FILED
Superior Court of California
County of Los Angeles

JUN 13 2012 MC

John A. Clarke, Executive Officer/ Clerk

By _____, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

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

Plaintiffs,

vs.

BLUE SHIELD OF CALIFORNIA, and DOES 1-25 inclusive,

Defendants.

Case No.: BC468900

ORDER SUSTAINING DEFENDANTS' DEMURRER TO THE FIRST AMENDED COMPLAINT

I. Introduction:

Plaintiffs hold health insurance policies issued by Defendant Blue Shield. They allege that Blue Shield improperly denied coverage for residential treatment in connection with their eating disorders. The policies at issue exclude residential treatment not only for eating disorders, but for all disorders, be they mental or physical. Plaintiffs have filed a proposed class action on behalf of all policyholders who were denied coverage for residential treatment of an eating disorder after July 1, 2000. They contend that eating disorders constitute mental illnesses that are covered by the California Mental Health Parity Act (hereinafter referred to as "the Parity Act" or "MHPA") and thus all medically necessary treatment must be covered, including residential.

The Complaint, filed September 2, 2011, contained causes of action for (1) breach of contract, (2) breach of the implied covenant, (3) declaratory relief, (4) violation of Bus. & Prof. Code §17200 and

(5) Violation of Health & Safety Code §1374.72 (MHPA) and Insurance Code §10144.5. The First Amended Complaint (FAC), filed December 1, 2011, eliminated the fifth cause of action and replaced it with a claim for an Unruh Act violation (Civ. Code §51 et seq.).

Defendant demurs to all causes of action. The Court concludes that the demurrers are well taken and sustains them without leave to amend.

II. Discussion:

Cal. Health & Safety Code §1374.72, the California Mental Health Parity Act (MHPA), provides as follows:

> (a) 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 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:
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> (1) Outpatient services.
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> (2) Inpatient hospital services.
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> (3) Partial hospital services.
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> (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:

. . .

(8) Anorexia nervosa.

(9) Bulimia nervosa.

The MHPA is part of the Knox-Keene Act (Health & Safety Code § 1340 et. seq.), which was enacted in 1999 to remedy the perceived disparity in coverage provided for mental illnesses compared to other medical conditions. (Sec. 1, Stats. 1999, c.534 (A.B. 88).)[1] The Knox-Keene Act requires that

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[1] In *Harlick v. Blue Shield of California* (9th Cir. 2012) --- F.3d ----, 2012 WL 1970881, the Ninth Circuit said that "[t]he legislature further found that coverage limitations had resulted in inadequate treatment of mental illnesses, causing 'relapse and untold suffering' for people with treatable mental illnesses, as well as increases in homelessness, increases in crime, and significant demands on the state budget." (*Id.* at *8, citing Sec. 1, Stats. 1999, c.534 (A.B. 88)).) In *Arce v. Kaiser Foundation Health Plan, Inc.* (2010) 181 Cal.App.4th 471, 491, the Court of Appeal stated that "The Legislature further found that "[t]he failure to provide adequate coverage for mental illnesses in private health insurance

"[a] health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345...." (H&S Code §1367(i)(1).)

Section 1345(b) defines "basic health care services" as including:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(7) Hospice care pursuant to Section 1368.2.

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policies has resulted in significant increased expenditures for state and local governments." (Stats. 1999, ch. 534, § 1.) The stated purpose of the statute was to "prohibit discrimination against people with biologically-based mental illnesses, dispel artificial and scientifically unsound distinctions between mental and physical illnesses, and require equitable mental health coverage among all health plans and insurers to prevent adverse risk selection by health plans and insurers." (Assem. Com. on Health, Rep. on Assem. Bill No. 88 (1999–2000 Reg. Sess.) March 9, 1999, p. 2.)."

The Department of Managed Health Care (DMHC) has stated, through its implementing regulation, 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 health care 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.

(28 Cal. Admin Code § 1300.74.72(a).)

