CASE NO. B244314

IN THE COURT OF APPEALS OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

MARISSA REA and KERRY MELACHOURIS, on behalf of themselves and all others similarly situated

Plaintiffs/Appellants,

v.

BLUE SHIELD OF CALIFORNIA,

Defendant/Appellee.

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND *AMICUS CURIAE* BRIEF IN SUPPORT OF APPELLANTS

On Appeal from Los Angeles Superior Court
Case No. BC468900
Honorable Anthony Mohr, Judge of Superior Court

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APPLICATION BY AND INTEREST OF THE *AMICUS CURIAE*

California Insurance Commissioner Dave Jones respectfully requests permission to submit this brief as *amicus curiae* in support of plaintiffs/appellants Marissa Rea and Kerry Melachouris to assist the court in interpreting the Mental Health Parity Act.

The Commissioner is one of eight statewide elected officials in California and is responsible for enforcing its insurance laws. The Commissioner oversees the Department of Insurance, a consumer protection agency with more than 1,200 employees throughout California. Among its responsibilities, the Department licenses insurers, agents and brokers; monitors insurers' financial solvency; protects consumers at the point of sale of insurance policies and when they make claims; makes sure the rates of certain lines of insurance are not unreasonable or excessive; enforces the provisions of the Insurance Code, including the Mental Health Parity Act ("MHPA" or "Act"), conducts market conduct examinations of insurers; brings enforcement actions against insurers, agents and brokers that break the law; and issues regulations to implement the insurance laws of California.

The Commissioner is specifically charged with regulating health insurance. Jurisdiction over the regulation of coverage for health care is divided between the Commissioner and the California Department of Managed Health Care ("DMHC"), a separate agency that reports to the Governor. The Commissioner regulates indemnity insurance (most commonly in the form of "preferred provider organization" or "PPO" insurance) and DMHC regulates health care plans (most commonly in the form of "health

maintenance organizations" or "HMOs").

Approximately 2.5 million Californians have health insurance subject to the Commissioner's jurisdiction. The MHPA is codified in virtually identical terms in the Knox-Keene Act ("Knox-Keene"), at Health & Safety Code section 1374.72, which DMHC enforces. The MHPA appears in the Insurance Code, at section 10144.5, which comes under the purview of the California Department of Insurance ("CDI").

The Commissioner has a strong interest in this case. Serious mental illness affects millions of Californians. According to a July 2013 study published by the California HealthCare Foundation ("CHCF"), approximately 1.9 million Californians, or 1 in 20, suffer from a severe mental illness.[1] Mental illness takes a heavy toll on the productivity of citizens at work and home, on the emotional lives of families and those surrounding individuals suffering mental illness, on the health care delivery system, and on the State of California's finances. California spent an estimated $7.76 billion to address the treatment and prevention of mental illness in California in fiscal year 2012-13.[2]

California's MHPA, passed in 1999, was crucially important in alleviating the financial and emotional toll exacted by mental illness by shifting the cost of care from the government to private insurers.[3] The Act requires private health insurers and health plans

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[1] California HealthCare Foundation, *Mental Health Care in California: Painting a Picture* at 2 (July 2013).

[2] California HealthCare Foundation, *A Complex Case: Public Mental Health Delivery and Financing in California* at 2 (July 2013)

[3] Cal. Assem. Comm. on Health, Committee Analysis of A.B. 88: Mental Health Parity Act, Reg. Sess. (Mar. 9, 1999).

to cover adequate treatment of severe mental illnesses and to do so on the same financial terms and conditions applicable to all benefits under the policy for the treatment of illnesses. In July 2011, the Commissioner expressed his view that the Act mandates coverage for all medically necessary treatment, in a Statement to the Senate Select Committee on Autism.[4]

The Commissioner enforces the Act with respect to indemnity insurance, and has taken enforcement actions to compel insurers to provide coverage for medically necessary behavioral health, speech and occupational therapy for insureds with autism. Most recently, CDI and the Commissioner promulgated an emergency regulation to clarify that insurers must provide all medically necessary treatment under the MHPA.[5] Those regulations became effective March 11, 2013.

The trial court's decision in this case construes the Act in a way that is inconsistent with CDI's interpretation, enforcement activities, and emergency regulation. It is also contrary to the well reasoned decision of the Ninth Circuit in *Harlick, v. Blue Shield of California* (9th Cir. 2012) 686 F.3d 699, as well as to the holding of a recent California Court of Appeal case, *Consumer Watchdog v. Dep't of Managed Health Care* (2d Dist. 2013) ___ Cal.App.4th ___ [162 Cal.Rptr.3d 85]. Unless reversed, the decision

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[4] California Department of Insurance Responses to Panel Questions, Senate Select Committee on Autism & Related Disorders Informational Hearing on Health Insurance Coverage for Autism Spectrum Disorders (ASD): Current Regulatory Oversight of Behavioral Intervention Therapy (July 13, 2011).

