NO. 101561-5

SUPREME COURT OF THE STATE OF WASHINGTON

Premera Blue Cross,

Petitioner,

v.

P.E.L., P.L., and J.L.,

Respondents.

AMICUS BRIEF BY THE
WASHINGTON STATE INSURANCE COMMISSIONER

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I. INTRODUCTION

Since 2010, the federal rules mandating parity for mental health[1] services have required that before a treatment limitation can be applied to any mental health service, the service in question must first be categorized into one of six types of services. Pursuant to the plain language of the federal rules, only the treatment limitations found in the same classification of services for both mental health and medical services may be compared to determine whether a treatment limitation complies with the federal mental health parity laws. This "apples to apples" comparison of treatment limitations prevents health plans from using treatment limitations that are wholly inappropriate for a particular classification of services from being imposed on mental health services.

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[1] Both state and federal rules refer to parity for services to treat mental health and substance use disorders verses medical and surgical services. For ease of reference, this brief will refer to mental health and substance use disorders as "mental health." Medical and surgical services will be referred to as "medical" services.

The Court of Appeals decision below erroneously excused Premera from complying with the federal requirements for demonstrating parity within the appropriate classification of services. As a result, the court below relied on irrelevant exclusions from different classifications of service to erroneously determine that Premera complied with the federal parity requirements for the exclusion at issue in this case. This incorrect analysis, if allowed to stand, could severely erode important mental health parity protections for vulnerable Washington State health plan enrollees, and could risk the Federal government taking over the review and enforcement of mental health parity requirements in Washington State.

II. IDENTITY AND INTEREST OF AMICUS

Mike Kreidler, Insurance Commissioner for the state of Washington (Commissioner), is the head of the Office of the Insurance Commissioner (OIC). He is charged with enforcing the provisions of both state and federal laws that apply to health

plans issued by regulated health carriers[2]. RCW 48.02.060(1-2); 42 U.S.C. § 300gg-22 (a)(1-2). Those duties include ensuring health carrier compliance with federal and state mental health parity requirements.

The Commissioner also has adopted state mental health parity rules, found at WAC 284-43-7000 through -7120. Those rules were adopted to implement federal requirements for determining mental health parity as required by 42 U.S.C. § 300gg-22 (a)(1-2). The Commissioner has a strong interest in ensuring that his work to protect the mental health parity rights of Washington consumers is not stymied by an erroneous understanding of what carriers must document to demonstrate compliance with federal (and State) mental health parity requirements. Further, as the chief insurance regulator in this

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[2] The definition of "health carrier" found in RCW 48.43.005(30), includes health care service contractors such as Premera, and includes the term "health plan issuer" as that term is used in federal law under the Patient Protection and Affordable Care Act of 2010.

State, the Commissioner has an interest in ensuring that the state retains the authority to enforce the federal mental health parity requirements, and does not cede that authority to the Federal government. Therefore, the Commissioner has an interest in ensuring that both federal and state mental health parity requirements are properly understood, and fully enforced.

III. ISSUE ADDRESSED BY AMICUS BRIEF

Does a health carrier fail to meet the federal mental health parity analysis requirements in 45 C.F.R. § 146.136(c)(4), where it admits that it failed to categorize a particular mental health service into a service classification, and therefore cannot demonstrate that required classification specific comparative analysis was conducted, and therefore cannot demonstrate that the nonquantitative treatment limitation was applied no more stringently than nonquantitative treatment limitations for medical services in the same classification?

This brief narrowly addresses the appropriate, classification specific, analysis that health plans have been

required to conduct since 2010 under the federal mental health parity rules. The classification specific analysis outlined in the plain language of the federal rules must be conducted prior to imposing any nonquantitative treatment limitation on a particular type of mental health service.

This brief does not address other arguments raised by the parties and other amici.