In the case at bar, Plaintiffs insist that the MHPA requires coverage for residential treatment of eating disorders when that treatment is medically necessary, even if an insurer does not provide comparable treatment for physical conditions. Defendant does not cover all medically-necessary treatment for physical conditions and thus, it argues, it need not cover all medically-necessary treatment for mental health disorders, just *comparable* treatment. (MP p. 6.) The issue hinges on the language of the MHPA which requires treatment "under the same terms and conditions applied to other medical conditions...." (H&S Code §1374.72(a).) So, for example, *Kaiser Foundation Health Plan, Inc. v. Zingale* (2002) 99 Cal.App.4th 1018, 1024 explained that all medically necessary prescription drugs are not covered for physical conditions and thus rejected the DMHC's attempt to force a plan to provide coverage for Viagra (a physical condition):

> If the Legislature intended to require the prescription drug benefit to include all medically necessary prescription drugs, subdivision (a) of section 1367.22 is superfluous. We, however, adopt the interpretation that gives each provision meaning. (See Dix v. Superior Court, supra, 53 Cal.3d at p. 459.)" (1027) and "If the Legislature had intended

to require every health care service plan that offers a prescription drug benefit to cover all medically necessary prescription drugs or to allow the Department to impose that requirement, it would have been simple for the Legislature to say so.

Defendant argues that since coverage need not be provided for all medically necessary treatment of physical conditions, as *Zingale* demonstrates, coverage for all medically necessary treatment for mental health conditions is also not required. This, Defendant claims, achieves the parity contemplated by the title of the MHPA. This Court agrees.

The Ninth Circuit has twice found in favor the Plaintiffs. *Harlick v. Blue Shield of California* (9th Cir. 2011) 656 F.3d 832, 851 held that the MHPA did require coverage for residential treatment for eating disorders and other mental illnesses simply because that treatment was medically necessary. Then on June 4, 2012, the Court withdrew that opinion and replaced it with *Harlick v. Blue Shield of California* (9th Cir. 2012) --- F.3d ----, 2012 WL 1970881. Once again the court found for Plaintiffs, but this time Judge Smith dissented. Defendant believes the case was wrongly decided both times, and this Court agrees, finding Judge Smith's dissent more persuasive than the majority opinion.

The scope of coverage required under the MHPA has been addressed in several published opinions and has been specifically raised in a lawsuit against the DMHC. However, the appellate decisions which are binding on this Court do not decide this precise issue, and *Harlick* -- which does -- is not binding.

We begin with the basic rules of statutory interpretation.

"In interpreting a statute where the language is clear, courts must follow its plain meaning. [Citation.] However, if the statutory language permits more than one reasonable interpretation, courts may consider various extrinsic aids, including the purpose of the statute, the evils to be remedied, the legislative history, public policy, and

the statutory scheme encompassing the statute. [Citation.] In the end, we ' "must select the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute, and avoid an interpretation that would lead to absurd consequences." [Citation.]' [Citation.]" (Torres v. Parkhouse Tire Service, Inc. (2001) 26 Cal.4th 995, 1003 [111 Cal.Rptr.2d 564, 30 P.3d 57].)

(*Kaiser Foundation Health Plan, Inc. v. Zingale* (2002) 99 Cal.App.4th 1018, 1023.)

A. Statutory Language

Defendant argues that the statutory language contemplates only parity, and no greater benefits for mental health concerns. (MP, p. 11.) Again, the statute specifies "coverage for the diagnosis and medically necessary treatment of severe mental illnesses [ ] *under the same terms and conditions* applied to other medical conditions as specified in subdivision (c). (H&S Code §1374.72 (emphasis added).)

1. "Terms and conditions"

Harlick had this to say about the "terms and conditions" language:

Subsection (a) contains only one limitation on the basic mandate that coverage be provided for "medically necessary treatment of severe mental illnesses": such coverage must be provided "under the same terms and conditions applied to other medical conditions as specified in subdivision (c)." **The parties agree that the phrase "terms and conditions" refers to monetary conditions, such as copayments and deductibles.** 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.

. . .

Subsection (c) gives three illustrative examples of "terms and conditions" that must apply equally to coverage for mental and physical illnesses: maximum lifetime benefits, copayments, and deductibles. As explained above, the parties agree that "terms and conditions" refers only to financial terms and conditions.

(*Harlick, supra*, 2012 WL 1970881 at *9 (emphasis added).)

