CASE NO. 10-15595

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JEANENE HARLICK,

Plaintiff/Appellant,

v.

BLUE SHIELD OF CALIFORNIA,

Defendant/Appellee.

BRIEF OF AMICUS CURIAE IN SUPPORT OF APPELLANT'S OPPOSITION TO BLUE SHIELD OF CALIFORNIA'S PETITION FOR REHEARING OR, IN THE ALTERNATIVE, EN BANC REVIEW OF THE COURT'S PANEL DECISION

(Filed by Consent of All Parties)

On Appeal from the United States District Court for the Northern District of California (DC NO. 3:08-CV-03651-SC)

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2A Norman J. Singer & J.D. Shambie Singer, *Sutherland Statutory Construction* § 47:17 (7th ed. 2007) 10

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Scott O. Lilienfeld, "Scientifically Unsupported and Supported Interventions for Childhood Psychopathology: A Summary," in *Pediatrics*, Vol. 115, No. 3, (March 2005) 11

South Carolina Department of Mental Health, "Eating Disorders," at http://www.state.sc.us/dmh/anorexia/statistics.htm 4

California Insurance Commissioner Dave Jones supports plaintiff/appellant Jeanene Harlick's opposition to Blue Shield of California's petition for rehearing or, in the alternative, en banc review of the Court's panel decision.

INTEREST OF THE AMICUS CURIAE[1]

The Commissioner is one of eight statewide elected officials in California and is responsible for enforcing the insurance laws of California. 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; 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 regulates heath insurance. Jurisdiction over the regulation of coverage for health care is divided between the Commissioner and

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[1] All parties consented to the Commissioner filing this brief. *See* Ninth Circuit Rule 29-2(a) (authorizing the filing if an amicus curiae brief in opposition to a petition for panel or en banc rehearing without leave of court when all parties consent).

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 Commissioner has a strong interest in this case. Mental illness affects millions of Californians. Data from 2004 show that more than two million Californians, or 6.5% of the population at that time, suffer serious mental illnesses or serious emotional disturbances.[2] Mental illness takes a heavy toll on the productivity of citizens at work and home, on the emotional lives of families and those surrounding those suffering mental illness, on the medical system, and on the State of California's finances. California spends more than $4 billion a year to address the treatment and prevention of mental illness.[3]

Critical to alleviating the financial and emotional toll exacted by mental illness is private Insurance. Since 2000, California has had a Mental Health Parity

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[2] *See* website of California Department of Mental Health ("DMH"), Prevalence Table 1 based on data from 2000 U.S. census, at http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/Prevalence_Rates/California/Table1.pdf.

[3] *See* DMH website description of California's annual public mental health budget, at http://www.dmh.ca.gov/About_DMH/default.asp.

Act ("Act") requiring private health insurers and health plans to cover treatment of severe mental illnesses and to do so on the same terms and conditions applied to the treatment of other illnesses. The Act was designed not only to protect patients with severe mental illnesses, but to reduce the financial burden on state and local governments by shifting the cost of treatment to insurers. *See* Mental Health Parity Act, Cal. Stats. 1999, Ch. 534 (AB 88), § 1(c)(2) ("The Legislature further finds and declares all of the following: . . . The failure to provide adequate coverage for mental illness in private health insurance policies has resulted in significant increased expenditures for state and local governments"). The Commissioner enforces the Act with respect to indemnity insurance.

The panel decision interprets the Act consistent with the Department's interpretation and enforcement activities. The decision provides important guidance to health insurers about the scope of the Act and the degree to which insurers may and may not limit coverage for mental illnesses. The Act applies not only to anorexia, but to eight other types of severe mental illness, including schizophrenia, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, and pervasive developmental disorder or autism.

ADDITIONAL BACKGROUND

A. Incidence and Severity of Anorexia and Other Eating Disorders

Eating disorders are prevalent and serious. They 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 Mental Health Parity Act.[4] Anorexia has the highest mortality rate of any psychiatric illness. It is estimated that 10% of people with anorexia will die within ten years of onset of the illness.[5]

The Department receives many complaints about insurer refusals to provide coverage for eating disorders. The Department assists people in obtaining coverage for those illnesses. Among other things, the Department oversees a program of independent medical review ("IMR"). Under IMR, an independent doctor evaluates an insured's file to determine whether treatment is medically necessary. In the great majority of cases, IMR reviewers find treatment for eating disorders to be medically necessary. An IMR decision is binding on an insurer. Ins. Code § 10169.3(f).[6]

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

[5] 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. Brownell eds. 1995.