IV. LEGAL BACKGROUND RELEVANT TO AMICUS

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Parity Act) was enacted in October 2008. The central purpose of the Federal Parity Act "is to ensure that individuals in group health plans or with group or individual health insurance coverage who seek treatment for covered mental health conditions or substance use disorders do not face greater barriers to accessing benefits for such mental health conditions or substance use

disorders.[3] . . ." The Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act (collectively, the Affordable Care Act) were both enacted in March 2010. The Affordable Care Act extended the Federal Parity Act to apply to the individual health insurance market, qualified health plans sold through exchanges, and to small group health plans. *See* 45 C.F.R. § 147.150; 45 C.F.R. § 156.115. Under the Affordable Care Act, states have the responsibility to enforce both the Affordable Care Act, and the provisions of the Federal Parity Act. 42 U.S.C. § 300gg-22 (a)(1-2). In Washington State, that responsibility has primarily fallen to the Washington State Insurance Commissioner for all health plans issued by health carriers regulated by the Commissioner.

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[3] "Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rules," July 31, 2023 ("Proposed Rules"), p. 9. These newly proposed rules have not yet been officially published in the Federal Register, but have been posted by the Department of Labor online, and can be found at https://public-inspection.federalregister.gov/2023-15945.pdf, last accessed July 31, 2023. These proposed rules are scheduled to be published in the Federal Register on August 3, 2023.

On February 2, 2010, the Federal Departments of the Treasury, Labor, and Health and Human Services (the Departments) published the "Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (Interim Rules). 75 FR 5410-01 (Feb. 2, 2010). The interim final regulations generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. 75 FR 5410-01, 5410. The Interim Rules provide that "the parity requirements for financial requirements and treatment limitations are applied on a classification-by-classification basis." 75 FR 5410-01, 5412. On November 13, 2013, the Departments published the "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program" (Final Rules). 78 FR 68240-01 (Nov. 13, 2013). The Final Rules "retain the six classifications enumerated in the interim final regulations . . . and

provide that the parity analysis be performed within each classification . . . .” 78 FR 68240-01, 68244. In addition, the Departments have issued various guidance documents in the form of “numerous sets of Frequently Asked Questions (FAQs), fact sheets, compliance assistance tools, templates, reports, and publications.”[4]

Under both the Interim and Final Rules, health plans:

> may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits *in any classification* that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits *in the same classification*.

45 C.F.R. § 146.136(c)(2)(i) (emphases added).

Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (such as medical necessity standards, prior

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[4] Proposed Rules, p. 13-17.

authorization processes and provider network composition). 45 C.F.R. § 146.136(a), (c)(4)(ii) Under the federal rules, before applying either a quantitative or a nonquantitative treatment limitation, a health plan issuer must first categorize the service in question into one of 6 classifications of service. Those classifications are:

> (1) Inpatient, in-network,
> (2) Inpatient, out-of-network,
> (3) Outpatient, in-network,
> (4) Outpatient, out-of-network,
> (5) Emergency care, and
> (6) Prescription drugs.

45 C.F.R. § 146.136(c)(2)(ii).

In adopting the Interim Rules, the Departments found the classification of benefits is necessary because:

> Plans often vary the financial requirements and treatment limitations imposed on benefits based on whether a treatment is provided on an inpatient, outpatient, or emergency basis; whether a provider is a member of the plan's network; or whether the benefit is specifically for a prescription drug. Therefore, determining the predominant financial requirements and treatment limitations for the entire plan without taking these distinctions into account could potentially lead to absurd results. For

> example, if a plan generally requires a $100 copayment on inpatient medical/surgical benefits and a $10 copayment on outpatient medical/surgical benefits, and most services (as measured by plan costs) are provided on an inpatient basis, the plan theoretically could charge a $100 copayment for outpatient mental health and substance use disorder benefits.

75 FR 5410-01, 5413.

The Departments determined the best way to avoid these absurd results is to require the categorization of services into one of six classifications and to compare the treatment limitations in that particular classification when evaluating whether a mental health service is covered in parity with medical services.

