAM criteria for substance use disorders and Level
15 of Care Utilization System, Child and Adolescent Level of Care
16 Utilization System, Child and Adolescent Service Intensity
17 Instrument, and Early Childhood Service Intensity Instrument
18 (LOCUS/CALOCUS and CASII/ECSII) criteria for mental health
19 disorders as prime examples of level of care criteria that are fully
20 consistent with generally accepted standards of mental health and
21 substance use care.

22 SEC. 2. Section 1367.045 is added to the Health and Safety
23 Code, to read:

24 1367.045. (a) If a health care service plan contract offered,
25 issued, delivered, amended, or renewed on or after January 1, 2021,
26 contains a provision that reserves discretionary authority to the
27 plan, or an agent of the plan, to determine eligibility for benefits
28 or coverage, to interpret the terms of the contract, or to provide
29 standards of interpretation or review that are inconsistent with the
30 laws of this state, that provision is void and unenforceable.

31 (b) For purposes of this section, the term "discretionary
32 authority" means a contract provision that has the effect of
33 conferring discretion on a health care service plan or other claims
34 administrator to determine entitlement to benefits or interpret
35 contract language that, in turn, could lead to a deferential standard
36 of review by a reviewing court.

37 (c) This section does not prohibit a health care service plan from
38 including a provision in a contract that informs an enrollee that,
39 as part of its routine operations, the plan applies the terms of its
40 contracts for making decisions, including making determinations

1 regarding eligibility, receipt of benefits and claims, or explaining
2 policies, procedures, and processes, so long as the provision could
3 not give rise to a deferential standard of review by a reviewing
4 court.

5 (d) This section applies to both group and individual health care
6 service plan contracts.

7 SEC. 3. Section 1374.72 of the Health and Safety Code is
8 repealed.

9 SEC. 4. Section 1374.72 is added to the Health and Safety
10 Code, to read:

11 1374.72. (a) (1) Every health care service plan contract issued,
12 amended, or renewed on or after January 1, 2021, *that provides*
13 *hospital, medical, or surgical coverage* shall provide coverage for
14 medically necessary treatment of mental health and substance use
15 disorders, under the same terms and conditions applied to other
16 medical conditions as specified in subdivision (c).

17 (2) For purposes of this section, “mental health and substance
18 use disorders” means a mental health condition or substance use
19 disorder that falls under any of the diagnostic categories listed in
20 the mental and behavioral disorders chapter of the most recent
21 edition of the International Classification of Diseases or that is
22 listed in the most recent version of the Diagnostic and Statistical
23 Manual of Mental Disorders. Changes in terminology, organization,
24 or classification of mental health and substance use disorders in
25 future versions of the American Psychiatric Association’s
26 Diagnostic and Statistical Manual of Mental Disorders or the World
27 Health Organization’s International Statistical Classification of
28 Diseases and Related Health Problems shall not affect the
29 conditions covered by this section as long as a condition is
30 commonly understood to be a mental health or substance use
31 disorder by health care providers practicing in relevant clinical
32 specialties.

33 (3) For purposes of this section, “medically necessary treatment
34 of a mental health or substance use disorder” means a service or
35 product prescribed, ordered, or provided by a treating physician
36 or other health care provider for the specific needs of that patient,
37 for the purpose of preventing, diagnosing, or treating an illness,
38 injury, condition, or its symptoms, including minimizing the
39 progression of that illness, injury, condition, or its symptoms, in
40 a manner that is all of the following:

1 (A) In accordance with the generally accepted standards of
2 mental health and substance use disorder care.

3 (B) Clinically appropriate in terms of type, frequency, extent,
4 site, and duration.

5 (C) Not primarily for the economic benefit of the health care
6 service plan and subscribers or for the convenience of the patient,
7 treating physician, or other health care provider.

8 (4) For purposes of this section, “health care provider” means
9 any of the following:

10 (A) A person who is licensed under Division 2 (commencing
11 with Section 500) of the Business and Professions Code.

12 (B) An associate marriage and family therapist or marriage and
13 family therapist trainee functioning pursuant to Section 4980.43.3
14 of the Business and Professions Code.

15 (C) A qualified autism service provider or qualified autism
16 service professional certified by a national entity pursuant to
17 Section 10144.51 of the Insurance Code and Section 1374.73.