The panel decision gives clear guidance on coverage for eating disorders, may obviate the need for IMR, and is likely to reduce delays in treatment and expenses to patients.

B. Autism

The panel's decision also provides important guidance regarding coverage for autism. The Commissioner is particularly concerned about insurers' refusal to provide coverage for autism. Autism is a disorder in which a person has deficits in social interaction and communication skills, accompanied with other developmental abnormalities. Autism covers a spectrum of mental illnesses, including autistic disorder, Asperger's Syndrome, pervasive developmental disorder, and Rett's Syndrome. About 1 in 110 people today have autism.[7]

The Department of Insurance receives many complaints from parents of children with autism that insurers refuse to provide coverage. For many complaints, the Department oversees IMR, which overwhelmingly results in a finding that treatment for autism is medically necessary. Even after IMR decisions requiring that an insurer provide coverage, some insurers refuse to provide coverage.

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[6] Unless otherwise indicated, all statutory references are to sections of the California Code.

[7] *See* Lorri S. Unumb & Daniel R. Unumb, *Autism and the Law: Cases, Statutes, and Materials* 3 (Carolina Academic Press 2011).

In July of this year, the Department filed an administrative enforcement action against Blue Shield of California Life and Health Insurance Company (an affiliate of Blue Shield of California, the defendant-appellee in this case) for denying coverage for autism treatment to two children. The Department contends that the Mental Health Parity Act requires Blue Shield to provide coverage. The panel's decision in *Harlick* provides guidance on many of the issues the Department raises.

ARGUMENT

A. The Panel Decision

The panel held that an exclusion for "residential care" treatment in Blue Shield's plan violated the Mental Health Parity Act.[8] The panel's analysis has several components.

First, because residential care is uniquely important for the treatment of mental illness and was medically necessary for Harlick, the panel held that excluding the coverage effectively would create a *disparity* against the treatment of a mental illness. *Harlick*, slip op. at 16429.

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[8] The Act appears in two parts of the California Code. First, it appears in the Knox-Keene Act, a part of the Health and Safety Code, at Section 1374.72. DMHC administers this Act. Second, the Act appears in the Insurance Code at Section 10144.5. The Commissioner administers this Act. The two Acts are identical in pertinent part.

Second, the Act lists four "benefits" that must be included in health care coverage: "(1) Outpatient services, (2) Inpatient hospital services, (3) Partial hospital services, and (4) Prescription drugs, if the plan contract includes coverage for prescription drugs." Health & Safety Code § 1374.72(b); Ins. Code § 10144.5(b). Blue Shield argued that this is an exhaustive listing of benefits that must be provided and it therefore could exclude all other benefits, including "residential care" treatment. The panel rejected this argument. Based on the language of the statute and a comparison to how other provisions are written, the panel held that the listing of benefits that must be provided is not an exhaustive list and that Blue Shield could not exclude residential care treatment. *Harlick*, slip op. at 16426-27.

Third, the Act provides that coverage for mental illness shall be subject to "the same terms and conditions applied to other medical conditions." Health & Safety Code § 1374.72(a); Ins. Code § 10144.5(a). The Act specifies: "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." Health & Safety Code § 1374.72(c); Ins. Code § 10144.5(c). The panel accepted the parties' view that "terms and conditions" is

limited to "financial limits – such as yearly deductibles and lifetime benefits." *Harlick*, slip op. at 16425.

Fourth, the panel held that Blue Shield must cover residential care treatment even if the treatment facility and its personnel are not licensed. *Harlick*, slip op. at 16433-34 (rejecting DMHC's assertion in litigation to the contrary). This conclusion flows from the panel's acceptance that terms and conditions restricting coverage are limited to financial terms, such as deductibles and annual limits.