Once a service is categorized, the analysis for determining parity within that classification differs for quantitative treatment limitations and nonquantitative treatment limitations (NQTLs). For quantitative treatment limitations, there is a mathematical calculation used to determine that a particular limit is "is no more restrictive than the predominant" limitation within that classification. 45 C.F.R. § 146.136(c)(3).

For NQTLs, which are not expressed in a numerical form, the process is somewhat more subjective than a mathematical equation. But the same process applies. NQTLs are not allowed unless a carrier can demonstrate that:

> any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

45 C.F.R. § 146.136(c)(4)(i). This requirement applies to the plan "as written and in operation. . ." 45 C.F.R. § 146.136(c)(4)(i).

Unfortunately, the Departments have found that despite the existence of these rules, and issuance of numerous guidance documents related to Federal Parity Act compliance, carriers continue to fail to provide parity for mental health services, particularly for NQTLs[5]. Instead, the Departments have found

[5] Proposed Rules, p. 17.

carriers continue “looking for ways to characterize the processes, strategies, evidentiary standards, and other factors associated with an NQTL as being ‘comparable’ and ‘applied no more stringently’ through careful word choice, without regard to how, in operation, the limitation burdens participants and beneficiaries . . . .”[6]

Since 2018, the Insurance Commissioner has been in receipt of a grant from the federal government designed to help the Commissioner determine “whether or not state-regulated health insurers are offering comprehensive and affordable access to mental health services and treatment for substance use disorders, identify the causes of any access issues, and propose solutions for improvements.”[7] That grant work, and any potential enforcement action that may come from it, are based on the

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[6] Proposed Rules, p. 21.

[7] “Behavioral health services federal grant overview page", found at https://www.insurance.wa.gov/behavioral-health-services-federal-grant-overview, last accessed July 24, 2023.

understanding that for all types of treatment limitations imposed on mental health services, carriers must conduct a classification specific comparative analysis of each treatment limitation as they design, implement, and analyze how those treatment limitations are applied in a particular classification of services for both mental health and medical services. Failure to complete this classification specific analysis is a violation of the federal (and state) mental health parity requirements.

V. ARGUMENT

A. The Plain Language of the Federal Rules Requires Parity To Be Demonstrated Within the Same Classification of Services.

The plain language of the Federal rules implementing the Federal Parity Act require all parity analyses be performed between mental health and medical services in the same classification. There is no valid basis for the Court of Appeals to have accepted any parity analysis that failed this requirement.

See P.E.L. v. Premera Blue Cross, 24 Wn. App. 2d 487, 506, 520 P.3d 486 (2022) (*P.E.L.-I*), *review granted*, 1 Wash.3d 1001, 526 P.3d 841 (2023).

Multiple times, the Final Rules demand that treatment limitations must be evaluated within a particular classification. Generally, 45 C.F.R. § 146.136(c)(2)(i) provides that for both quantitative and nonquantitative treatment limitations, the treatment limitation cannot be more restrictive than treatment limitations applied to "substantially all medical/surgical benefits *in the same classification*." 45 C.F.R. § 146.136(c)(2)(i) (emphasis added). For quantitative treatment limitations, health carriers must show the quantitative treatment limitation "is no more restrictive than the predominant" limitation *within that classification*." 45 C.F.R. § 146.136(c)(3) (emphasis added). For NQTLs, health carriers must demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards,

or other factors used in applying the limitation with respect to medical/surgical benefits *in the classification*." 45 C.F.R. § 146.136(c)(4)(i) (emphasis added).