18 (D) *An associate clinical social worker functioning pursuant*
19 *to Section 4996.23.2 of the Business and Professions Code.*

20 (E) *An associate professional clinical counselor or professional*
21 *clinical counselor trainee functioning pursuant to Section*
22 *4999.46.3 of the Business and Professions Code.*

23 (5) For purposes of this section, “generally accepted standards
24 of mental health and substance use disorder care” has the same
25 meaning as defined in paragraph (1) of subdivision (f) of Section
26 1374.721.

27 (6) A health care service plan shall not limit benefits or coverage
28 for mental health and substance use disorders to short-term or acute
29 treatment.

30 (7) All medical necessity determinations by the health care
31 service plan concerning service intensity, level of care placement,
32 continued stay, and transfer or discharge of enrollees diagnosed
33 with mental health and substance use disorders shall be conducted
34 in accordance with the requirements of Section 1374.721. This
35 paragraph does not deprive an enrollee of the other protections of
36 ~~this article, chapter,~~ including, but not limited to, grievances,
37 appeals, independent medical review, discharge, transfer, and
38 continuity of care.

39 (8) A health care service plan that authorizes a specific type of
40 treatment by a provider pursuant to this section shall not rescind

1 or modify the authorization after the provider renders the health
2 care service in good faith and pursuant to this authorization for
3 any reason, including, but not limited to, the plan's subsequent
4 rescission, cancellation, or modification of the enrollee's or
5 subscriber's contract, or the plan's subsequent determination that
6 it did not make an accurate determination of the enrollee's or
7 subscriber's eligibility. This section shall not be construed to
8 expand or alter the benefits available to the enrollee or subscriber
9 under a plan.

10 (b) The benefits that shall be covered pursuant to this section
11 shall include, but not be limited to, the following:

12 (1) Basic health care services, as defined in subdivision (b) of
13 Section 1345.

14 (2) Intermediate services, including the full range of levels of
15 care, including, but not limited to, residential treatment, partial
16 hospitalization, and intensive outpatient treatment.

17 (3) Prescription drugs, if the plan contract includes coverage
18 for prescription drugs.

19 (c) The terms and conditions applied to the benefits required
20 by this section, that shall be applied equally to all benefits under
21 the plan contract, shall include, but not be limited to, all of the
22 following patient financial responsibilities:

23 (1) Maximum annual and lifetime benefits, if not prohibited by
24 applicable law.

25 (2) Copayments and coinsurance.

26 (3) Individual and family deductibles.

27 (4) Out-of-pocket maximums.

28 (d) If services for the medically necessary treatment of a mental
29 health or substance use disorder are not available in network within
30 the geographic and timely access standards set by law or regulation,
31 the health care service plan shall arrange coverage of
32 out-of-network services, to ensure access to medically necessary
33 services, to the maximum extent possible, within the *services that*
34 *meets those* geographic and timely access standards set by law or
35 ~~regulation. standards.~~ The enrollee shall pay no more than the
36 same cost sharing that the enrollee would pay for the same covered
37 services received from an in-network provider. ~~For the first 12~~
38 ~~months, a health care service plan shall not interrupt a course of~~
39 ~~treatment initiated out of network due to network inadequacy if~~
40 ~~in-network services subsequently become available. Thereafter, a~~

1 ~~health care service plan, for the purposes of the enrollee~~
2 ~~maintaining in-network cost sharing, may require a transition to~~
3 ~~in-network services if the plan is able to demonstrate, to the~~
4 ~~satisfaction of the department, that care may be safely and~~
5 ~~appropriately transitioned.~~

6 (e) ~~(1)~~—This section shall not apply to contracts entered into
7 pursuant to Chapter 7 (commencing with Section 14000) or Chapter
8 8 (commencing with Section 14200) of Part 3 of Division 9 of the
9 Welfare and Institutions Code, between the State Department of
10 Health Care Services and a health care service plan for enrolled
11 Medi-Cal beneficiaries.