[5] Cal. Code Regs., tit. 10 § 2562.1 et seq.

would allow insurers to impose treatment and coverage limits on medically necessary treatment for autism, anorexia and other severe mental illnesses by using policy language which applies those limits to physical illnesses, even where the treatment is the medical standard of care. Furthermore, the lower court decision would allow insurers to continue the practices the Legislature sought to end in 1999 and CDI addressed in its regulations.

BACKGROUND

A. Incidence and Severity of Anorexia and Other Eating Disorders

Eating disorders are prevalent, serious and mainly affect women. One in 200 hundred women in the United States suffer from anorexia. Two to three percent of women in the United States suffer from bulimia nervosa, another eating disorder identified as a serious mental illness in the MHPA.[6] Anorexia has the highest mortality rate of any psychiatric illness. An estimated 10% of people with anorexia will die within ten years of onset of the illness.[7]

The Department receives many complaints about insurer refusals to provide coverage for eating disorders and assists people in obtaining coverage for those illnesses. Among other things, the Department oversees Independent Medical Review ("IMR") of these cases. Under IMR, an independent physician evaluates an insured's file to

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[6] South Carolina Department of Mental Health, "Eating Disorders," at http://www.state.sc.us/dmh/anorexia/statistics.htm.

[7] Patrick F. Sullivan, "Course and outcome of anorexia nervosa and bulimia nervosa," reproduced in *Eating Disorders and Obesity* 226-32 (Christopher G. Fairburn & Kelly D. Brownwell eds. 1995).

determine whether treatment is medically necessary. In the great majority of cases, IMR reviewers find residential treatment for eating disorders to be medically necessary. An IMR decision is binding on an insurer. Ins. Code § 10169.3(f).

B. Autism

Autism is a neurobiological disorder that affects a child's development by severely limiting his or her ability to interact with others.[8] It is a developmental disability that significantly hinders verbal and nonverbal communication and social interaction and is generally evident before age 3.[9] Autism is part of a larger class of pervasive developmental disorders (PDD) or autism spectrum disorders (ASD), which are synonymous terms referring to a continuum of related cognitive and neurobehavioral disorders. These disorders are characterized by severe and pervasive impairment in reciprocal social interaction and communication skills and stereotyped behavior, interests, and activities. The conditions are present from birth or early in development and are typically diagnosed in early childhood.[10] According to a March 2013 report, the United States Department of Health & Human Services Centers for Disease Control and

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[8] *McHenry v. PacificSource Health Plans*, No. CV-08-562-ST, slip op. at 1230 (D. Or. Jan. 5, 2010) (citing Dep't of Defense, Report and Plan on Services to Military Dependent Children with Autism 5 (2007) for definitions and 34 C.F.R. §300.8(c)(1)(i) (2012), which defines autism as a "developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before agree three, that adversely affects a child's educational performance").

[9] *See Id.*

[10] Pauline A. Filipek, *Intervention for Autism Spectrum Disorders*, 3 NeuroRx 207, 207-08 (2006).

Prevention estimated that 2.00% of children aged 6-17 were diagnosed with ASD in 2011-2012.[11] This prevalence estimate of 1 in 50 children with ASD is significantly higher than the estimate (1.16%, or 1 in 86) for children in that age group in 2007.[12]

Disputes over whether certain types of treatments are medically necessary or a covered health care service often delay necessary treatment for children with autism. CDI has tracked cases involving delays and denials of behavioral health treatment, as well as speech and occupational therapy, for children with this serious disorder since 2009. The decisions in CDI's IMRs consistently find behavioral health treatment, such as Applied Behavior Analysis therapy ("ABA"), as well as speech and occupational therapies to be medically necessary. The scientific literature relied on by these independent medical reviewers demonstrates that treatment is efficacious, well-documented through decades of research, and consistent with the recommendations from the Office of the Surgeon General, the National Institute of Mental Health, and other national governmental agencies, scientific institutions and professional organizations. Despite the use of overwhelming scientific evidence and IMR decisions requiring that an insurer provide coverage, some insurers refuse to provide coverage.

CDI similarly has required insurers under its jurisdiction to provide ABA treatment when medically necessary for autism. CDI ordered Anthem to provide ABA in

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[11] Stephen J, Blumberg, et al., *National Health Statistics Reports: Changes in Prevalence of Parent-reported Autism Spectrum Disorder in School-aged U.S. Children: 2007 to 2011-2012*, CENTERS FOR DISEASE CONTROL, March 20, 2013.

