FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RYAN S., individually and on behalf of all others similarly situated, *Plaintiff-Appellant*, v. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE SERVICES, INC., a Minnesota corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UHC OF CALIFORNIA, a California corporation; UNITED HEALTHCARE SERVICES, LLC, a Delaware limited liability company; UNITED BEHAVIORAL HEALTH, INC., a California corporation; OPTUMINSIGHT, INC., a Delaware corporation; OPTUM SERVICES, INC., a Delaware corporation; OPTUM, INC., a Delaware corporation, *Defendants-Appellees*.	No.22-55761 D.C. No. 8:19-cv-01363-JVS-KES OPINION

Appeal from the United States District Court
for the Central District of California
James V. Selna, District Judge, Presiding

Argued and Submitted October 19, 2023
Pasadena, California

Filed April 11, 2024

Before: Richard R. Clifton and Gabriel P. Sanchez, Circuit Judges, and Edward R. Korman,* District Judge.

Opinion by Judge Clifton

SUMMARY**

ERISA

The panel reversed in part and affirmed in part the district court's judgment, and remanded for further proceedings, in a case in which Ryan S. brought a putative class action under the Employee Retirement Income Security Act of 1974 ("ERISA") against UnitedHealth Group, Inc. and its subsidiaries (collectively, "UnitedHealthcare").

* The Honorable Edward R. Korman, United States District Judge for the Eastern District of New York, sitting by designation.

** This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

Ryan S. alleged that UnitedHealthcare applies a more stringent review process to benefits claims for outpatient, out-of-network mental health and substance use disorder ("MH/SUD") treatment than to otherwise comparable medical/surgical treatment. Ryan S. asserted that by doing so, UnitedHealthcare has violated the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act"), 29 U.S.C. § 1185a, in the process also breaching its fiduciary duty and violating the terms of his plan.

The district court granted UnitedHealthcare's motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) based primarily on its conclusions that Ryan S. (1) failed to allege that his claims had been "categorically" denied and (2) insufficiently identified analogous medical/surgical claims that he had personally submitted and UnitedHealthcare had processed more favorably.

The panel concluded that Ryan S. adequately stated a claim for a violation of the Parity Act. The panel explained that an ERISA plan can violate the Parity Act in different ways, including by applying, as Ryan S. alleged here, a more stringent internal process to MH/SUD claims than to medical/surgical claims. A plaintiff presenting that type of contention may be able to allege a plausible claim without having to allege a categorical practice or differential treatment for his or her medical/surgical claims. It is enough for such a plaintiff to allege the existence of a procedure used in assessing MH/SUD benefit claims that is more restrictive than those used in assessing medical/surgical claims under the same classification, as long as the allegation is adequately pled. By alleging a systematic denial of those MH/SUD benefit claims and citing a California state agency report concluding that certain UnitedHealthcare entities

were applying a more stringent review process to such claims, Ryan S. plausibly alleges that UnitedHealthcare was applying an improper internal process in violation of the Parity Act.

Citing ERISA language suggesting that a violation of 29 U.S.C. § 1185a is a breach of fiduciary duty, the panel concluded that Ryan S. also alleged a breach of fiduciary duty.

The panel therefore reversed the dismissal of Ryan S.'s claims based on the Parity Act and for breach of fiduciary duty. As Ryan S. failed to identify any specific plan terms that the alleged practices would violate, the panel affirmed the dismissal of his claims based on a violation of the terms of his plan.

COUNSEL

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OPINION

CLIFTON, Circuit Judge:

Plaintiff-Appellant Ryan S. brought a putative class action under the Employee Retirement Income Security Act of 1974 ("ERISA") against UnitedHealth Group, Inc. and its subsidiaries (collectively "UnitedHealthcare"). He alleges that UnitedHealthcare applies a more stringent review process to benefits claims for outpatient, out-of-network mental health and substance use disorder ("MH/SUD") treatment than to otherwise comparable medical/surgical treatment. Ryan S. asserts that by doing so, UnitedHealthcare has violated the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act"), 29 U.S.C. § 1185a, in the process also breaching its fiduciary duty and violating the terms of his plan.

