Mental Health Parity and Medical Necessity in California: Frequently Asked Questions

What is parity?
The term parity means "equal to." Parity in health care is fundamentally grounded in ensuring mental health and addiction treatment services are delivered at the same level, frequency, and availability as medical and surgical services.

What is the Federal Parity Act?
The Federal Parity Act, also known as the Mental Health Parity and Addiction Equity Act (MHPAEA), requires most insurers to cover illnesses of the brain, such as depression or addiction, no more restrictively than illnesses of the body, such as diabetes and cancer. The Federal Parity Act requires that a health plan's policies and practices for covering behavioral health services must be no more restrictive than policies and practices for covering medical or surgical services.

Does the Federal Parity Act require plans to offer mental health and addiction benefits?
No. The Federal Parity Act does not require plans to offer mental health and addiction benefits. Instead, the Federal Parity Act requires that, *if mental health and addiction benefits are covered*, the plan must do so at parity with medical/surgical benefits. However, the Affordable Care Act requires individual and small group plans to offer mental health and addiction coverage, which triggers the Federal Parity Act's protections for those plans. Under the ACA, these plans must offer mental health and addiction coverage that is consistent with each state's "benchmark" plan. Together, the Federal Parity Act and the ACA are a powerful combination.

Don't the ACA and Federal Parity Act guarantee that needed mental health and addiction care is covered?
No. First, state benchmark plans do not necessarily offer a full range of mental health and addiction services. Second, and more importantly, plans can use managed care practices such as medical necessity determinations to deny coverage for mental health and addiction services.

What happens if the Affordable Care Act is overturned?
If the ACA is overturned, coverage for mental health and addiction services would be adversely impacted. This is because many insurers could once again choose to exclude and/or restrict mental health and addiction benefits from their individual and small group policies, leaving millions of Americans without adequate coverage. Without the ACA, individual and small group plans that chose not to offer mental health or substance use benefits would not be subject to the Federal Parity Act. (Additionally, managed Medicaid plans would lose their essential health benefits, including for mental health and addiction services.) Of course, if the ACA is overturned, individuals with mental health and substance use disorders would face discrimination because of their pre-existing conditions.

What is the California Parity Act?
The California Parity Act is codified in both the Health & Safety Code § 1374.72 and the Insurance Code § 10144.5. The Act predates the Federal Parity Act, and its non-discrimination provisions are much less comprehensive than the Federal Parity Act's provisions, which also apply to state-regulated plans.

Why is the California Parity Act important if the Federal Parity Act is much comprehensive on parity?
The California Parity Act is so important because it includes a coverage requirement. The California law compels "coverage for the diagnosis and *medically necessary treatment of severe mental illnesses*" and "serious emotional disturbances" of a child. This effectively requires health insurance to cover medically necessary care for these conditions.

Does the California Parity Act apply to all mental health and substance use disorders?
No. Although the California Parity Act has been interpreted by two appellate courts to require coverage for "all" medically necessary care regardless of plan exclusions,[1] the law only applies to nine severe mental illnesses (SMIs) and does not extend to substance use disorders.[2] As such, under California law, there is no requirement that the majority of mental health or any substance use disorders be covered.

What is "medical necessity"?
Health care services that are clinically indicated for the diagnosis and/or treatment of a medical or behavioral health condition.

What are "medical necessity criteria"?
To assess if care is medically necessary, insurers primarily rely on "medical necessity criteria," which are synonymous with "medical necessity guidelines," "coverage guidelines," and "clinical criteria." Medical necessity criteria describe admission, continued stay, and discharge factors for mental health and addiction services at any level of care or service intensity.

How do insurers determine medical necessity?
Typically, insurers first determine whether the recommended treatment is covered by the administered health plan. This is sometimes referred to as an "administrative coverage determination." Then, insurers determine the medical necessity of the recommended service or treatment by evaluating whether a patient's clinical circumstances support the need for the specific treatment. In the mental health and addiction context, insurers base their determinations on satisfaction of medical necessity criteria. This more nuanced aspect of the review process is often referred to as utilization review or utilization management.

Why are medical necessity criteria so important?
Medical necessity criteria are central to mental health and substance use disorder treatment access because they are the primary clinical tool with which insurers deny coverage and ration care. For example, a federal court recently found that the country's largest insurer, United Behavioral Health ("UBH," a subsidiary of UnitedHealthGroup and a UnitedHealthcare affiliate), used flawed medical necessity criteria to deny mental health and substance use coverage over a 7 year-period.[3] In fact, contrary to generally accepted standards of care, many insurers rely on similar medical necessity criteria that improperly ration treatment – at all levels of care – to "acute" episodes or "short-term" crises.

Doesn't the Federal Parity Act require health plans to cover medically necessary mental health and addiction treatment?
No, it doesn't. The Federal Parity Act is fundamentally a procedural law, and it does not require that any

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[1] *Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2012), cert. denied 133 S.Ct. 1492 (2013) and *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209 (2014), as modified on denial of rehearing (July 9, 2014).
[2] Covered severe mental illnesses included under California parity law include: major depression; bipolar (manic-depressive) disorder; panic disorder; anorexia; bulimia; obsessive-compulsive disorder; autism or pervasive developmental disorders; schizophrenia; schizoaffective disorder; and children's severe emotional disturbances.
[3] *Wit v. United Behavioral Health*, No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

specific treatment be covered. Rather, it requires equity in how mental health and addiction services are limited compared to how medical/surgical services are limited. This comparison to determine Federal Parity Act comliance is often complex. In contrast, requiring that medically necessary care be covered can be simpler.

How does the California Parity Act define "medically necessary treatment"?
Problematically, it is not defined by state law.

Do parity laws add to health plans' costs or result in fewer people covered?
No. Under the federal parity law, group health plans could apply for exemptions to the parity law if their costs increased more than 2% due to their implementation of the parity law. No health plan has applied for this exemption. Research has also demonstrated that increasing parity has not resulted in higher insurance costs.[4] One study in The New England Journal of Medicine concluded, "When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs."

[4] For example, see Colleen Barry, Richard Frank, and Thomas McGuire, *The Costs of Mental Health Parity: Still An Impediment?* Health Affairs 25, no. 3 (2006), and Howard Goldman, et al., *Behavioral Health Insurance Parity for Federal Employees*, New England Journal of Medicine, 2006;354:1378-86.