[12] *Id.*

November 2009, took enforcement action against Blue Shield in July 2011 and negotiated settlements with Blue Shield, Cigna, Health Net, and United Health Group early in 2012 requiring coverage of ABA therapy. The CDI agreements expired on July 1, 2012, when Senate Bill 946 ("S.B. 946"), became effective. Despite the measures taken by the Commissioner, CDI found it necessary in March 2013 to promulgate an emergency regulation clarifying that insurers must provide all medically necessary treatment to consumers under the MHPA. The Department of Insurance believes that the MHPA mandates insurers to provide coverage for all medically necessary treatment for enumerated serious mental illnesses. The decision in *Harlick* and the medical standards of care are entirely consistent with the Department's interpretation of the MHPA.

ARGUMENT

THE COURT ERRED IN FINDING THAT THE MHPA DOES NOT REQUIRE COVERAGE FOR ALL MEDICALLY NECESSARY TREATMENT OF ENUMERATED MENTAL ILLNESSES

I. THE MHPA REQUIRES INSURERS TO COVER TREATMENT FOR ENUMERATED MENTAL ILLNESSES

The Act enumerates nine types of mental illnesses insurers must cover.[13] To

[13] (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.

ensure parity, the Act requires insurers to offer viable treatment options for both physical illnesses *and* mental illnesses. Effective treatment of mental illness may require services that do not apply to physical illnesses. For example, residential care is often the *only* acceptable treatment for mental illnesses. But residential care often is not a necessary treatment for physical illnesses. The Act does not permit an insurer to eliminate coverage for mental illnesses by placing in the physical illness part of a policy an exclusion (e.g., for residential care) of minimal relevance to the treatment of physical illness but which is critical to the treatment of mental illness.

Additionally, the Legislature envisioned "equitable mental health coverage" for the treatment of mental health illnesses.[14] But that coverage is only possible if the "benefits" for mental illnesses are consistent with the medical standard of care for mental illness. Providing treatment benefits that fail to meet the standard of care would not provide "adequate coverage" for patients with severe mental illnesses.[15]

This comports with the text of the MHPA. Subsection (b) of the Act states that the covered benefits for those listed mental illnesses "shall include the following: (1) Outpatient services, (2) Inpatient hospital services, (3) Partial hospital services, and (4)

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(8) Anorexia nervosa.
(9) Bulimia nervosa.

Health & Saf. Code, § 1374.2 & Ins. Code, § 10144.5.

[14] Feb. 24, 1999, California Bill Analysis, Assembly Committee, 1999-2000 Regular Session, Assembly Bill 88, CA B. An., A.B. 88 Assem., 2/24/1999.

[15] Mar. 9, 1999, California Bill Analysis, Assembly Committee, 1999-2000 Regular Session, Assembly Bill 88, CA B. An., A.B. 88 Assem., 3/9/1999.

Prescription drugs, if the plan contract includes coverage for prescription drugs." Health & Safety Code § 1374.72(b); Ins. Code § 10144.5(b). When the Legislature used the term "shall include" in subsection (b), it indicated that the list was only a partial enumeration of the covered benefits within the ambit of the MHPA. Moreover, the California Department of Managed Health Care ("DMHC") promulgated a regulation implementing the Parity Act in 2003 that makes clear that the list of benefits in subsection (b) of the Act is not exhaustive.[16] Reading subsections (b) and (d) together, it is clear that the MHPA mandates coverage for all medically necessary treatment for the listed mental health illnesses, even those treatments not enumerated, provided they are the standard of care for that illness.

Therefore, where medically necessary residential treatment is the standard of care for anorexia, MHPA mandates that such benefits are covered despite not being expressly listed in subdivision (b) of the statute.

II. THE TRIAL COURT MISINTERPRETED THE PHRASE "TERMS AND CONDITIONS" IN THE MHPA

The trial court incorrectly interpreted the phrase "terms and conditions" in the MHPA.

The court read subsection (a) in isolation, finding that although the Act requires treatment for mental illnesses "under the same terms and conditions applied to other medical conditions,"[17] it does not require coverage for all medically necessary treatment

[16] *See* Cal. Admin. Code, tit. 28, § 1300.74.72(a)

[17] *Rea*, Order Sustaining Defendant's Demurrer to First Amended Complaint at 7-8.

for mental health conditions if the treatment is not also required for physical conditions.[18] This interpretation ignores the specific language of subsection (c), which defines "terms and conditions" in subsection (a). "Terms and conditions" refers to *financial* terms. Subsection (c) provides that "terms and conditions" "shall include, but not be limited to, the following: (1) Maximum lifetime benefits (2) Copayments (3) Individual and family deductibles." Health & Safety Code § 1374.72 (c); *accord* Ins. Code § 10144.5 (c). Under governing rules of statutory construction, the terms and conditions are limited to financial terms.