This Court declines to follow *Harlick* for several basic reasons. The first is not the Ninth Circuit's fault. There, both parties agreed "that the phrase 'terms and conditions' refers to monetary conditions, such as copayments and deductibles." In the case at bar, the parties most definitely do not agree,[2] which leaves the Court free to draw its own conclusion. Without question, the three enumerated "terms and conditions" in subsection (c) involve financial subjects, but the use of "including but not limited to" implies that the legislature did not intend to so limit the conditions. If they had intended otherwise, they would not have added the last five words. It follows that one could conceive of more than the three enumerated terms and conditions, and that they need not be limited to financial points.

Blue Shield points out that if "terms and conditions" included only the financial limitations listed in (c), then "the plan is not allowed to enforce the numerous substantive (i.e. nonfinancial) terms and conditions that are generally applicable to all benefits under the EOC." (MP pp. 15-16.) This means, for example, the plan would be required to cover the following for mental health conditions, even when not covered for physical conditions: services performed in a hospital by interns or others in training, services performed by a close relative who lives with the plan member, drugs not approved by the FDA,

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[2] Blue Shield disputes that it *ever* agreed to the interpretation of "terms and conditions" in *Harlick*. (MP p. 15; Def's RJN Exh. B, p. 9; Reply p. 10.) The Court need not resolve that point. Here, it is clear the parties don't agree.

services for vocational and other forms of therapy, services by an unlicensed individual, services covered by workers' compensation, experimental procedures and treatments that exceed a determined number of days (i.e. 100 days at a skilled nursing facility). (MP p. 16; Reply p. 9.) An amicus brief filed by the Insurance Commissioner on Plaintiffs' behalf in *Harlick* confirms that coverage for treatment by a mental health patient's unlicensed provider would be required under Plaintiffs' interpretation. (Pltf's RJN Exh. B, pp. 11-12.)

This cannot be the result intended by a statute designed to achieve parity.

2. "Including, but not limited to"

This Court respectfully disagrees with the Ninth Circuit's conclusion that "include" means "including but not limited to." Plaintiffs argue, and *Harlick* concluded, that the list of benefits in subsection (b) is not exhaustive. *Harlick* observed:

> Subsection (b) of the Act says that benefits "shall include" the four listed treatments, but it does not explicitly say whether the list is exhaustive. By contrast, the list of "terms and conditions" in subsection (c) of the Act is explicitly characterized as a non-exhaustive list. Cal. Health & Safety Code § 1374.72(c) ("The terms and conditions ... shall include, but not be limited to, the following."). At least two district courts have concluded that the difference in wording means that the list of benefits in subsection (b) is exhaustive. Wayne W. v. Blue Cross of Cal., No. 1:07–CV–00035, 2007 WL 3243610, at *4 (D.Utah Nov. 1, 2007); Daniel F. v. Blue Shield of Cal., No. C09–2037, 2011 WL 830623, at *8–9 (N.D.Cal. Mar. 3, 2011).
>
> However, the California Department of Managed Health Care ("DMHC"), promulgated a regulation implementing the Parity Act in 2003. The regulation makes clear that the list

of benefits in subsection (b) of the Act is not exhaustive. 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 Parity Act] shall include, when medically necessary, all health care 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.

28 Cal. Admin. Code § 1300.74.72(a) (emphasis added). The words "including, but not limited to" in the regulation suggest that the list of benefits in subsection (b) of the Act, as well as the "basic health care services" specified in the regulation, are illustrative rather than exhaustive.

(*Harlick, supra*, 2012 WL 1970881 at **10-11.)

This Court does not agree that "include" means "including but not limited to." It is nearly impossible to conclude that whoever drafted this statute meant for the former to include the latter when, in the same statute, the drafters used both terms. One must presume they did so for a reason. The Court appreciates the cases cited at page 14 of Plaintiffs' points and authorities, but none of them interprets a fact situation like this, where both "include" and "including but not limited to" appear in the same piece of legislation. In such a situation, "[i]t is well recognized that '[w]hen one part of a statute contains a term or provision, the omission of that term or provision from another part of the statute indicates the Legislature intended to convey a different meaning.'" (*Krug v. Maschmeier* (2009) 172 Cal.App.4th 796, 803 (citation omitted).) Put another way, "'[o]rdinarily, where the Legislature uses a different word or phrase in one part of a statute than it does in other sections or in a similar statute concerning a related subject, it must be presumed that the Legislature intended a different meaning.'" (*Roy v. Superior Court* (2011) 198 Cal.App.4th 1337, 1352 (citations omitted).)