12 ~~(2) This section does not apply to specialized health care service~~
13 ~~plans that provide only dental or vision services.~~

14 (f) (1) For the purpose of compliance with this section, a health
15 care service plan may provide coverage for all or part of the mental
16 health and substance use disorder services required by this section
17 through a separate specialized health care service plan or mental
18 health plan, and shall not be required to obtain an additional or
19 specialized license for this purpose. ~~This paragraph shall not apply~~
20 ~~to health care service plans that are subject to Section 1367.005.~~

21 (2) A health care service plan shall provide the mental health
22 and substance use disorder coverage required by this section in its
23 entire service area and in emergency situations as may be required
24 by applicable laws and regulations. For purposes of this section,
25 health care service plan contracts that provide benefits to enrollees
26 through preferred provider contracting arrangements are not
27 precluded from requiring enrollees who reside or work in
28 geographic areas served by specialized health care service plans
29 or mental health plans to secure all or part of their mental health
30 services within those geographic areas served by specialized health
31 care service plans or mental health plans, provided that all
32 appropriate mental health or substance use disorder services are
33 actually available within those geographic service areas within
34 timeliness standards.

35 (3) Notwithstanding any other law, in the provision of benefits
36 required by this section, a health care service plan may utilize case
37 management, network providers, utilization review techniques,
38 prior authorization, copayments, or other cost sharing, provided
39 that these practices are consistent with Section 1374.76 of this
40 code, and Section 2052 of the Business and Professions Code.

1 (g) This section shall not be construed to deny or restrict in any
2 way the department's authority to ensure plan compliance with
3 this ~~chapter when a health care service plan provides coverage for~~
4 ~~prescription drugs.~~ *chapter.*

5 (h) A health care service plan shall not limit benefits or coverage
6 for medically necessary services on the basis that those services
7 should be or could be covered by a public entitlement program,
8 including, but not limited to, special education or an individualized
9 education program, Medicaid, Medicare, Supplemental Security
10 Income, or Social Security Disability Insurance, and shall not
11 include or enforce a contract term that excludes otherwise covered
12 benefits on the basis that those services should be or could be
13 covered by a public entitlement program.

14 (i) A health care service plan shall not adopt, impose, or enforce
15 ~~additional~~ terms in its plan contracts or provider agreements, in
16 writing or in operation, that undermine, alter, or conflict with the
17 requirements of this section.

18 SEC. 5. Section 1374.721 is added to the Health and Safety
19 Code, to read:

20 1374.721. (a) A health care service plan *that provides hospital,*
21 *medical, or surgical coverage* shall base any medical necessity
22 determination or the utilization review criteria that the plan, and
23 any entity acting on the plan's behalf, applies to determine the
24 medical necessity of health care services and benefits for the
25 diagnosis, prevention, and treatment of mental health and substance
26 use disorders on current generally accepted standards of mental
27 health and substance use disorder care.

28 (b) In conducting utilization review of all covered health care
29 services and benefits for the diagnosis, prevention, and treatment
30 of mental health and substance use disorders in children,
31 adolescents, and adults, a health care service plan shall apply the
32 criteria and guidelines set forth in the most recent versions of
33 treatment criteria developed by the nonprofit professional
34 association for the relevant clinical specialty.

35 (c) In conducting utilization review involving level of care
36 placement decisions or any other patient care decisions that are
37 within the scope of the sources specified in subdivision (b), a health
38 care service plan shall not apply different, additional, conflicting,
39 or more restrictive utilization review criteria than the criteria and
40 guidelines set forth in those sources. This subdivision does not