Each example of a term or condition specified in subsection (c) is financial. The rule of statutory construction *ejusdem generis* provides that "when a particular class of things modifies general words, those general words are construed as applying only to things of the same nature or class as those enumerated." *Scally v. Pacific Gas & Electric Co.* (1972) 23 Cal.App.3d 806, 819. Furthermore, "*ejusdem generis* applies whether specific words follow general words in a statute or vice versa. In either event, the general term or category is 'restricted to those things that are similar to those which are enumerated specifically.'" *International Federation of Professional & Technical Engineers, Local 21, AFL-CIO v. Superior Court* (2007) 42 Cal.4th 319, 342.

The Court of Appeal recently affirmed the proposition that "terms and conditions" in the MHPA is limited to financial terms. In *Consumer Watchdog v. Dep't of Managed*

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[18] *Rea* at 8 ("This means, for example, the plan would be required to cover the following for mental health conditions, even when not covered for physical conditions . . .").

Health Care (2d Dist. 2013) ___ Cal.App.4th ___ [162 Cal.Rptr.3d 85] the court held:

> The MHPA provides that the medically necessary treatments must be provided "under the same terms and conditions applied to other medical conditions as specified in subdivision (c)." (Health & Saf. Code, § 1374.72, subd. (a).) Those conditions *are financial in nature* – the maximum lifetime benefit, copayments, and deductibles. (Health & Saf. Code, § 1374.72, subd. (c).)

Consumer Watchdog v. Dep't of Managed Health Care (2d Dist. 2013) ___ Cal.App.4th ___ [162 Cal.Rptr.3d 85, 92, fn. 7] (emphasis added).

The legislative history of the MHPA confirms this. The Assembly Committee on Health ("Assembly Committee" and the Senate Health and Human Services Committee ("Senate Committee") explained the rationale and impetus of the MHPA. The Senate Committee, in reviewing the MHPA (A.B. 88), explained that one of the main purposes of the legislation was to "lessen out-of-pocket expenses for persons with mental illnesses."[19] The Assembly Committee looked to the federal Mental Health Parity Act for guidance: "The federal Mental Health Parity Act, effective last year, prohibits health plans from setting annual or lifetime dollar limits on an enrollee's mental health benefits that are lower than such limits on other medical care."[20] Both committees understood "terms and conditions" to be *financial* terms and conditions.

The court in *Harlick* confirmed this interpretation:

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[19] June 30, 1999, California Bill Analysis, Senate Committee, 1999-2000 Regular Session, Assembly Bill 88, CA B. An., A.B. 88 Sen., 6/30/1999.

[20] March 24, 1999, California Bill Analysis, Assembly Committee, 1999-2000 Regular Session, Assembly Bill 88, CA B. An., A.B. 88 Assem., 3/24/1999.

> Thus, plans need not provide more generous financial terms for coverage for severe mental illnesses than they provide for coverage of physical illnesses. For instance, if a plan has a twenty dollar deductible for each office visit to treat a physical illness, it may also have a twenty dollar deductible for each office visit to treat a severe mental illness.

Harlick, 686 F.3d at 711. But:

> In summary, plans that come within the scope of the Act must cover all "medically necessary" treatment for "severe mental illnesses," including the nine illnesses specifically listed, but can apply the same financial conditions—such as deductibles and lifetime benefits—that are applied to coverage for physical illnesses.

Id. at 712.

The trial court's interpretation of "terms and conditions" to apply to substantive terms and conditions, in particular, the availability of residential treatment, was erroneous.

CONCLUSION

The trial court erroneously interpreted the MHPA to permit insurers to avoid coverage for mental illnesses. Contrary to the court's holding, the MHPA does not permit insurers to eliminate medically necessary treatments for mental illness by adopting, under the rubric "terms and conditions," exclusions that have no adverse effect on the treatment of physical illnesses (because the excluded treatment is of minimal or no use for physical illnesses) but are necessary to treat mental illness. That outcome undermines parity and runs counter to the objective of the MHPA to expand, not reduce,

the availability of coverage for mental illness. The Commissioner respectfully urges this Court to reverse.

Dated: October 14, 2013

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CERTIFICATE OF WORD COUNT COMPLIANCE

Counsel of Record hereby certifies that pursuant to Rule 8.204(c)(1) of the California Rules of Court, this brief is produced using 13-point Roman type including footnotes and contains approximately 3,147 words, which is less than the total words permitted by the rules of court. Counsel relies on the word count of the computer program used to prepare this brief.

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