In *In re Johnny M.* (2002) 100 Cal.App.4th 1128, 1135, just ahead of the passage on which Plaintiffs rely, the Court says, "[i]In *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1389, [ ], our Supreme Court held that the phrase 'including, but not limited to' is a phrase of enlargement." Meanwhile, one of the two cases on which *Dyna-Med* relied is Justice Mosk's dissent in *American National Ins. Co. v. Fair Employment & Housing Com.* (1982) 32 Cal.3d 603, 611 which states, "[a]nd in still further provisions the Legislature makes it clear that it is using 'includes' as a term of enlargement by adding the phrase, 'including, but not limited to ....' (See §§ 12961, 12970, subd. (a).)."

Unless we are prepared to say that "includes" and "including but not limited to" are synonymous, the plain meaning rule suggests that that latter encompasses more than the former. Moreover, Plaintiffs' "interpretation renders subsection (b) completely superfluous. They cannot explain why the Legislature would have used 'include' to introduce a supposedly *non*-exhaustive list in subsection (b), then used the phrase 'include, *but not [ ] limited to'* to introduce a non-exhaustive list in subsection (c), and used 'include' in subsection (d) to introduce an *exhaustive* list of the mental illnesses covered by the Parity Act." (Reply p. 7 (emphasis in original).) "Subsection (d) of the Parity Act introduces the list of Severe Mental Illnesses subject to the Parity Act with the word 'include' – the same word that Plaintiffs claim is used non-exhaustively in subsection (b). But no one, including Plaintiffs, has claimed that the list of covered mental illnesses in subsection (d) is anything other than exhaustive. The legislative history confirms this, as it shows the Legislature added, and then deleted, certain categories and repeatedly referred to the Parity Act as extending only to 'selected' mental illnesses. See Legislative History at LH 11, LH 17, LH 46, LH 72, LH 84." (Reply p. 7 & n. 6.)

This was the also the conclusion reached by the dissent in *Harlick*:

> The majority notes that at least two district courts have interpreted language, similar to section (b) language, to indicate an exhaustive list. Revised Maj. Op. 6196 (citing *Wayne W. v. Blue Cross of Cal.*, No. 1:07–CV–00035, 2007 WL 3243610, at *4 (D.Utah Nov. 1,

2007); *Daniel F. v. Blue Shield of Cal.*, No. C09–2037, 2011 WL 830623, at *8–9 (N.D.Cal. Mar. 3, 2011)). Specifically, the district court in *Daniel F.* arrived at a very similar conclusion to the one that Blue Shield advocates here. 2011 WL 830623, at *8 (noting that "the Parity Act does not require that insurers cover residential treatment, and does not require coverage for all 'medically necessary health care service"; rather, only the specific benefits enumerated under the Parity Act are required, as well as benefits voluntarily "provided under a given plan"; thus "if the plan at issue covers hospitalization for physical illness where medically necessary, it must cover hospitalization for mental illness where medically necessary"). I agree that this interpretation is a consistent interpretation of the Parity Act, because the services specifically required under the Parity Act and its implementing regulation are exhaustive, unless the insurer has voluntarily chosen to provide a non-mandated benefit for a physical condition.

(*Harlick, supra,* 2012 WL 1970881 at *21 (Smith, J., dissenting).)

Accordingly, the Court finds the list of benefits in subsection (b) is exhaustive.

3. "The Act"

Although the latest *Harlick* opinion concludes that that the Knox-Keene Act goes into the brackets in the Parity Act's implementing regulation, the majority still believes that Knox-Keene's boundaries do not confine the Parity Act. But as Defendant points out, the DMHC's implementing regulation dictates that the benefits provided for by the MHPA be determined by reference to the Knox-Keene Act, and Knox-Keene does not require coverage for all medically necessary treatment for physical conditions. It should follow that parity does not require coverage for all medically necessary treatment for mental illnesses. The majority in *Harlick* disagreed:

Blue Shield writes in its brief that [the Parity Act's implementing regulation]

> states that the mental health services required under the Parity Act "shall include, when medically necessary, all health care services required under the [Knox–Keene] Act, including, but not limited to, basic health care services within the meaning of[the statutory provisions]."

