



The increasing importance of mental health parity laws

State and federal laws require that mental and physical illnesses be treated equally, but getting the health insurer to comply can still be difficult

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Mental health is in the news more than ever before. And with scarier undertones than ever before. From Santa Barbara to Sandy Hook, on college campuses to elementary schools, and in small towns and big cities nationwide, there's a new, dark math. Take individuals with serious mental health problems, add lax gun control laws, and the results have increasingly been fatal.

Practically speaking, there may be very little that can be done to the gun control part of the equation. But when it comes to identifying and treating individuals with serious mental health problems, getting help before a worst-case-scenario situation plays out has never been more important.

Enter the Mental Health Parity Laws. These laws, which mandate that health-care providers provide equal coverage for serious mental illnesses as they do for "physical" illnesses or injuries, have never been more important. So if a health policy or plan covers cancer treatment, for example, no matter how long the patient's hospital stay, the carrier must also cover all medically necessary mental healthcare and treatment. If a plan covers prescription drugs for physical problems, so must it equally cover prescription drugs to treat mental health problems.

We have previously written about the parity laws in the pages of *Plaintiff* magazine (June 2011). California has parity laws, other states have them, and the

Obama administration recently strengthened the Federal Parity Law. But as recently as two or three years ago, this issue was so new that there had been precious little litigation exploring the boundaries of these statutes. With scant case law, the nuances of the California's Mental Health Parity Act had not been fleshed out, and health insurers continued to improperly refuse coverage for medically necessary mental healthcare.

However, two relatively recent appellate court decisions, one from the Ninth Circuit Court of Appeals, and the other from the California Court of Appeal, have made the parity-law landscape more certain, and have brought us much closer to realizing the goal of the parity laws: to insure that individuals with mental health problems get the treatment they need.¹

California's Mental Health Parity Act

First is the California Mental Health Parity Act itself. As codified in both the Insurance Code and the Health and Safety Code, it mandates that:

(a) Every healthcare service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall 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, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

- (1) Maximum lifetime benefits.
- (2) Copayments.
- (3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism.
- (8) Anorexia nervosa.
- (9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance



use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.²

The only major shortcoming in the above language is that California's Parity Act does not include treatment for substance abuse. Yet since substance abuse is often one component of a greater set of mental illnesses, especially in children, do not concede that the Parity Law is inapplicable to a particular case before fully understanding a client's overall mental health picture, and history.

California's Mental Health Parity Act was intended to be a powerful tool. The implementing regulations evidence this intent. They explain that:

(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, *all healthcare services required under the Act including, but not limited to, basic health care services* within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health-care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.³

The key phrase here is "all healthcare services." This should be read into subsection (b) of the Parity Act. It confirms that the benefit list there is illustrative and nonexclusive, and that it is the treatment, not the place of treatment, that is important. This is a crucial distinction, since many mental health programs and facilities do not fall neatly into recognizable categories such as outpatient services, inpatient care, or partial hospitalization.

The law becomes clearer

There are two seminal cases concerning California's Parity Act. Both involve Blue Shield. The first is *Harlick v. Blue Shield*.⁴ That action involved a woman who had suffered from anorexia nervosa for more than 20 years. When multiple treatment efforts failed, and she was at 65 percent of her ideal body weight, the last resort was enrollment in a Residential Treatment Center, where she could be cared for on a 24-hour basis, for as long as was needed.

The only problem is that residential treatment facilities are expensive (although, to be sure, not as expensive as inpatient care at a "regular" hospital). Unsurprisingly, the Blue Shield policy at issue contained a blanket exclusion for residential treatment. During litigation, Blue Shield contended that since residential treatment is not explicitly referenced in the body of the Parity Act, its exclusion was enforceable. "Not so fast, Blue Shield," claimed the plaintiff. If residential treatment was medically necessary, it must be covered, she contended.

The Ninth Circuit agreed (reversing the district court grant of summary judgment). The Court held that Blue Shield "must provide coverage of all "medically necessary treatment" for "severe mental illnesses" under the same financial terms as those applied to physical illnesses."⁵ This perforce included mental health care at residential treatment facilities.

Blue Shield's second bite at the Parity Law apple came in *Rea v. Blue Shield*, a California state court case.⁶

Rea also involved a trial court ruling (on demurrer) that favored the insurer, but that was reversed on appeal. Like *Harlick*, *Rea* involved a woman with a serious eating disorder who was treated at a Residential Treatment Center, and whose Blue Shield policy contained a blanket exclusion for Residential Treatment.

In ruling for the insured, the court in *Rea* (as did the Ninth circuit in *Harlick*) engaged in extensive statutory analysis. It even discussed, at length, the legislative

history behind the Parity Act. Finally, as in *Harlick*, the California Court of Appeal rejected the insurer's limited interpretation of the Parity Act and held that medically necessary services must be covered on par with the level of services offered for physical injuries and sicknesses, including Residential Treatment.

As a result, *Rea* harmonizes the potential split between the federal and state courts, and gives insurers nowhere to turn with their efforts to circumscribe California's Parity Act (except, perhaps, the California Supreme Court in *Rea*).

Medical necessity — always a focus

Although residential treatment is one of the most high profile – and litigated – Parity Law issues, Parity Laws are about much more than this specific modality of mental health treatment and care. For those plans that do not contain blanket exclusions, the heart of the case will usually revolve around medical necessity.