- 1 prohibit a health care service plan from applying utilization review
2 criteria to health care services and benefits for mental health and
3 substance use disorders that meet either of the following criteria:
4 (1) Are outside the scope of the criteria and guidelines set forth
5 in the sources specified in subdivision (b), provided the utilization
6 review criteria were developed in accordance with subdivision (a).
7 (2) Relate to advancements in technology or types of care that
8 are not covered in the most recent versions of the sources specified
9 in subdivision (b), provided that the utilization review criteria were
10 developed in accordance with subdivision (a).
- 11 (d) If a health care service plan purchases or licenses utilization
12 review criteria pursuant to paragraph (1) or (2) of subdivision (c),
13 the plan shall verify and document before use that the criteria were
14 developed in accordance with subdivision (a).
- 15 (e) To ensure the proper use of the criteria described in
16 subdivision (b), every health care service plan shall do all of the
17 following:
- 18 (1) Sponsor a formal education program by nonprofit clinical
19 specialty associations to educate the health care service plan's
20 staff, including any third parties contracted with the health care
21 service plan to review claims, conduct utilization reviews, or make
22 medical necessity determinations about the clinical review criteria.
- 23 (2) Make the education program available to other stakeholders,
24 including the health care service plan's participating providers and
25 covered lives. Participating providers shall not be required to
26 participate in the education program.
- 27 (3) ~~Provide~~ *Provide, at no cost*, the clinical review criteria and
28 any training material or resources to providers and health care
29 service plan ~~patients~~ *enrollees*.
- 30 (4) Track, identify, and analyze how the clinical review criteria
31 are used to certify care, deny care, and support the appeals process.
- 32 (5) Conduct interrater reliability testing to ensure consistency
33 in utilization review decisionmaking covering how medical
34 necessity decisions are made. This assessment shall cover all
35 aspects of utilization review as defined in paragraph (3) of
36 subdivision (f).
- 37 (6) Run interrater reliability reports about how the clinical
38 guidelines are used in conjunction with the utilization management
39 process and parity compliance activities.

1 (7) Achieve interrater reliability pass rates of at least 90 percent
2 and, if this threshold is not met, immediately provide for the
3 remediation of poor interrater reliability and interrater reliability
4 testing for all new staff before they can conduct utilization review
5 without supervision.

6 (f) The following definitions apply for purposes of this section:

7 (1) “Generally accepted standards of mental health and substance
8 use disorder care” means standards of care and clinical practice
9 that are generally recognized by health care providers practicing
10 in relevant clinical specialties such as psychiatry, psychology,
11 clinical sociology, ~~and addiction medicine and counseling,~~
12 *counseling, and behavioral health treatment pursuant to Section*
13 *1374.73*. Valid, evidence-based sources establishing generally
14 accepted standards of mental health and substance use disorder
15 care include peer-reviewed scientific studies and medical literature,
16 clinical practice guidelines and recommendations of nonprofit
17 health care provider professional associations, specialty societies
18 and federal government agencies, and drug labeling approved by
19 the United States Food and Drug Administration.

20 (2) “Mental health and substance use disorders” has the same
21 meaning as defined in paragraph (2) of subdivision (a) of Section
22 1374.72.

23 (3) “Utilization review” means either of the following:

24 (A) Prospectively, retrospectively, or concurrently reviewing
25 and approving, modifying, delaying, or denying, based in whole
26 or in part on medical necessity, requests by health care providers,
27 enrollees, or their authorized representatives for coverage of health
28 care services prior to, retrospectively or concurrent with the
29 provision of health care services to enrollees.

30 (B) Evaluating the medical necessity, appropriateness, level of
31 care, service intensity, efficacy, or efficiency of health care
32 services, benefits, procedures, or settings, under any circumstances,
33 to determine whether a health care service or benefit subject to a
34 medical necessity coverage requirement in a health care service
35 plan contract is covered as medically necessary for an enrollee.

36 (4) “Utilization review criteria” means any criteria, standards,
37 protocols, or guidelines used by a health care service plan to
38 conduct utilization review.

39 ~~(g) Changes in terminology, organization, or classification of~~
40 ~~mental health or substance use disorders in future versions of the~~

~~1 American Psychiatric Association's Diagnostic and Statistical
2 Manual of Mental Disorders or the World Health Organization's
3 International Statistical Classification of Diseases and Related
4 Health Problems shall not affect the conditions covered by this
5 section as long as a condition is commonly understood to be a
6 mental health or substance use disorder by health care providers
7 practicing in relevant clinical specialties.~~

~~8 (h)~~

9 (g) This section applies to all health care services and benefits
10 for the diagnosis, prevention, and treatment of mental health and
11 substance use disorders covered by a health care service plan
12 contract, including prescription drugs.

~~13 (i)~~

14 (h) This section applies to a health care service plan that
15 conducts utilization review as defined in this section, and any entity
16 or contracting provider that performs utilization review or
17 utilization management functions on behalf of a health care service
18 plan.

~~19 (j)~~

20 (i) The director may assess administrative penalties for violations
21 of this section as provided for in Section 1368.04, in addition to
22 any other remedies permitted by law.

~~23 (k)~~

24 (j) A health care service plan shall not adopt, impose, or enforce
25 additional terms in its plan contracts or provider agreements, in
26 writing or in operation, that undermine, alter, or conflict with the
27 requirements of this section.

