



RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

NOTICE

TO: All Health Insurance Companies

FROM: Insurance Commissioner Ricardo Lara

DATE: December 10, 2020

RE: Enactment of Senate Bill 855 – Submission of Health Insurance Policies for Compliance Review

The purpose of this Notice is to inform health insurers of the recent enactment of [Senate Bill 855](#) (Wiener, Chapter 151, Statutes of 2020), which substantially expanded the California Mental Health Parity Act of 1999, and the requirements under this new law that will take effect on January 1, 2021.

Insurance Code section 10144.5(a)(1), as added by SB 855, provides that “[e]very disability insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions....” Therefore, effective January 1, 2021, issuing, amending, or renewing a policy form that is incompliant with SB 855 would violate state law. **As policy forms are subject to the Department’s review prior to use, insurers who have not already done so must submit amended forms to the Department as soon as possible, but no later than December 31, 2020.** SB 855 applies to grandfathered and non-grandfathered health insurance policies offered in all three market segments, excluding dental-only and vision-only specialized health, and student blanket health insurance. Student blanket health insurance policies that will not be issued, amended, or renewed before the 2021-22 school year may instead be submitted in the spring on a date specified in forthcoming filing instructions.

In addition to revising and submitting policy forms for review, insurers must review their medical necessity criteria and utilization review policies and procedures and implement any changes necessary to ensure they are consistent and compliant with SB 855 by January 1, 2021. Insurance Code section 10144.52 applies to all health insurance policies, including student health, in effect on or after January 1, 2021, even if a contract renews later in the year. Utilization review policies and procedures maintained pursuant to Insurance Code section 10123.135(b) should be revised accordingly.

SB 855 repealed and replaced Insurance Code section 10144.5 and added new section 10144.52 (Stats. 2020, ch. 151, §§ 6-8). Significant changes that the bill made to the California Mental Health Parity Act include:

- Requiring health insurance policies to cover medically necessary prevention, diagnosis, and treatment of all mental health conditions, as well as substance use disorders, that are listed in the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) or the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10).
- Defining medical necessity for purposes of the coverage mandate.
- Prohibiting limiting coverage to short-term or acute treatment.
- Providing that if medically necessary mental health or substance use disorder services are not available in-network within the geographic and timely access standards set by network adequacy law or regulation, an insurer must arrange for the provision of out-of-network services that, to the maximum extent possible, meet the network adequacy standards, and cover the out-of-network services subject to in-network cost sharing.
- Prohibiting coverage limitations and exclusions for medically necessary services because the 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.
- Providing that medical necessity determinations, including on service intensity, level of care placement, continued stay, and transfer or discharge, must be made using the most recent versions of clinical practice guidelines developed by nonprofit professional associations for the relevant clinical specialty.
 - For coverage determinations concerning service intensity, level of care placement, continued stay, transfer, and discharge, the Department considers use of the most recent versions of the following nonprofit professional association guidelines compliant with SB 855:
 - For a primary diagnosis of a substance use disorder in adolescents and adults, *The ASAM Criteria* developed by the American Society of Addiction Medicine.
 - For a primary diagnosis of a mental health condition in adults, the *Level of Care Utilization System for Psychiatric and Addiction Services* (LOCUS) developed by the American Association for Community Psychiatry (AACP).
 - For a primary diagnosis of a mental health condition in children ages 6-18, the *Child and Adolescent Level of Care Utilization System* (CALOCUS) developed by AACP and the American Academy of Child & Adolescent Psychiatry (AACAP).

- For a primary diagnosis of a mental health condition in children ages 5 and younger, the *Early Childhood Service Intensity Instrument (ECSII)* developed by AACAP.
- For coverage determinations involving services for gender dysphoria, the Department considers use of the most recent version of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* developed by The World Professional Association for Transgender Health compliant with SB 855.
- Requiring an insurer to base medical necessity determinations and utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
- Defining “generally accepted standards of mental health and substance use disorder care” for purposes of medical necessity and conducting utilization review.
- Adding requirements for training staff who conduct utilization review, tracking and analyzing how medical necessity criteria are used in utilization review and appeals, and conducting interrater reliability testing to ensure consistency in utilization review decision making.

Please direct questions concerning this Notice to:

Jessica Ryan, Attorney III, at jessica.ryan@insurance.ca.gov, or

Sheirin Ghoddoucy, Attorney III, at sheirin.ghoddoucy@insurance.ca.gov.