UnitedHealthcare moved to dismiss under Federal Rule of Civil Procedure 12(b)(6). The district court granted the motion, concluding that all of Ryan S.'s claims were insufficient as a matter of law. It based the dismissal primarily on its conclusions that Ryan S. had (1) failed to allege that his claims had been "categorically" denied and (2) insufficiently identified analogous medical/surgical claims that he had personally submitted and UnitedHealthcare had processed more favorably.

We conclude that Ryan S. adequately stated a claim for a violation of the Parity Act. An ERISA plan can violate the Parity Act in different ways: it can explicitly exclude some form of treatment for MH/SUD issues that is offered for comparable medical/surgical issues; it can apply a facially neutral plan term in an unequal way between MH/SUD and

medical/surgical benefits; or it can apply a more stringent internal process to MH/SUD claims than to medical/surgical claims. In this case, Ryan S. alleges a violation of the third type, claiming that UnitedHealthcare applied a more restrictive review process to his outpatient, out-of-network MH/SUD claims. A plaintiff presenting that type of contention may be able to allege a plausible claim without having to allege a categorical practice or differential treatment for his or her medical/surgical claims. It is enough for such a plaintiff to allege the existence of a procedure used in assessing MH/SUD benefit claims that is more restrictive than those used in assessing medical/surgical claims under the same classification, as long as the allegation is adequately pled.

By alleging a systematic denial of those MH/SUD benefit claims and citing a California state agency report that had concluded that certain UnitedHealthcare entities, including Defendant UnitedHealthcare of California ("UHC"), were applying a more stringent review process to such claims, Ryan S. plausibly alleges that UnitedHealthcare was applying an improper internal process in violation of the Parity Act. The allegations might ultimately not be proven, but they are sufficient at the pleading stage.

We reverse the dismissal of Ryan S.'s claims based on the Parity Act and for breach of fiduciary duty. As Ryan S. fails to identify any specific plan terms that the alleged practices would violate, we affirm the dismissal of his claims based on a violation of the terms of his plan. We thus reverse the judgment in part, affirm it in part, and remand the matter for further proceedings.

I. Background

Ryan S. is a California resident and a beneficiary of an ERISA group health plan insured, managed, and administered by UnitedHealthcare. Ryan S.'s plan covers outpatient, out-of-network MH/SUD treatment at 70% of covered charges, and 100% once the out-of-pocket maximum is met. Over the course of many months between 2017 and 2019, Ryan S. completed two different outpatient, out-of-network substance use disorder programs. UnitedHealthcare did not cover most of the costs of the programs. Ryan S. was variously informed that his claims were denied because "your plan does not cover the services you received," "no documentation was submitted," and "the information submitted does not contain sufficient detail." Overall, Ryan S. was left personally responsible for hundreds of thousands of dollars in charges.

Ryan S. filed a putative class action against UnitedHealth Group, Inc. and eight of its wholly owned subsidiaries on July 11, 2019. That complaint was subsequently amended. The operative Third Amended Complaint ("TAC") alleges that UnitedHealthcare violated three of ERISA's requirements: (1) the Parity Act, codified at 29 U.S.C. § 1185a; (2) the fiduciary duty of loyalty, described in 29 U.S.C. § 1104; and (3) the requirement under § 1104 to follow the contractual terms of a beneficiary's plan. The TAC seeks various forms of relief on behalf of the putative class, including a declaration that UnitedHealthcare's practices violated ERISA, an injunction requiring Defendants to re-evaluate all claims for substance use disorder and related laboratory services, and disgorgement of profits.

