SENATE BILL No. 855

Introduced by Senator Wiener
(Principal coauthor: Senator Beall)
(Principal coauthors: Assembly Members Aguiar-Curry and Chiu)
(Coauthors: Senators Glazer and Hill)
(Coauthors: Assembly Members Maienschein and Wicks)

January 14, 2020

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

LEGISLATIVE COUNSEL'S DIGEST

SB 855, as introduced, Wiener. Health coverage: mental health or substance abuse disorders.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law, known as the California Mental Health Parity Act, requires every health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, as specified. Existing law requires those benefits to include, among other things, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the plan contract or policy includes coverage for prescription drugs.

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

This bill would authorize certain individuals or entities to pursue a civil action against a health care service plan or health insurer for a violation of the above-described provisions either independently or through a class action lawsuit, and would authorize the imposition of penalties in a civil action under these provisions, including attorney's fees. The bill would declare that its provisions are severable.

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

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

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

(a) The California Mental Health Parity Act (Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code) was enacted in 1999 to require coverage of all diagnosis and medically necessary treatment of nine listed severe mental illnesses, as well as serious emotional disturbances of a child. However, this list of nine severe mental illnesses is not only incomplete and out-of-date, but also fails to encompass the range of mental health and substance use disorders whose complex interactions are contributing to overdose deaths from opioids and

methamphetamines, the increase in suicides, and other so-called deaths of despair.

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

(c) The federal Affordable Care Act (ACA) includes mental health and addiction coverage as one of its 10 essential health benefits, but it does not contain a definition for medical necessity, and despite the ACA, needed mental health and addiction coverage can be denied through overly restrictive medical necessity determinations.

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

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

(f) If the California Mental Health Parity Act is so expanded, coverage of medically necessary treatment would increase for the fewer than one-half of adults with a mental health disorder who now receive treatment and the fewer than 1 in 10 individuals 12 years of age or older with a substance use disorder who now receive treatment.

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

(h) In 2016, approximately 6,000,000 veterans in the United States had private health care coverage, making it critical to ensure

that the veterans' private health plans cover all medically necessary treatment for the invisible wounds of war.

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

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

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

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

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

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

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

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

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

(*l*) In March 2019, the United States District Court of the Northern District of California ruled in Wit v. United Behavioral Health, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement

criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to "mitigate" the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

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

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

(2) Treatment of cooccurring behavioral health disorders or medical conditions in a coordinated manner.

(3) Treatment at the least intensive and restrictive level of care that is safe and effective; a lower level or less intensive care is appropriate only if it safe and just as effective as treatment at a higher level or service intensity.

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

(5) Treatment to maintain functioning or prevent deterioration.

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

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

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

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

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

1367.045. (a) If a health care service plan contract offered, issued, delivered, or renewed on or after January 1, 2021, whether or not in California, that provides health care coverage for a California resident contains a provision that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, "renewed" means continued in force on or after the contract's anniversary date.

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

(d) This section does not prohibit a health care service plan from including a provision in a contract that informs an enrollee that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

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

(f) The director may adopt regulations reasonably necessary to implement this section.

(g) This section is self-executing. If a health care service plan contract contains a provision rendered void and unenforceable by this section, the parties to the contract and the courts shall treat that provision as void and unenforceable.

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

~~1374.72. (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:~~

~~(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.~~

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

~~(g) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.~~

~~(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.~~

~~(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.~~

~~(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.~~

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

1374.72. (a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders, including, but not limited to, severe mental illnesses of a person of any age, and serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) Mental health and substance use disorders shall mean a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(3) Medically necessary treatment of a mental health or substance use disorder shall be a covered service that is all of the following:

(A) Recommended by the patient's treatment provider.

(B) Furnished in the manner and setting that can most effectively and comprehensively address the patient's conditions, including, but not limited to, functional impairments, lack of coping skills, symptoms, and the underlying biopsychosocial determinants of mental health, substance use, and medical disorders, and any combination thereof.

(C) Provided in sufficient amount, duration, and scope to do any of the following:

(i) Prevent, diagnose, or treat a disorder.

(ii) Minimize the progression of a disorder or its symptoms.

(iii) Achieve age-appropriate growth and development.

(iv) Minimize the progression of disability.

(v) Attain, maintain, regain, or maximize full functional capacity.

(D) Consistent with generally accepted standards of practice, which shall be based on either of the following:

(i) Scientific evidence published in peer-reviewed medical literature generally recognized by the relevant clinical community.

(ii) Clinical specialty society recommendations, professional standards, and consensus statements.

(4) A health care service plan shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment.

