SB-999 Health coverage: mental health and substance use disorders. (2021-2022)

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CALIFORNIA LEGISLATURE— 2021–2022 REGULAR SESSION

SENATE BILL NO. 999

Introduced by Senator Cortese
(Coauthor: Assembly Member Low)

February 14, 2022

An act to amend Section 1374.721 of the Health and Safety Code, and to amend Section 10144.52 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 999, Cortese. Health coverage: mental health and substance use disorders.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care.

This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including that a health care service plan and a disability insurer, or an entity acting on the plan's or insurer's behalf, maintain telephone access during California business hours for a

health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding specific issues related to treatment. Because a willful violation of the requirements governing a health care service plan would be a crime, the 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 Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. This act shall be known, and may be cited, as the California Mental Health and Substance Use Disorder Treatment Patient Safety and Fairness Act.

SEC. 2. The Legislature finds and declares all of the following:

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

(b) 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.

(c) In two court decisions, Harlick v. Blue Shield of California (9th Cir. 2012) 686 F.3d. 699, cert. den., (2013) 133 S.Ct. 1492, and Rea v. Blue Shield of California (2014) 226 Cal.App.4th 1209, 1227, the California Mental Health Parity Act was interpreted to require coverage of medically necessary residential treatment.

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

SEC. 3. Section 1374.721 of the Health and Safety Code is amended to read:

1374.721. (a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or

make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.

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

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

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

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, after, or concurrent with, the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.

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

(k) A health care service plan, and an entity acting on a plan's behalf, shall ensure compliance with all of the following:

(1) Utilization review determinations, including, but not limited to, initial determinations and appeals, shall be made by a health care provider practicing in the relevant clinical specialty with the same level of education, training, and experience in the

relevant diagnosis or field of expertise, and holding the same applicable certification as the health care provider requesting the authorization.

(2) The health care service plan, or an entity acting on the plan's behalf, shall maintain telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination.

(3) An individual or health care provider performing utilization review shall disclose to the treating health care provider and the enrollee the health plan's basis for a denial, including a citation to the clinical guidelines reviewed, and an analysis of why the enrollee did not meet the clinical criteria.

(l) This section does 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.

SEC. 4. Section 10144.52 of the Insurance Code is amended to read:

10144.52. (a) A disability insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a disability insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a disability insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a disability insurer from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a disability insurer purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the insurer shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every disability insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the disability insurer's staff, including any third parties contracted with the disability insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

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

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

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

(f) The following definitions apply for purposes of this section:

(1) “Generally accepted standards of mental health and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 10144.51. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) “Mental health and substance use disorders” has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(3) “Utilization review” means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, after, or concurrent with, the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a disability insurance policy is covered as medically necessary for an insured.

(4) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by a disability insurer to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a disability insurance policy, including prescription drugs.

(h) This section applies to a disability insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer’s behalf.

(i) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

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

(k) A disability insurer, and an entity acting on an insurer’s behalf, shall ensure compliance with all of the following:

(1) Utilization review determinations, including, but not limited to, initial determinations and appeals, shall be made by a health care provider practicing in the relevant clinical specialty with the same level of education, training, and experience in the relevant diagnosis or field of expertise, and holding the same applicable certification as the health care provider requesting the authorization.

(2) The disability insurer, or an entity acting on the insurer’s behalf, shall maintain telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination.

(3) An individual or health care provider performing utilization review shall disclose to the treating health care provider and the insured the health plan’s basis for a denial, including a citation to the clinical guidelines reviewed, and an analysis of why the insured did not meet the clinical criteria.

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

SEC. 5. 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.