Unfortunately, there is no overarching, statutory definition for medical necessity. Here again, though, the *Harlick* case is instructive in the need for a carrier to set forth the specific reasons behind a claim denial. In *Harlick*, the carrier had the opportunity to make a medical necessity determination. It chose not to deny the claim based on medical necessity, choosing instead to rely on the blanket exclusion described above. The court held that an insurer does not get a second bite at the apple – it cannot deny a claim based on one reason, then on appeal or during litigation bring up other bases for claim denial.

Thus, consumer attorneys should always home in on the insurer's claim denial rationale. Consider the claims handler, but also consider any medical professionals whose opinions provided the pretext for the claim denial. In one case the reviewing medical consultant testified that he denied 30 percent of the claims he reviewed, spent an average of 12 minutes per claim review, and had no



problem dismissing the opinions of treating physicians.⁷ Jurors did not take kindly to this, finding the carrier liable for punitive damages.⁸

Separately, to the extent that a policy's definition of medical necessity is ambiguous, with one interpretation favoring coverage, and the other supporting a claim denial, the doctrine of reasonable expectations holds that coverage must be granted.⁹

Remember ERISA; Avoid ERISA

The beauty of the twin Parity Law cases discussed above, *Harlick* and *Rea*, is that together they cover the vast majority of the litigation landscape. In *Harlick* the health insurance policy at issue was governed by the Employee Retirement Security Act of 1974, more commonly referred to as ERISA.¹⁰ Most group policies come under ERISA's ambit. But not all do – be very careful before conceding that ERISA governs a particular policy, or action.

Since ERISA preempts state law causes of action, thereby guaranteeing that the carrier cannot be held liable for the emotional distress caused by an unreasonable claim denial, much less for punitive damages, carriers will try every trick in the book to persuade a judge that ERISA applies. They know that if successful, at best they could be liable for the benefits they should have approved in the first place, along with – maybe – some attorneys' fees.¹¹ This provides almost no incentive for an insurer to properly adjudicate mental health claims. Carriers also know full well that ERISA has been interpreted, unfairly some say, as precluding the plaintiff/insured's right to a jury trial; and to virtually all discovery. Thus it is important to understand that insurance companies have nothing to lose and everything to gain by playing the ERISA card.

Finally, until recently, an ERISA claim denial could often be overturned only upon a finding that the carrier acted arbitrarily or capriciously, or abused its discretion. Thanks to the great work of consumer attorneys, and to an insurance commissioner who understood the injustice of such a standard, the arbitrary and capricious standard of review is, for the most part, a thing of the past.¹²

The *Rea* case, on the other hand, is a class action not subject to ERISA's preemptive power. As a bad-faith action, tort damages may be available if a jury finds the carrier acted unreasonably toward its insured(s).¹³ Given the potentially devastating nature of a mental healthcare claim denial, the potential damages for emotional and financial distress can be substantial.

Thus, to fully understand an insured's rights, it is essential to determine whether an action can be brought under California's consumer-friendly bad faith laws, or will be preempted by the insurer-friendly federal ERISA statute.

Now is the time for action

Tens of millions of Americans suffer from some form of mental illness.¹⁴ Regrettably, without proper treatment, the results can be devastating, not just for the individuals themselves and their families, but for innocent victims of mental health violence. Now, with the scope of the California Mental Health Parity Act more fully fleshed out, more guideposts exist to ensure that proper treatment and care is provided, by insurers who previously gave such care short shrift.

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Endnotes:

¹ The vast credit for the sea change in Parity Law jurisprudence goes to Lisa Kantor and everyone at Kantor and Kantor. Visit them at www.kantorlaw.net.

² The act is codified in two places: Cal. Health & Saf. Cod. e § 1374.72, Cal. Ins. Code, §10144.5.

³ 28 C.C.R. §1300.74.72 (emphasis added).

⁴ *Harlick v. Blue Shield* (9th Cir. 2011) 656 F.3d 832 (9th Cir. 2011).

⁵ *Id.* at p. 849.

⁶ *Rea v. Blue Shield of California* (2011) 226 Cal.App.4th 1209.

⁷ See *Hughes v. Blue Cross of Northern California*, (Cal.App.2d. 2014) 215 Cal.App.3d 832, 843 (Cal.App.1st 1989).

⁸ That element of the *Hughes* case has been superseded by Civ. Code, § 3 294, which sets the current standards for a finding of punitive damages.

⁹ See, e.g. *Hughes*, supra; see also *Padfield v. AIG Life Ins. Co.* (9th Cir. 2002) 290 F.3d 1121, 1123 (applying the doctrine of reasonable expectations and holding that death by autoerotic asphyxiation cannot be reasonably interpreted as an intentionally self-inflicted injury in order to justify the denial of a life insurance claim).

¹⁰ The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*

¹¹ The contention ERISA preempts parity laws was put to rest in *Thompkins v. BC Life and Health Ins. Co.* (C.D.Cal. 2006) 414 F.Supp.2d 953, n.4.

¹² See Cal. Ins. Code, §,10110.6.

¹³ See, e.g. *California Shoppers v. Royal Globe Ins. Co.* (1985) 175 Cal.App.3d 1.

¹⁴ See National Institute of Mental Health "The Numbers Count: Mental Disorders in America." (<http://www.nimh.nih.gov/statistics/index.shtml>)