In support of these allegations, the TAC does not rely solely on Ryan S.'s personal experiences with denied claims. It also cites a 2018 report by the California Department of Managed Health Care, which concluded that Defendant UHC violated the Parity Act by imposing a more stringent review process on MH/SUD treatment claims.[1] The report based this conclusion on the existence of an algorithm, applied solely to MH/SUD treatment programs, which assessed patients' progress and referred cases for additional review, leading to the potential denial of benefits if results were deemed insufficient.

The district court initially dismissed the TAC under Rule 12(b)(1) for lack of standing. On appeal, our court held that Ryan S. had standing to pursue claims based on three alleged practices: (1) refusing to cover outpatient MH/SUD treatment, (2) refusing to pay for certain "auxiliary treatments," and (3) refusing to cover clinical laboratory claims for MH/SUD patients. *Ryan S. v. UnitedHealth Grp., Inc.*, 2022 WL 883743, at *2-4 (9th Cir. 2022). On remand, UnitedHealthcare renewed its motion to dismiss under Rule 12(b)(6) for failure to state a claim. The district court granted the motion, and this appeal followed.

II. Discussion

We review de novo the grant of a motion to dismiss under Rule 12(b)(6). *Mudpie, Inc. v. Travelers Cas. Ins. Co. of Am.*, 15 F.4th 885, 889 (9th Cir. 2021). A court conducting

[1] CAL. DEP'T MANAGED HEALTH CARE, OFF. PLAN MONITORING, FINAL REPORT: FOCUSED SURVEY OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) IMPLEMENTATION 15-16 (July 18, 2018) [hereinafter FINAL REPORT], https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/126_r_MHPAEA_071818.pdf (last visited Feb. 6, 2024).

such an inquiry "accept[s] the factual allegations of the complaint as true and construe[s] them in the light most favorable to the plaintiff." *Id.* (citation omitted). The motion should be denied if the claim is plausible on its face, that is, if "the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)).

Ryan S. alleges that UnitedHealthcare maintains a system that subjects MH/SUD treatment claims to a more stringent review process than other medical/surgical claims. He argues that this practice violates three of the duties that ERISA imposes on administrators: (1) the requirement that administrators treat MH/SUD and medical/surgical claims equally, (2) the fiduciary duty of loyalty, and (3) the mandate to follow all plan terms. Based on each of these three alleged violations, Ryan S. seeks relief under 29 U.S.C. § 1132(a)(3), which allows a plaintiff to bring a claim based on "any act or practice which violates" ERISA.[2]

[2] The Supreme Court has described Section 1132(a)(3) as a "catchall" designed to "act as a safety net, offering appropriate equitable relief for injuries caused by violations that [Section 1132] does not elsewhere adequately remedy." *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). While conceding that the question is not yet before us, UnitedHealthcare asserts that "reprocessing of claims[] *cannot be granted* . . . under 29 U.S.C. § 1132(a)(3) as a matter of law." It bases this assertion on our recent decision in *Wit v. United Behav. Health*, 79 F.4th 1068 (9th Cir. 2023), where we held that "the district court erred in concluding that reprocessing was an available remedy under 29 U.S.C. § 1132(a)(3)." *Id.* at 1086. However, UnitedHealthcare overstates the breadth of that decision. In *Wit*, class certification was improper "[b]ecause the classes

A. Parity Act

The Parity Act requires that any limitations on "mental health or substance use disorder benefits" in an ERISA plan be "no more restrictive than the predominant treatment limitations applied to substantially all [covered] medical and surgical benefits." 29 U.S.C. § 1185(a)(3)(A)(ii). Thus, to succeed on a claim under the Parity Act, a plaintiff must show that an ERISA plan that offers both medical/surgical benefits and MH/SUD benefits imposed a "more restrictive limitation on [MH/SUD] treatment than limitations on treatment for medical and surgical issues." *Stone v. UnitedHealthcare Ins. Co.*, 979 F.3d 770, 774 (9th Cir. 2020). The district court held that Ryan S. did not plausibly allege the existence of such a limitation. We disagree.