(quoting § 1300.74.72(a); italics, "[Knox–Keene]", and "[the statutory provisions]" added by Blue Shield). The Knox–Keene Act regulates insurance coverage of physical illness, without restriction on the type or severity of the illness. Unlike the Parity Act, it is not limited to "severe" illnesses. The Knox–Keene Act does not mandate coverage of all medically necessary treatments for physical illnesses. Cal. Health & Safety Code §§ 1345(b), 1367(i); 28 Cal. Admin. Code § 1300.67. Blue Shield contends that under the regulation, coverage mandated by the Parity Act for severe mental illnesses is no greater than coverage mandated by the Knox–Keene Act for physical illnesses.

The regulation implementing the Parity Act does not specify whether the "Act" to which it refers without specification is the Knox–Keene Act or the Parity Act. We are willing to assume, as Blue Shield assumes, that the word "Act" refers to the Knox–Keene Act. Administrative Code § 1300.45 provides definitions for terms used in health care regulations. Section 1300.45(a), promulgated in 1976, defines "Act" to mean "the Knox–Keene Health Care Service Plan Act of 1975." See also Arce v. Kaiser Foundation Health Plan, Inc ., 181 Cal.App.4th 471, 492 (2010) (inserting "Knox–Keene" in brackets when quoting § 1300.74.72(a)). But see Daniel F. v. California Physicians' Service, 2009 WL 2581303 at *6 (N.D.Cal. Aug. 20, 2009)) (observing that § 1300.74.72(a) "provides that the mental health services required under § 1374.72 shall include all health care services required under the *Parity Act*" (emphasis added)). But it does not follow that the coverage for severe mental illnesses mandated by the Mental Health Parity Act is restricted to the coverage for physical illnesses mandated by the Knox–Keene Act.

> The implementing regulation for the Parity Act provides, as noted above, that the mandated coverage of the Parity Act "shall include, when medically necessary, all health care services required under the Act, including but not limited to, basic health care services within the meaning of § 1345(b) [.]" § 1300.74.72(a) (emphasis added). In quoting the regulation, Blue Shield plays down the importance of the phrase "including but not limited to" by italicizing the words preceding and following that phrase. But the phrase is critical. It makes clear that the Parity Act mandates coverage of the "basic health care services" appropriate to physical illnesses specified in § 1345(b), and that the Parity Act's mandated coverage for severe mental illnesses includes but is not limited to those basic health care services.

(*Harlick, supra,* 2012 WL 1970881 at **11-12.)

While accusing Blue Shield of "play[ing] down" the importance of the phrase "including but not limited to," *Harlick* ignores the fact that that phrase is necessarily circumscribed by the immediately preceding passage, "all health care services required under the [Knox Keene] Act." The "including but not limited to" language cannot expand beyond the universe of the Knox-Keene Act, which does not provide coverage for all medically necessary treatment of physical conditions -- a position again endorsed by the dissenting opinion in *Harlick*:

> Once we agree that the word "Act" is referencing the Knox–Keene Act, the majority's conclusion that "it does not follow that the coverage for severe mental illnesses mandated by the Mental Health Parity Act is restricted to the coverage for physical illnesses mandated by the Knox–Keene Act," is a non sequitur. Revised Maj. Op. 6199. This reference acts as a statutory limit on the type of benefits that insurers are required to cover. Thus, only the interpretation of the Parity Act that adheres to this text is appropriate.
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> . . .