(5) (A) Consistent with paragraph (3), for all medical necessity determinations concerning level of care placement, continued stay, and transfer or discharge, a health care service plan shall exclusively rely on the most recent editions of the following:

(i) The American Society of Addiction Medicine (ASAM) criteria developed by the American Society of Addiction Medicine for substance use disorders for patients of any age.

(ii) The Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists for mental health disorders for patients 18 years of age and over.

(iii) The Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of

Community Psychiatrists or the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients 6 to 17 years of age, inclusive.

(iv) The Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients zero to five years of age, inclusive.

(v) The American Psychiatric Association criteria for eating disorders for a primary diagnosis of an eating disorder for patients any of age.

(vi) "Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers" or subsequent guidelines developed by the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts for individuals with autistic spectrum disorders undergoing behavior therapy.

(B) As specified in clauses (i) to (vi), inclusive, of subparagraph (A), reviewers shall err on the side of caution and safety in making medical necessity determinations by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care.

(6) To ensure the proper use of the criteria described in paragraph (5), every health care service plan shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate plan staff, including any third parties contracted with the health plan to review claims, conduct utilization reviews, or make medical necessity determinations, and other stakeholders, including the plan's participating providers and covered lives, about the guidelines, and provide the guidelines and any training material or resources to providers and insured patients.

(B) Track, identify, and analyze how the clinical guidelines are used to certify care, deny care, and support the appeals process.

(C) Run inter-rater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(D) Achieve inter-rater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the

remediation of poor inter-rater reliability and inter-rater relatability testing for all new staff before they can conduct utilization review without supervision.

(E) Report the activities in this paragraph to the plan's quality assurance committee.

(b) These benefits shall include, but not be limited to, the following:

(1) Outpatient services.

(2) Inpatient services.

(3) Intermediate services, including the full range of levels of care in the most recent edition of the ASAM criteria, LOCUS, CALOCUS, ECSII, and CASII, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(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, all of the following patient financial responsibilities:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) If any of the medically necessary mental health services enumerated in subdivision (b) are not available in network within the geographic and timeliness standards set by law or regulation, the health care service plan shall immediately cover out-of-network services, whether secured by the patient or the health care service plan, at an in-network benefit level and reimburse out-of-network providers for those services at full billed charges. A health care service plan may not interrupt a course of treatment initiated out of network due to network inadequacy if in-network services subsequently become available.

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

(f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

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

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

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

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

(i) A health care service plan shall not adopt, impose, or enforce additional terms in its policies or provider agreements, in writing or in operation, that undermine or alter the requirements of this section.

(j) (1) An enrollee, subscriber, or in-network or out-of-network provider on behalf of an enrollee or subscriber may bring a civil action in a court of competent jurisdiction individually or on behalf of a class against a health care service plan for a violation of this section or Section 1374.73 or 1374.76.

(2) The remedies in a civil action brought pursuant to this section include, independent of causation or damages, a five-thousand-dollar ($5,000) statutory penalty per act or offense, general and special damages, which may be trebled for knowing conduct, injunctive relief, restitution of premium, and attorney's fees and costs, including expert expenses.

(3) If a claim is litigated on a class basis, the same act or offense shall be counted with respect to each class member.

(4) An administrative action taken or not taken by the department with regard to the health care service plan's conduct shall not provide an affirmative defense in the court's consideration of the claim. A claimant shall be promptly notified in writing by the health care service plan and by the department of any administrative action, including the final outcome, against a health care service plan as a result of the claimant's complaint.

SEC. 5. Section 10144.5 of the Insurance Code is repealed.

~~10144.5. (a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, 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 policy or 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 disability insurance policy shall include, but not be limited to, the following:~~

~~(1) Maximum lifetime benefits.~~

~~(2) Copayments and coinsurance.~~

~~(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.~~

~~(f) (1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.~~

~~(2) A disability insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health~~

~~services within those geographic areas served by specialized health care service plans or mental health plans.~~

~~(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a disability insurer may utilize case management, managed care, or utilization review.~~

~~(4) Any action that a disability insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.~~

~~(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.~~

SEC. 6. Section 10144.5 is added to the Insurance Code, to read:

10144.5. (a) (1) Every health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders, including, but not limited to, severe mental illnesses of a person of any age, and serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) Mental health and substance use disorders shall mean a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(3) Medically necessary treatment of a mental health or substance use disorder shall be a covered service that is all of the following:

(A) Recommended by the patient's treatment provider.

(B) Furnished in the manner and setting that can most effectively and comprehensively address the patient's conditions, including, but not limited to, functional impairments, lack of coping skills, symptoms, and the underlying biopsychosocial determinants of

mental health, substance use, and medical disorders, and any combination thereof.