~~28 (l) (1)~~

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

~~35 (2) This section does not apply to specialized health care service
36 plan contracts that provide only dental or vision services.~~

37 SEC. 6. Section 10144.5 of the Insurance Code is repealed.

38 SEC. 7. Section 10144.5 is added to the Insurance Code, to
39 read:

1 10144.5. (a) (1) Every disability insurance policy issued,
2 amended, or renewed on or after January 1, 2021, that provides
3 hospital, medical, or surgical coverage shall provide coverage for
4 medically necessary treatment of mental health and substance use
5 disorders, under the same terms and conditions applied to other
6 medical conditions as specified in subdivision (c).

7 (2) For purposes of this section, “mental health and substance
8 use disorders” means a mental health condition or substance use
9 disorder that falls under any of the diagnostic categories listed in
10 the mental and behavioral disorders chapter of the most recent
11 edition of the World Health Organization’s International Statistical
12 Classification of Diseases and Related Health Problems, or that is
13 listed in the most recent version of the American Psychiatric
14 Association’s Diagnostic and Statistical Manual of Mental
15 Disorders. Changes in terminology, organization, or classification
16 of mental health and substance use disorders in future versions of
17 the American Psychiatric Association’s Diagnostic and Statistical
18 Manual of Mental Disorders or the World Health Organization’s
19 International Statistical Classification of Diseases and Related
20 Health Problems shall not affect the conditions covered by this
21 section as long as a condition is commonly understood to be a
22 mental health or substance use disorder by health care providers
23 practicing in relevant clinical specialties.

24 (3) For purposes of this section, “medically necessary treatment
25 of a mental health or substance use disorder” means a service or
26 product prescribed, ordered, or provided by a treating physician
27 or other health care provider for the specific needs of that patient,
28 for the purpose of preventing, diagnosing, or treating an illness,
29 injury, condition, or its symptoms, including minimizing the
30 progression of an illness, injury, condition, or its symptoms, in a
31 manner that is all of the following:

32 (A) In accordance with the generally accepted standards of
33 mental health and substance use disorder care.

34 (B) Clinically appropriate in terms of type, frequency, extent,
35 site, and duration.

36 (C) Not primarily for the economic benefit of the disability
37 insurer and insureds or for the convenience of the patient, treating
38 physician, or other health care provider.

39 (4) “Health care provider” means any of the following:

1 (A) A person who is licensed under Division 2 (commencing
2 with Section 500) of the Business and Professions Code.

3 (B) An associate marriage and family therapist or marriage and
4 family therapist trainee functioning pursuant to Section 4980.43.3
5 of the Business and Professions Code.

6 (C) A qualified autism service provider or qualified autism
7 service professional certified by a national entity pursuant to
8 Section 1374.73 of the Health and Safety Code and Section
9 10144.51.

10 (D) *An associate clinical social worker functioning pursuant*
11 *to Section 4996.23.2 of the Business and Professions Code.*

12 (E) *An associate professional clinical counselor or professional*
13 *clinical counselor trainee functioning pursuant to Section*
14 *4999.46.3 of the Business and Professions Code.*

15 (5) For purposes of this section, “generally accepted standards
16 of mental health and substance use disorder care” has the same
17 meaning as defined in paragraph (1) of subdivision (f) of Section
18 10144.52.

19 (6) A disability insurer shall not limit benefits or coverage for
20 mental health and substance use disorders to short-term or acute
21 treatment.

22 (7) All medical necessity determinations made by the disability
23 insurer concerning service intensity, level of care placement,
24 continued stay, and transfer or discharge of insureds diagnosed
25 with mental health and substance use disorders shall be conducted
26 in accordance with the requirements of Section 10144.52.

27 (8) A disability insurer that authorizes a specific type of
28 treatment by a provider pursuant to this section shall not rescind
29 or modify the authorization after the provider renders the health
30 care service in good faith and pursuant to this authorization for
31 any reason, including, but not limited to, the insurer’s subsequent
32 rescission, cancellation, or modification of the insured’s or
33 policyholder’s contract, or the insurer’s subsequent determination
34 that it did not make an accurate determination of the insured’s or
35 policyholder’s eligibility. This section shall not be construed to
36 expand or alter the benefits available to the insured or policyholder
37 under an insurance policy.