> The majority's current interpretation of the regulation reads out the modifying text: that the benefits must be provided when "required under the [Knox–Keene] Act...." Such a reading contradicts California's longstanding rule against interpreting portions of statutory or regulatory text to be superfluous. *See Wells v. One2One Learning Found.*, 141 P.3d 225, 248 (Cal.2006) ("[I]nterpretations which render any part of a statute superfluous are to be avoided.").
>
> The "including, but not limited to," language (on which the majority relies) does not contradict this interpretation of the Parity Act. California courts have explained that, while the phrase "including, but not limited to" is admittedly a "phrase of enlargement," this phrase is "not a grant of carte blanche that permits all actions without restriction," and it cannot be used to create an "unreasonable expansion of the legislature's words...." Wainwright v. Superior Court, 100 Cal.Rptr.2d 749, 752–53 (2000); see also People v. Giordano, 170 P.3d 623, 634 (Cal.2007) ("Although the phrase 'including, but not limited to' is a phrase of enlargement, the use of this phrase does not conclusively demonstrate that the Legislature intended a category to be without limits." (internal quotation marks omitted)). Thus, the context surrounding the "including, but not limited to" phrase cannot be ignored when determining the extent of the "enlarging" effect this phrase has on benefits that § 1300.74.72(a) requires insurance companies to provide.
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> . . .
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> A narrow interpretation of the implementing regulation comporting with *ejusdem generis* mandates only one conclusion: any other services offered beyond what the Knox–Keene Act requires should be interpreted narrowly, and would likely only include those services specifically mandated by the Parity Act or in parity with physical health benefits that have voluntarily been provided by the insurer.

(*Harlick, supra*, 2012 WL 1970881 at **20, 23, 24 (Smith, J., dissenting).)

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4. Prescription drug coverage

A portion of *Harlick* reads as follows:

> If additional demonstration of the incorrectness of Blue Shield's argument is necessary, we point to subsection (b)(4) of the Parity Act. Subsection (b)(4) provides that plans within the scope of the Act must cover "[p]rescription drugs, if the plan contract includes coverage for prescription drugs." The Parity Act thus specifies that a plan need not cover prescription drugs for severe mental illnesses, even if they are medically necessary, unless the plan covers such drugs for physical illnesses. The Parity Act's specific carve-out from the coverage mandate for medically necessary prescription drugs indicates that all other benefits for severe mental illnesses must be provided whenever they are medically necessary, whether or not such benefits are covered for physical illnesses.
>
> Further, Blue Shield's argument lacks support in common sense. Some medically necessary treatments for severe mental illness have no analogue in treatments for physical illnesses. For example, it makes no sense in a case such as Harlick's to pay for time 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 treating eating disorders.

(*Harlick, supra*, 2012 WL 1970881 at *14.)

This portion of *Harlick* raises a valid point – one of the few which weigh in favor of Plaintiffs' position. It would be a strange move, indeed, for the legislature to specifically indicate that all medically necessary prescription drugs need not be covered if it did not intend the MHPA to cover all medically necessary treatment, generally. However, this singular point in favor of Plaintiffs is more than outweighed by the considerations noted above and continued below.

B. DHMC Interpretation

Although far from crystal clear, the DMHC's interpretation of the MHPA appears to indicate its belief that not all medically necessary treatment is covered.

1. Notice and comment period

Harlick observed that DMHC appeared to reject Defendants' position during the notice and comment period for its administrative regulation, Cal.Code Regs., tit. 28, § 1300.74.72. However, a review of the DMHC's full commentary suggests that its position is that all medically necessary treatment must be covered *in parity* with other conditions:

> During the notice-and-comment process leading up to the promulgation of § 1300.74.72, Blue Shield made the same argument about the mandated coverage of the Parity Act that it now makes to us. The DMHC unambiguously rejected Blue Shield's argument.
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> Blue Shield wrote to the DMHC during the comment period, stating that it was concerned that the Parity Act might be interpreted to require that a plan cover all "medically necessary treatments."
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> . . .
>
> The DMHC responded, rejecting Blue Shield's suggested language. It wrote:
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> > **REJECT**. Health & Safety Code section 1374.72 requires health plans to provide mental health coverage for specified mental conditions, to the same extent as the health plan covers other medical conditions. The regulation must be read and applied so as to interpret, make specific, or clarify a statute. Given that the statute requires parity in coverage, the commentator's concern is without merit; the regulation requires only that health plans provide mental

> health coverage in parity with what the plan provides for other medical conditions. The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.

DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16–9/30/2002, at 1.