(C) Provided in sufficient amount, duration, and scope to do any of the following:

(i) Prevent, diagnose, or treat a disorder.

(ii) Minimize the progression of a disorder or its symptoms.

(iii) Achieve age-appropriate growth and development.

(iv) Minimize the progression of disability.

(v) Attain, maintain, regain, or maximize full functional capacity.

(D) Consistent with generally accepted standards of practice, which shall be based on either of the following:

(i) Scientific evidence published in peer-reviewed medical literature generally recognized by the relevant clinical community.

(ii) Clinical specialty society recommendations, professional standards, and consensus statements.

(4) A health insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment.

(5) (A) Consistent with paragraph (3), for all medical necessity determinations concerning level of care placement, continued stay, and transfer or discharge, a health insurer shall exclusively rely on the most recent editions of the following:

(i) The American Society of Addiction Medicine (ASAM) criteria developed by the American Society of Addiction Medicine for substance use disorders for patients of any age.

(ii) The Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists for mental health disorders for patients 18 years of age and over.

(iii) The Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the Child and Adolescent Service Intensity Instrument (CASII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients 6 to 17 years of age, inclusive.

(iv) The Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy of Child and Adolescent Psychiatry for mental health disorders for patients zero to five years of age, inclusive.

(v) The American Psychiatric Association criteria for eating disorders for a primary diagnosis of an eating disorder for patients any of age.

(vi) "Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers" or subsequent guidelines developed by the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts for individuals with autistic spectrum disorders undergoing behavior therapy.

(B) As specified in clauses (i) to (vi), inclusive, of subparagraph (A), reviewers shall err on the side of caution and safety in making medical necessity determinations by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care.

(6) To ensure the proper use of the criteria described in paragraph (5), every health insurer shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health insurer's staff, including any third parties contracted with the health insurer to review claims, conduct utilization reviews, or make medical necessity determinations, and other stakeholders, including the insurer's participating providers and covered lives, about the guidelines, and provide the guidelines and any training material or resources to providers and insured patients.

(B) Track, identify, and analyze how the clinical guidelines are used to certify care, deny care, and support the appeals process.

(C) Run inter-rater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(D) Achieve inter-rater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor inter-rater reliability and inter-rater relatability testing for all new staff before they can conduct utilization review without supervision.

(E) Report the activities in this paragraph to the plan's quality assurance committee.

(b) These benefits shall include, but not be limited to, the following:

(1) Outpatient services.

(2) Inpatient services.

(3) Intermediate services, including the full range of levels of care in the most recent edition of the ASAM criteria, LOCUS, CALOCUS, ECSII, and CASII, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(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, all of the following patient financial responsibilities:

(1) Maximum lifetime benefits.

(2) Copayments.

(3) Individual and family deductibles.

(d) If any of the medically necessary mental health services enumerated in subdivision (b) are not available in network within the geographic and timeliness standards set by law or regulation, the health insurer shall immediately cover out-of-network services, whether secured by the patient or the health insurer, at an in-network benefit level and reimburse out-of-network providers for those services at full billed charges. A health insurer may not interrupt a course of treatment initiated out of network due to network inadequacy if in-network services subsequently become available.

(e) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(f) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health insurance policy or mental health insurance policy, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurance policies that provide benefits to insureds through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas

served by specialized health insurance policies or mental health insurance policies to secure all or part of their mental health services within those geographic areas served by specialized health insurance policies or mental health insurance policies, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

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

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure a health insurer's compliance with this chapter when a health insurer provides coverage for prescription drugs.

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

(i) A health insurer shall not adopt, impose, or enforce additional terms in its policies or provider agreements, in writing or in operation, that undermine or alter the requirements of this section.

(j) (1) An insured, policyholder, or in-network or out-of-network provider on behalf of an insured or policyholder may bring a civil action in a court of competent jurisdiction individually or on behalf of a class against a health insurer for a violation of this section.

(2) The remedies in a civil action brought pursuant to this section include, independent of causation or damages, a five-thousand-dollar ($5,000) statutory penalty per act or offense, general and special damages, which may be trebled for knowing conduct, injunctive relief, restitution of premium, and attorney's fees and costs, including expert expenses.

(3) If a claim is litigated on a class basis, the same act or offense shall be counted with respect to each class member.

(4) An administrative action taken or not taken by the department with regard to the health insurer's conduct shall not provide an affirmative defense in the court's consideration of the claim. A claimant shall be promptly notified in writing by the health insurer and by the department of any administrative action, including the final outcome, against a health insurer as a result of the claimant's complaint.

SEC. 7. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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