38 (b) The benefits that shall be covered pursuant to this section
39 shall include, but not be limited to, the following:

- 1 (1) Basic health care services, as defined in subdivision (b) of
2 Section 1345 of the Health and Safety Code.
- 3 (2) Intermediate services, including the full range of levels of
4 care, including, but not limited to, residential treatment, partial
5 hospitalization, and intensive outpatient treatment.
- 6 (3) Prescription drugs, if the policy includes coverage for
7 prescription drugs.
- 8 (c) The terms and conditions applied to the benefits required
9 by this section, that shall be applied equally to all benefits under
10 the disability insurance policy shall include, but not be limited to,
11 all of the following patient financial responsibilities:
 - 12 (1) Maximum and annual lifetime benefits, if not prohibited by
13 applicable law.
 - 14 (2) Copayments and coinsurance.
 - 15 (3) Individual and family deductibles.
 - 16 (4) Out-of-pocket maximums.
- 17 (d) If services for the medically necessary treatment of a mental
18 health or substance use disorder are not available in network within
19 the geographic and timely access standards set by law or regulation,
20 the disability insurer shall arrange coverage of out-of-network
21 ~~services, to ensure access to medically necessary services, to the~~
22 ~~maximum extent possible, within the services that meet those~~
23 ~~geographic and timely access standards set by law or regulation.~~
24 ~~standards.~~ The insured shall pay no more than the same cost
25 sharing that the insured would pay for the same covered services
26 received from an in-network provider. ~~For the first 12 months, a~~
27 ~~disability insurer shall not interrupt a course of treatment initiated~~
28 ~~out of network due to network inadequacy if in network services~~
29 ~~subsequently become available. Thereafter, a disability insurer,~~
30 ~~for the purposes of the insured maintaining in-network cost sharing,~~
31 ~~may require a transition to in-network services if the disability~~
32 ~~insurer is able to demonstrate, to the satisfaction of the department,~~
33 ~~that care may be safely and appropriately transitioned.~~
- 34 (e) This section shall not apply to accident-only, specified
35 disease, hospital indemnity, Medicare supplement, dental-only, or
36 vision-only insurance policies.
- 37 (f) (1) For the purpose of compliance with this section, a
38 disability insurer may provide coverage for all or part of the mental
39 health and substance use disorder services required by this section
40 through a separate specialized health insurance policy or mental

1 health policy. This paragraph shall not apply to policies that are
2 subject to Section 10112.27.

3 (2) A disability insurer shall provide the mental health and
4 substance use disorder coverage required by this section in its
5 entire service area and in emergency situations as may be required
6 by applicable laws and regulations. For purposes of this section,
7 disability insurance policies that provide benefits to insureds
8 through preferred provider contracting arrangements are not
9 precluded from requiring insureds who reside or work in
10 geographic areas served by specialized health insurance policies
11 or mental health insurance policies to secure all or part of their
12 mental health services within those geographic areas served by
13 specialized health insurance policies or mental health insurance
14 policies, provided that all appropriate mental health or substance
15 use disorder services are actually available within those geographic
16 service areas within timeliness standards.

17 (3) Notwithstanding any other law, in the provision of benefits
18 required by this section, a disability insurer may utilize case
19 management, network providers, utilization review techniques,
20 prior authorization, copayments, or other cost sharing, provided
21 that these practices are consistent with Section 10144.4 of this
22 code, and Section 2052 of the Business and Professions Code.

23 (g) This section shall not be construed to deny or restrict in any
24 way the department's authority to ensure a disability insurer's
25 compliance with this ~~code when a disability insurer provides~~
26 ~~coverage for prescription drugs.~~ *code.*

27 (h) A disability insurer shall not limit benefits or coverage for
28 medically necessary services on the basis that those services should
29 be or could be covered by a public entitlement program, including,
30 but not limited to, special education or an individualized education
31 program, Medicaid, Medicare, Supplemental Security Income, or
32 Social Security Disability Insurance, and shall not include or
33 enforce a contract term that excludes otherwise covered benefits
34 on the basis that those services should be or could be covered by
35 a public entitlement program.