Despite the plain language of these various rules, the Court of Appeals wholly excused Premera from selecting a particular classification, and conducting any meaningful comparative analysis in the selected classification of services. The Court of Appeals cited the requirements of 45 C.F.R. and found, "P.E.L. is correct that the record does not show Premera categorized wilderness programs in one of the six categories of services under 45 C.F.R. § 146.136(c)(2)(ii)(A)." (*P.E.L.-I*). The court also acknowledged the language of the Final Rules. *P.E.L.-I*, 24 Wn. App. 2d at 506. The court nevertheless excused this failing by holding that the "Premera showed that the process it used to determine whether a mental health service is nontreatment is the same process it used to determine whether a medical service is nontreatment." *Id.* But, as the preamble to the Interim Rules makes clear, for any type of treatment limitation,

it is not sufficient that the treatment limitation apply to other classifications of services. It must apply to the same classification of services, or "absurd results" may occur. 75 FR 5410-01, 5413. Further, the plan must demonstrate, through a full comparative analysis that the NQTL is applied "no more stringently" to mental health services than to medical services. 45 C.F.R. § 146.136(c)(4)(i).

The Court of Appeals accepted conclusory testimony that Premera used the same process for evaluating medical and mental health services, namely the Delfini Group Model. The opinion below, and the records cited by the parties, are wholly devoid of any analysis that shows, both in writing and in operation, how stringently the "processes, strategies, evidentiary standards, or other factors" used to apply the Delfini Group Model to determine medical necessity for medical services were applied. For example, there is no analysis or review of how stringently the "potential bias" component of the Delfini Group Model was applied in evaluating the literature used to determine

the medical necessity of medical services in the "out patient, out of network" service classification. Therefore, there is no way to compare whether the "bias" component of the Delfini Group Model was applied "no more stringently" to the literature concerning "out patient, out of network" services for mental health.

In addition, the Court of Appeals pointed to the exclusion of other services, such as gym memberships, as evidence these standards are applied no more stringently. But, there is no evidence that Premera categorized gym memberships and other excluded services in the same classification as overnight programs. And, evidence that services are excluded in a different classification is wholly irrelevant to whether standards have been no more stringently applied in the same classification. Instead, Premera must first identify the relevant service classification, and then must demonstrate through comparative analysis it has carefully reviewed how stringently a particular NQTL has been

designed and applied within that classification in order to demonstrate parity under the federal requirements.

B. Adoption of the Court of Appeals' Parity Analysis for NQTLs Would Risk the State's Authority to Enforce Compliance with Federal Mental Health Parity Requirements.

If the erroneous Court of Appeals parity analysis for NQTLs is allowed to stand, this could risk the State's ability to exercise enforcement authority over compliance with federal mental health parity requirements. Under the Affordable Care Act, if the Federal Government determines that a State has failed to substantially enforce portions of the Affordable Care Act, including the expansion of the Federal Parity Act, then the Federal Government "shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State." 42 U.S.C. § 300gg-22 (a)(2). Currently the federal government, specifically the Centers for Medicare and Medicaid Services (CMS),

enforces MHPAEA with respect to health plan issuers in Texas, Wyoming, Alabama, Florida, Louisiana, Montana, and Wisconsin. [8] If the federal government determines that the State of Washington will follow the Court of Appeals' acceptance of "neutrality" rather than requiring carriers to demonstrate classification specific parity in writing and in operation, this could result in the federal government taking over enforcement of federal mental health parity requirements. This could create a more complex and expensive regulatory environment for carriers and consumers. *See* 42 U.S.C. § 300gg-22 (b)(2)(C)(i). This would also be an erosion of the State's autonomy over the regulation of insurance.

VI. CONCLUSION

Under the Federal Parity Act and the rules implementing it, which have been in place for over a decade, health carriers must conduct a classification specific comparative analysis. This requires that health carriers demonstrate that the NQTLs they

[8] Proposed Rules, p. 13, fn. 41.

have applied to a particular classification of mental health services are applied no more stringently than they are applied to medical services in that classification, in both writing and in operation. Mere statements that the process is the same, or that services are excluded in other classifications of service, are wholly inadequate.

This document contains 3,000 words, excluding the parts of the document exempted from the word count by RAP 18.17.

RESPECTFULLY SUBMITTED this 31st day of July, 2023.

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