We appreciate the challenge posed here for the district court. We have previously noted that although the Parity Act's "language is quite clear," it has "left some room for uncertainty or ambiguity regarding its application to specific ERISA plan terms and situations." *Danny P. v. Catholic Health Initiatives*, 891 F.3d 1155, 1158 (9th Cir. 2018) (citing 29 U.S.C. § 1185a(a)(3)(A)). The guidance provided by our court or other circuit courts is limited. As the district

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were not limited to those claimants whose claims were denied based only on the challenged [process] . . . ." *Id.* The plaintiffs attempted to use Section 1132(a)(3) to circumvent that conclusion, arguing that reprocessing could still be an *equitable* remedy for class members who had not been affected by the challenged process. *Id.* We rejected that argument, holding that reprocessing was not available in equity for class members for whom the challenged process was "*unrelated to Plaintiffs' claim for benefits*." *Id.* (emphasis added). Should this case proceed to class certification, reprocessing could still be an appropriate equitable remedy for any individuals whose claims were denied *because* UnitedHealthcare applied the challenged review process.

court noted, one ambiguity concerns "how to *state a claim* for a Parity Act violation," on which "[t]here is no clear law." *Patrick S. v. United Behavioral Health*, 516 F. Supp. 3d 1303, 1306 (D. Utah 2021) (emphasis added).

Without clear guidance, district courts have improvised when crafting pleading standards, often with inconsistent results. *Compare Michael W. v. United Behav. Health*, 420 F. Supp. 3d 1207, 1235 (D. Utah 2019), *with Welp v. Cigna Health & Life Ins. Co.*, 2017 WL 3263138, at *5-6 (S.D. Fla. 2017). These inconsistencies result from the fact that the language of the Parity Act is broad enough to contemplate multiple types of claims. Plaintiffs can allege that an ERISA plan contains an exclusion that is *discriminatory on its face*, that the plan contains a facially neutral term that is *discriminatorily applied* to MH/SUD treatment, or that the plan administrator applies an improper *internal process* that results in the exclusion of some MH/SUD treatment. *Michael W.*, 420 F. Supp. 3d at 1235-36. These three types of cases can be referred to respectively as (1) *facial exclusion* cases, (2) *as-applied* cases, and (3) *internal process* cases. Attempts to craft and apply a rigid multi-prong test that applies to all three situations can lead to the erroneous dismissal of potentially meritorious Parity Act claims.

The last type of case is at issue here. As this court stated in our previous decision in this case: "The thrust of Ryan S.'s lawsuit is that United [Healthcare] handles claims for treatment of substance use disorder differently than it handles treatment for other claims." *Ryan S.*, 2022 WL 883743, at *3; *see id.* at *4 (Collins, J., dissenting in part) ("[Ryan S.'s] complaint rests on the distinct theory that Defendants adopted certain general 'practices' for handling particular types of claims that were not consistent with . . . ERISA's 'parity provisions.'"). Ryan S. does not

allege any express exclusions in his plan, nor identify specific terms that, as applied, led to the denial of his claims. Instead, he alleges that UnitedHealthcare uses improper internal processes in determining whether outpatient, out-of-network MH/SUD treatment is covered under the plan. *See* 29 C.F.R. § 2590.712(c)(4)(i) ("processes, strategies, evidentiary standards, or other factors" may not be applied in a discriminatory manner); *cf. Bushell v. UnitedHealth Grp. Inc.*, 2018 WL 1578167, at *5 (S.D.N.Y. 2018). This case thus presents the question of what pleading standard applies to cases alleging an improper internal process.