While the DMHC's response rejected Blue Shield's interpretation of the Act, it did not explicitly say that plans had to cover all medically necessary treatment for the listed mental illnesses. But the DMHC's response to other comments was more explicit on this point. One commentator had suggested that DMHC "should look at developing a list of services specific to mental health care that will capture all those services needed for the state to provide full parity coverage." Id. at 2. The DMHC wrote in response:

> **REJECT**. It is not appropriate to list all services that a plan must provide in order to meet the obligations of section 1374.72 [the Parity Act]. Beyond specifying some of the essential services in the amended section 1300.74.72(b), it is sufficient to state that the plans must provide all medically necessary services. To the extent that certain services are medically necessary, then those services will be provided.

Id. (emphasis added). Another commentator made a similar suggestion, and the DMHC gave the same response. See id. at 18 ("[I]t is not appropriate to list all services, including 'rehabilitative services,' that a plan must provide in order to meet the obligations of section 1374.72. It is sufficient that plans provide all medically necessary services. To the extent that certain rehabilitative services are medically necessary, then those services will be provided.").

(*Id.* at **12-14 (emphasis in original).)

The *Harlick* court's conclusion that the "DMHC's response clearly rejected Blue Shield's interpretation of the Act" lacks support. The DMHC confirmed that medically necessary treatment must be provided for mental health conditions *in parity with other conditions*; it simply rejected Blue Shield's request that the statute be rephrased to state that not all medically necessary treatment was covered. Moreover, the DMHC's response that it need not enumerate specific rehabilitative services because all medically necessary treatment was covered does not undermine the requirement that parity be maintained. Again, the *Harlick* dissent explains:

> The record shows that, when Blue Shield expressed concern that the regulation might be read to require coverage for all medically necessary care, the DMHC rejected the comment. However, the DMHC rejected the comment, not because it disagreed with Blue Shield, but because the DMHC viewed the regulation as already clearly stating what Blue Shield was requesting. "Given that the statute requires parity in coverage, the commentator's concern is without merit; the regulation requires only that health plans provide mental health coverage in parity with what the plan provides for other medical conditions. The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health care provided by the plan." DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16–9/30/2002, at 1 (emphasis added). Notably, the DMHC's response was not that mental health coverage must be provided regardless of whether it was medically necessary or on parity with other health care provided by the plan. Thus, medical necessity was not demonstrated as an independent basis for receiving coverage, and the DMHC viewed Blue Shield's concern as "without merit."
>
> Furthermore, when DMHC responded to another commentator by stating that "it is sufficient to state that the plans must provide all medically necessary services," DMHC

was responding to a commentator's suggestion that "a list of services specific to mental health" be developed so that all services needed "to provide full parity coverage" would be available. Id. at 2 (emphasis added). The commentator was arguably asking for a list of mental health benefits to be provided in parity, or equal measure, to physical health coverage. The commentator was clearly not asking for coverage of all medically necessary mental health benefits without limit.

(*Harlick, supra,* 2012 WL 1970881 at **25-26 (Smith, J., dissenting).)

2. Litigation position

Blue Shield next claims, as it did in *Harlick*, that the DMHC has taken a contrary position in other litigation. *Harlick* notes that "[p]ositions taken by an agency for purposes of litigation ordinarily receive little deference under California law. *See Yamaha*, 19 Cal.4th at 23–24, [ ] (citing *Culligan Water Conditioning v. State Bd. of Equalization*, 17 Cal.3d 86, 130 Cal.Rptr. 321, 550 [ ] (1976))." (*Harlick, supra*, 2012 WL 1970881 at *16.) But as Blue Shield points out, the DMHC's presentation of its position in *Consumer Watchdog v. California Department of Managed Health Care*, LASC No. BS121397 was relatively clear:

> [The MHPA] does not require coverage for ***all*** *medically necessary treatment* for autism and should not be read to do so absent a clear intent on the face of that statute.... Had that been the Legislature's intent, the statute would have specified all medically necessary treatment.... [¶] Furthermore, Petitioners' interpretation does not make sense in the...framework of the Knox-Keene Act because it would mandate coverage for mental health services on a scope far exceeding what is required for basic health care services.
>
> . . .
>
> It would be illogical to construe the Knox-Keene Act as appropriately allowing plans to limit their coverage for essential basic health care services, while requiring limitless

coverage for mental health services. Though mental health services are undeniably important, there is nothing in the Knox-Keene Act suggesting the Legislature intended for them to have paramount significance above all other services....

