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Advocacy in the Post Healthcare Reform Era

Selected Article:
The Importance of Litigation in the Development and Application of the
California Mental Health Parity Act

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Sandy Hook. The Sikh Temple. Aurora, Colorado. Fort Hood. Virginia Tech. Mass shootings have become so common in this country that we identify them by these phrases. And after each shooting, the same conversation invariably follows about the importance of getting treatment for those with severe mental illnesses. What is generally not discussed, however, is who will pay for that treatment. This article explores the role of judicial advocacy in pursuing mental health insurance coverage from for-profit health insurers under the California Mental Health Parity Act.

In the United States, $113 billion is spent annually on mental health treatment. That works out to about 5.6% of all national healthcare spending (Kliff, 2012). Mental health dollars mostly go toward prescription drugs and outpatient treatment. The shift away from in-patient treatment began in the 1960s, when care was moved from state-run psychiatric facilities to community treatment settings (Kliff, 2012). But deinstitutionalization has fallen short, and state budget cuts have affected the accessibility of treatment. A quarter of the 15.7 million Americans who receive mental health care report that they themselves are the main payer for their services (Kliff, 2012). Although the majority of Americans have some form of health care coverage, there are often significant limitations on coverage for mental health care services.

The California Mental Health Parity Act was meant to address this disparity by requiring health plan insurers to provide mental health coverage that is on par with medical coverage. In 1999, the California Legislature did something quite remarkable: it enacted a law requiring that any health care insurance company that provided medical or surgical coverage must also provide all medically necessary treatment for severe mental illness to patients on the same financial terms and conditions (e.g., co-payments, deductibles, and lifetime maximums) as for physical illnesses. The Legislature did so because it found that:

a) Mental illness is real.

b) Mental illness can be reliably diagnosed.

c) Mental illness is treatable.

d) The treatment of mental illness is cost effective.1

The Legislature also found that most private health insurance policies had, until then, provided coverage for mental illnesses at levels far below coverage for physical illnesses; that limitations in coverage for mental illness in private insurance policies had resulted in inadequate treatment; that inadequate treatment had caused "relapse and untold suffering for individuals with mental illnesses and their families;" and that inadequate treatment for mental illness "had contributed significantly to homelessness, involvement with the criminal justice system, and other significant social

problems” (Kliff, 2012).

To remedy this disparity, the Legislature enacted the Mental Health Parity Act, which mandates broad coverage for "Severe Mental Illnesses."2 The Parity Act is codified at California Insurance Code §10144.5 (for policies overseen by the California Department of Insurance, such as PPOs and indemnity policies) and Health and Safety Code §1374.72 (for healthcare service plans overseen by the Department of Managed Care, such as HMOs).

But problems remain. Less than one in three people who suffer from severe mental illness get the services they need. The reason? Over 65% cited money-related issues as the primary reason for not seeking treatment (Weiss, 2013). So the question becomes, why is this happening when we have the Parity Act in place?

One reason is that although the statute is labeled the Mental Health Parity Act, neither the statute nor its legislative history defines exactly what is meant by "parity.” This has left patients and insurance companies grappling with the scope of the statute and how it should be applied. Patients and providers, not surprisingly, advocate a broad reading of the statute to include "all medically necessary treatment” for mental illness. Health insurance companies, in contrast, argue for a narrow reading of the statute. They bristle at providing all medically necessary treatment, advocating instead for a discrete set of limited services such as diagnostic laboratory tests, physician services, in-patient hospitalization, and preventive health services. Blue Shield, for example, argues that because coverage for physical illnesses is limited to specific services—as opposed to on the basis of a diagnosis or condition as specified in the Parity Act—a disparity arises in favor of mental health coverage because it is not limited to specific services. Such a result would "obligate plans to provide far greater coverage for mental illnesses than for other conditions,” Blue Shield claims. 3

So a legal fight is on over the interpretation of the Parity Act, and it is a close one. And while the momentum seems to be in favor of broadly applying the Parity Act, the fight is far from over. The insurance industry has signaled that it will appeal negative verdicts for as long as it can. In fact, one case has already been appealed to the United States Supreme Court, Harlick v. Blue Shield of Cal. (9th Cir. 2012) 686 F.3d 699,

cert. denied, 133 S.Ct. 1492 (2013). Although the Supreme Court declined to hear the matter, the case illustrates how committed the industry is to challenging the Parity Act.

Psychologists and their patients are stakeholders in this fight. Improper denials, oppressive utilization review procedures, and payment delays harm patients and negatively affect psychotherapy practices. And these improper activities are frequent—many, many insurance companies are not in compliance with the Parity Act.

These unlawful practices can—and have been—changed. Through class action litigation, companies have been forced to make restitution on wrongful denials. Insurance policy language has been modified, and harsh utilization review (and pre-service authorization) procedures have been successfully challenged. I accomplished these changes, in fact, in my Parity Act class action work. Other class action attorneys have as well.

Litigation is an important means of enforcing rights granted by the Legislature. It is a necessary and natural consequence, to ensure that the legislation is applied properly. While state regulators also have the authority to enforce these statutes, they lack the resources and manpower to address every violation. Patients often don’t bring violations to regulators’ attention because they don’t know how. Class actions assist our state regulators and are a most effective tool in addressing harmful business practices directed at a large number of people.

Psychologists can help in this fight by partnering with knowledgeable lawyers. By working together—and litigating when necessary—we have the best chance of carrying out the promise of the Parity Act.

1

1999 Cal. Legis. Serv. ch. 534 (A.B. 88).

2

The 9 severe mental illnesses that are covered by the Parity Act are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, and pervasive developmental disorder of children including autism, anorexia nervosa and bulimia nervosa.

3

Rea v. Blue Shield of California, Respondent's Brief, No. B244314, pp. 1 – 2.

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