36 (i) A disability insurer shall not adopt, impose, or enforce
37 ~~additional~~ terms in its policies or provider agreements, in writing
38 or in operation, that undermine, alter, or conflict with the
39 requirements of this section.

1 (j) If the commissioner determines that a disability insurer has
2 violated this section, the commissioner may, after appropriate
3 notice and opportunity for hearing in accordance with the
4 Administrative Procedure Act (Chapter 5 (commencing with
5 Section 11500) of Part 1 of Division 3 of Title 2 of the Government
6 Code), by order, assess a civil penalty not to exceed five thousand
7 dollars (\$5,000) for each violation, or, if a violation was willful,
8 a civil penalty not to exceed ten thousand dollars (\$10,000) for
9 each violation.

10 SEC. 8. Section 10144.52 is added to the Insurance Code, to
11 read:

12 10144.52. (a) A disability insurer that provides hospital,
13 medical, or surgical coverage shall base any medical necessity
14 determination or the utilization review criteria that the insurer, and
15 any entity acting on the insurer's behalf, applies to determine the
16 medical necessity of health care services and benefits for the
17 diagnosis, prevention, and treatment of mental health and substance
18 use disorders on current generally accepted standards of mental
19 health and substance use disorder care.

20 (b) In conducting utilization review of all covered health care
21 services and benefits for the diagnosis, prevention, and treatment
22 of mental health and substance use disorders in children,
23 adolescents, and adults, a disability insurer shall apply the criteria
24 and guidelines set forth in the most recent versions of the treatment
25 criteria developed by the nonprofit professional association for the
26 relevant clinical specialty.

27 (c) In conducting utilization review involving level of care
28 placement decisions or any other patient care decisions that are
29 within the scope of the sources specified in subdivision (b), a
30 disability insurer shall not apply different, additional, conflicting,
31 or more restrictive utilization review criteria than the criteria and
32 guidelines set forth in those sources. This subdivision does not
33 prohibit a disability insurer from applying utilization review criteria
34 to health care services and benefits for mental health and substance
35 use disorders that meet either of the following criteria:

36 (1) Are outside the scope of the criteria and guidelines set forth
37 in the sources specified in subdivision (b), provided the utilization
38 review criteria were developed in accordance with subdivision (a).

39 (2) Relate to advancements in technology or types of care that
40 are not covered in the most recent versions of the sources specified

1 in subdivision (b), provided that the utilization review criteria were
2 developed in accordance with subdivision (a).

3 (d) If a disability insurer purchases or licenses utilization review
4 criteria pursuant to paragraph (1) or (2) of subdivision (c), the
5 insurer shall verify and document before use that the criteria were
6 developed in accordance with subdivision (a).

7 (e) To ensure the proper use of the criteria described in
8 subdivision (b), every disability insurer shall do all of the
9 following:

10 (1) Sponsor a formal education program by nonprofit clinical
11 specialty associations to educate the disability insurer's staff,
12 including any third parties contracted with the disability insurer
13 to review claims, conduct utilization reviews, or make medical
14 necessity determinations about the clinical review criteria.

15 (2) Make the education program available to other stakeholders,
16 including the insurer's participating providers and covered lives.

17 (3) ~~Provide~~ *Provide, at no cost*, the clinical review criteria and
18 any training material or resources to providers and insured patients.

19 (4) Track, identify, and analyze how the clinical review criteria
20 are used to certify care, deny care, and support the appeals process.

21 (5) Conduct interrater reliability testing to ensure consistency
22 in utilization review decisionmaking covering how medical
23 necessity decisions are made. This assessment shall cover all
24 aspects of utilization review as defined in paragraph (3) of
25 subdivision (f).

26 (6) Run interrater reliability reports about how the clinical
27 guidelines are used in conjunction with the utilization management
28 process and parity compliance activities.

29 (7) Achieve interrater reliability pass rates of at least 90 percent
30 and, if this threshold is not met, immediately provide for the
31 remediation of poor interrater reliability and interrater reliability
32 testing for all new staff before they can conduct utilization review
33 without supervision.