B. The Panel Correctly Analyzed the Mental Health Parity Act

The panel's decision correctly analyzed three basic points of critical interest to the Commissioner.

1. The Act Creates a Mandate to Cover All Medically Necessary Diagnosis and Treatment of Mental Illness

The panel held that the Act is both a *mandate* and a source of *parity*. *Harlick*, slip op. at 16425. The mandate is expressed as follows:

> Every health care 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* . . . .

Ins. Code § 10144.5(a) (emphasis added). The California Court of Appeal has confirmed that the Act creates a mandate. *Arce v. Kaiser Found. Health Plan, Inc.*, 181 Cal. App. 4th 471, 491 (2010) ("In essence, section 1374.72 [the Knox-Keene

Mental Health Parity Act] is a mental health insurance *mandate* . . .") (emphasis added).

Picking up from where the indented quotation left off, the Act provides for parity:

> *under the same terms and conditions* applied to other medical conditions as specified in subdivision (c).

Id. § 10144.5(a) (emphasis added); *see Arce*, 181 Cal. App. 4th at 491 (the Act "'obligate[s] health plans to provide coverage (not merely offer it) for the diagnosis and treatment of mental illness *equal to coverage* that the plans appl[y] to other medical conditions'") (quoting *Yeager v. Blue Cross of California*, 175 Cal. App. 4th 1098, 1103 (2009)) (emphasis added).

The panel therefore correctly concluded that the Act mandates insurers to cover all medically necessary treatment of the enumerated mental illnesses. "In summary, plans that come within the scope of the Act must cover all 'medically necessary' treatment for the nine listed mental illnesses . . . ." *Harlick*, slip op. at 16425. Moreover, the required equality of coverage must mandate those treatments which are medically necessary to comply with the standard of care for a specific disease. The appropriate treatments will necessarily differ depending on the medical condition of the patient. Anorexia cannot be effectively treated in the same way as a serious physical illness such as pancreatic cancer.

2. "Terms and Conditions" Are Limited to Financial Terms, Such as Deductibles and Annual Limits

The panel accepted the proposition that "terms and conditions" restricting coverage for mental health treatment are limited to financial terms, such as maximum lifetime benefits, copayments, and deductibles. The panel was correct to accept that interpretation.

The Act gives examples of three types of terms or conditions an insurer may impose: Maximum lifetime benefits, copayments, and deductibles. Health & Safety Code § 1374.72(c); Ins. Code § 10144.5(c). All of these are financial conditions. When a statute contains a non-exhaustive list, one looks to the *characteristic* of listed items to determine what additional items may included on the list. *See* 2A Norman J. Singer & J.D. Shambie Singer, *Sutherland Statutory Construction* § 47:17 (7th ed. 2007) ("[w]here general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words"; this interpretive principle applies whether the general word precedes or follows the specific words; the word "include" (as in "including but not limited to") is a general word subject to this interpretive principle) (footnotes omitted) (citing cases). The characteristic of the terms and conditions listed in the Mental Health Parity is that they are financial terms.

A broader reading of the phrase "terms and conditions" could eviscerate medically necessary coverage for many mental illnesses. For example, a "term" or "condition" some insurers attempt to impose in connection with autism is a limit on the number of speech therapy visits. An insurer might point to a limit of 20 doctor visits per year applicable to speech therapy for non-mental illnesses and argue that satisfies parity. But treating speech impairment, a core deficit of autism, may require many more regular visits. A 20-visit limit therefore would vitiate coverage for autism and cannot be justified by the assertion that a limit of 20 visits also applies to treating speech impairments caused by a physical accident or injury.

3. Licensure of Mental Health Providers Is Not Required

The panel correctly held that insurers may not require licensure of treatment providers. This holding follows from the fact that the only permitted terms and conditions are financial terms and conditions. Licensure is not a financial term and therefore is not permitted.