(MP p. 20; Def's RJN, Exh. A, 3:21-25, 5:3-15, 5:25-6:2 (emphasis in original).) *Harlick* merely concluded that the DMHC had not put forth "any persuasive arguments" in *Consumer Watchdog* and that the superior court had thus overruled its demurrer. (*Harlick, supra*, 2012 WL 1970881 at *16.)

This is the DMHC's most recent statement about the coverage required under the MHPA. It is clearer than its earlier positions, and there is no reason to discard it wholesale, as the *Harlick* majority did.

C. Statutory Scheme

Plaintiffs argue that the Legislature has passed many statutes requiring that plans cover specific illness and/or treatments. (Opp. p. 15). But unlike the MHPA, the statutes they cite in footnote 9 of their brief are clear (in Blue Shield's words, "narrow, pinpoint requirements"). For example, plans that offer hospital, medical, or surgical expenses on a group basis must offer certain equipment for the management and treatment of diabetes (H&S Code §1367.51) and osteoporosis (§1367.67), AIDS vaccines (§1367.45) and benefits for comprehensive preventive care of children (§ 1367.3). Plans covering prescription drugs must cover inhaler spacers for the management and treatment of pediatric asthma (§1367.06). Place these focused mandates next to the fuzzy, confusing language of the MHPA, and it becomes difficult to conclude that the MHPA is a comprehensive mandate for mental health treatment modalities ranging beyond what a policy provides for physical conditions. Actually, Plaintiffs' observation supports the fact that the Knox-Keene Act does not state that all medically necessary physical health care be covered. Yet arguably, that could become the law with respect to mental health coverage if Plaintiffs' interpretation of the MHPA stands. This is not what our legislature intended. If they did, one wonders why, in October 2011, they enacted H&S Code § 1374.73. That statute requires health plans to provide coverage for behavioral treatment for autism. Yet autism is listed

in the MHPA, §1374.72(d)(7), which means, if Plaintiffs are right, plans would already have to include behavioral treatment.

D. Conclusion

Blue Shield is right: Plaintiffs' interpretation of the MHPA would "impose new requirements on health plans with regard to provider networks and access requirements, would void important benefit limits and exclusions, and would fundamentally alter the coverage and cost of health plans offered to Californians. It would limit the types of plans that could be offered in the market and create a significant coverage disparity in favor of Severe Mental Illnesses." (Reply p. 3.) It would "impose far broader coverage mandates for mental health care only, limited by nothing except medical necessity. It would increase costs to plans, employers, and individuals, and limit consumers' options by **requiring** them to buy plans with unlimited mental health coverage." (Reply p. 5 (emphasis in original).) In essence, mental health parity could morph into mental health preference, the precise opposite result of the evil the MHPA was passed to prevent.

Residential treatment can be helpful to people with anorexia nervosa. But our duty is to follow the law, and the MHPA's purpose is limited: to equalize with physical illness the benefits that health insurers offer for mental illness, in other words, to "end [] decades of discrimination against mental illnesses in health insurance coverage by providing that coverage for mental illnesses must be comparable to that of physical illnesses." (Legislative History of H&S Code §1374.72 (LH) at 189.)

III. Disposition:

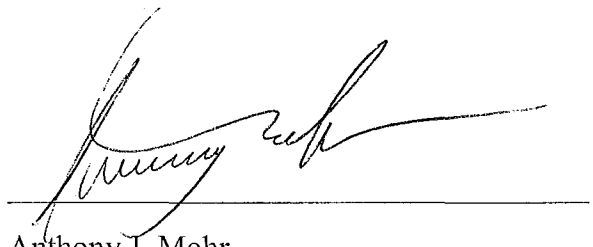
For the reasons stated above, this Court concludes that Defendant's interpretation of the MHPA is correct: the MHPA requires coverage for mental health conditions, including bulimia and anorexia, which is equal to that provided for physical conditions. The interpretation advocated by Plaintiffs and the *Harlick* court, that the MHPA requires coverage for all medically necessary treatment of mental

disease, even where such coverage is not required for physical conditions, reaches beyond the goal of the MHPA.

Defendant's demurrer to all causes of action is accordingly sustained without leave to amend.

IT IS SO ORDERED.

DATED: June 13, 2012



Anthony J. Mohr

Judge of the Los Angeles Superior Court