34 (f) The following definitions apply for purposes of this section:

35 (1) "Generally accepted standards of mental health and substance
36 use disorder care" means standards of care and clinical practice
37 that are generally recognized by health care providers practicing
38 in relevant clinical specialties such as psychiatry, psychology,
39 clinical sociology, ~~and~~ addiction medicine and ~~counseling~~.
40 *counseling, and behavioral health treatment pursuant to Section*

1 10144.51. Valid, evidence-based sources establishing generally
2 accepted standards of mental health and substance use disorder
3 care include peer-reviewed scientific studies and medical literature,
4 clinical practice guidelines and recommendations of nonprofit
5 health care provider professional associations, specialty societies
6 and federal government agencies, and drug labeling approved by
7 the United States Food and Drug Administration.

8 (2) “Mental health and substance use disorders” has the same
9 meaning as defined in paragraph (2) of subdivision (a) of Section
10 10144.5.

11 (3) “Utilization review” means either of the following:

12 (A) Prospectively, retrospectively, or concurrently reviewing
13 and approving, modifying, delaying, or denying, based in whole
14 or in part on medical necessity, requests by health care providers,
15 insureds, or their authorized representatives for coverage of health
16 care services prior to, retrospectively or concurrent with the
17 provision of health care services to insureds.

18 (B) Evaluating the medical necessity, appropriateness, level of
19 care, service intensity, efficacy, or efficiency of health care
20 services, benefits, procedures, or settings, under any circumstances,
21 to determine whether a health care service or benefit subject to a
22 medical necessity coverage requirement in a disability insurance
23 policy is covered as medically necessary for an insured.

24 (4) “Utilization review criteria” means any criteria, standards,
25 protocols, or guidelines used by a disability insurer to conduct
26 utilization review.

27 ~~(g) Changes in terminology, organization, or classification of~~
28 ~~mental health or substance use disorders in future versions of the~~
29 ~~American Psychiatric Association’s Diagnostic and Statistical~~
30 ~~Manual of Mental Disorders or the World Health Organization’s~~
31 ~~International Statistical Classification of Diseases and Related~~
32 ~~Health Problems shall not affect the conditions covered by this~~
33 ~~section as long as a condition is commonly understood to be a~~
34 ~~mental health or substance use disorder by health care providers~~
35 ~~practicing in relevant clinical specialties.~~

36 ~~(h)~~

37 (g) This section applies to all health care services and benefits
38 for the diagnosis, prevention, and treatment of mental health and
39 substance use disorders covered by a disability insurance policy,
40 including prescription drugs.

1 ~~(i)~~
 2 (h) This section applies to a disability insurer that covers
 3 hospital, medical, or surgical expenses and conducts utilization
 4 review as defined in this section, and any entity or contracting
 5 provider that performs utilization review or utilization management
 6 functions on an insurer’s behalf.

7 ~~(j)~~
 8 (i) If the commissioner determines that a disability insurer has
 9 violated this section, the commissioner may, after appropriate
 10 notice and opportunity for hearing in accordance with the
 11 Administrative Procedure Act (Chapter 5 (commencing with
 12 Section 11500) of Part 1 of Division 3 of Title 2 of the Government
 13 Code), by order, assess a civil penalty not to exceed five thousand
 14 dollars (\$5,000) for each violation, or, if a violation was willful,
 15 a civil penalty not to exceed ten thousand dollars (\$10,000) for
 16 each violation.

17 ~~(k)~~
 18 (j) A disability insurer shall not adopt, impose, or enforce
 19 ~~additional~~ terms in its policies or provider agreements, in writing
 20 or in operation, that undermine, alter, or conflict with the
 21 requirements of this section.

22 ~~(l)~~
 23 (k) This section does not apply to accident-only, specified
 24 disease, hospital indemnity, Medicare supplement, dental-only, or
 25 vision-only insurance policies.

26 SEC. 9. The provisions of this act are severable. If any
 27 provision of this act or its application is held invalid, that invalidity
 28 shall not affect other provisions or applications that can be given
 29 effect without the invalid provision or application.

30 SEC. 10. No reimbursement is required by this act pursuant to
 31 Section 6 of Article XIII B of the California Constitution because
 32 the only costs that may be incurred by a local agency or school
 33 district will be incurred because this act creates a new crime or
 34 infraction, eliminates a crime or infraction, or changes the penalty
 35 for a crime or infraction, within the meaning of Section 17556 of
 36 the Government Code, or changes the definition of a crime within
 37 the meaning of Section 6 of Article XIII B of the California
 38 Constitution.

O