A requirement of licensure would eviscerate coverage for some mental illnesses. For example, the standard of care for autism treatment is applied behavior analysis ("ABA").[9] There is no license in California and many other states for ABA therapy. Rather, there is a nationally recognized certification from

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[9] *See, e.g.*, Scott O. Lilienfeld, "Scientifically Unsupported and Supported Interventions for Childhood Psychopathology: A Summary," in *Pediatrics*, Vol.

the Behavior Analysis Certification Board ("BACB"). The model for autism treatment is that a licensed doctor prescribes ABA and it is carried out by a BACB-certified professional, who may also supervise other personnel. A requirement of licensure for the ABA provider would vitiate most coverage for autism.

C. Blue Shield's Arguments Are Unpersuasive

Blue Shield contends that a DMHC regulation interpreting the Mental Health Parity Act establishes that insurers are not required to provide all medically necessary coverage for severe mental illnesses. The regulation provides:

> The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 [the Mental Health Parity Act] shall include, when medically necessary, all health care services required under *the Act* including, but not limited to, basic health services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28.

28 Cal. Code Regs. § 1300.74.72(a) (emphasis added).

Blue Shield interprets the italicized phrase "the Act" to refer to the Knox-Keene Act, not the Mental Health Parity Act. Appellee's Petition for Panel Rehearing 5-6. Blue Shield asserts that the Knox-Keene Act does not require coverage for all medically necessary treatments. *Id.* at 3-4 ("The Knox-Keene Act, the statutory scheme that governs managed health care plans in California, does not

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115, No. 3, p. 762 (March 2005) ("[t]he most efficacious psychosocial treatment for autism is applied behavior analysis…").

require plans to cover all health care services that may be medically necessary. It only requires coverage for enumerated 'basic health care services' and certain discrete other services specified in the statute.")

The panel correctly rejected Blue Shield's argument. It held that the phrase "the Act" in DMHC's regulation refers to the Mental Health Parity Act. *Harlick*, slip op. at 16428. But Blue Shield's argument fails even if, for the sake of argument, "the Act" as used in DMHC's regulation refers to the Knox-Keene Act. The Knox-Keene Act *includes* the Mental Health Parity Act. The Knox-Keene Act encompasses sections 1340 to 1399.818 of the Health and Safety Code. *See* Health & Safety Code § 1340 (defining scope of Knox-Keene Health Care Service Plan Act of 1975). The Mental Health Parity Act appears within that range, at Health and Safety Code section 1374.72. DMHC's regulation therefore means insurers must provide coverage for all treatments necessary to satisfy the Mental Health Parity Act.

Blue Shield further argues that the panel's interpretation of the Act gives *more* coverage for mental illnesses than for other illnesses, thereby destroying parity. Blue Shield is wrong.

The issue is whether Blue Shield must provide coverage for "residential care" if it is medically necessary to treat a mental illness. Blue Shield's plan excludes coverage for residential care both for mental illnesses and other types of

illnesses. Blue Shield therefore contends that the exclusion creates parity. But the exclusion in fact creates *disparity* because residential care is often the *only* way to treat certain mental illnesses, whereas other options are available for the treatment of other types of illnesses. For example, Blue Shield's plan offers skilled nursing home treatment for all types of illnesses. That option will be effective for many types of non-mental illnesses. But it is not effective for the treatment of mental illnesses such as Ms. Harlick's anorexia. The panel correctly rejected Blue Shield's argument: "[I]t makes no sense in a case such as Harlick's to pay for 100 days in a Skilled Nursing Facility – which cannot effectively treat her anorexia nervosa – but not to pay for time in a residential treatment facility that specializes in eating disorders." *Harlick*, slip op. at 16429.

CONCLUSION

The Commissioner urges the Court to deny Blue Shield's petition for rehearing or, in the alternative, en banc review and allow the soundly reasoned panel decision to continue to provide guidance to regulators and protection to consumers.

Dated: November 10, 2011

CALIFORNIA DEPARTMENT OF INSURANCE
By:______________________________
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BRIEF FORMAT CERTIFICATION

Pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached amicus brief is proportionally spaced, has a typeface of 14 points or more and contains 2777 words, not including the Table of Contents, Table of Authorities, the caption page, or this certification page.

Dated: November 10, 2011

CALIFORNIA DEPARTMENT OF INSURANCE
By:____________________________
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Dave Jones, Insurance Commissioner of the State of California

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