In assessing that question for any category of Parity Act claims, we must keep certain principles in mind. Because violations of the Parity Act can take different forms, an evaluation of the plausibility of a complaint must reflect the specific violation alleged. For instance, Ryan S. did not need to allege a "categorical" practice or the uniform denial of his benefits, as the district court appeared to require. We previously held that because Ryan S.'s claims are based on the existence of an internal process, he "need not necessarily prove that any practice was categorical." *Ryan S.*, 2022 WL 883743, at *3; *see also A.Z. by & through E.Z. v. Regence Blueshield*, 333 F. Supp. 3d 1069, 1082 (W.D. Wash. 2018). Handling MH/SUD treatment claims more stringently violates the Parity Act regardless of whether such differential treatment leads to the uniform denial of all claims.

In addition, a plaintiff need not identify an analogous category of claims with precision. While a plaintiff alleging a Parity Act violation must give reason to believe that some analogous category of claims is treated differently, the plaintiff can define that analogous category quite broadly. The statute and its implementing regulations require only a

comparison between the MH/SUD treatment at issue and other treatment within the same "classification"—in this case, outpatient, out-of-network treatment. *See* 29 U.S.C. § 1185a(a)(8)(A)(iv); *see also* 29 C.F.R. § 2590.712(c)(2)(ii)(A) (enumerating the six different classifications of benefits). Any other medical/surgical treatment within that classification can be a sufficient comparator.

A plaintiff alleging an improper internal process also need not specify the different process that allegedly applies to the analogous category of medical/surgical benefits. Plaintiffs who have not received medical/surgical treatment in the same classification as their MH/SUD treatment would have no basis to determine the process used for those analogous claims. *See Bushell*, 2018 WL 1578167, at *6 ("If the Court required Bushell's complaint to specify the exact process by which United reached its decision on anorexia cases *and* the exact process it employed for diabetes treatment, it would likely create a serious obstacle to meritorious Parity Act claims."); *Melissa P. v. Aetna Life Ins. Co.*, 2018 WL 6788521, at *3 (D. Utah 2018) ("To require more would prevent any plaintiff from bringing a mental health parity claim based on disparate operation unless she had . . . personal experience with both standards."); *see Vorpahl v. Harvard Pilgrim Health Ins. Co.*, 2018 WL 3518511, at *3 (D. Mass. 2018) ("[T]he process and factors by which [a] nonquantitative treatment limitation could even be applied both to mental health benefits and medical/surgical benefits . . . need[] to be resolved as the case proceeds after the benefit of discovery."). A plaintiff must merely allege facts sufficient to suggest that the challenged process is specific to MH/SUD claims in order to meet the plausibility pleading standard.

Overall, that standard requires a plaintiff bringing an internal process case to plausibly allege the existence of a procedure used in assessing MH/SUD benefit claims that is more restrictive than those used in assessing some other claims under the same classification. *Cf. Twombly*, 550 U.S. at 557 (holding that allegations of conduct that are merely consistent with wrongdoing do not state a claim unless "placed in a context that raises a suggestion of" such wrongdoing). A plaintiff advancing an internal process challenge needs to provide some reason to believe that the denial of MH/SUD claims was impacted by a process that does not apply to medical/surgical claims.

Simply alleging the denial of a plaintiff's claims for behavioral health benefits is unlikely by itself to support a plausible inference that a defendant employed policies in violation of the Parity Act. *See H.H. v. Aetna Ins. Co.*, 342 F. Supp. 3d 1311, 1320-21 (S.D. Fla. 2018) ("While . . . Plaintiffs need not have proof of the specific processes that [the defendant] allegedly uses to deny coverage . . . , Plaintiffs must still include some factual allegations to lend support to their claim.").

In this case, Ryan S. pleads something more. Beyond his own denied claims, he cites the 2018 report by the California Department of Managed Healthcare, described above. That report concluded that UHC processed MH/SUD claims differently. According to the report, claims submitted to UHC for outpatient MH/SUD treatment are evaluated using a process called Algorithms for Effective Reporting and Treatment (ALERT). FINAL REPORT at 15-16. The algorithms identify how often an enrollee is receiving outpatient, out-of-network treatment and whether the enrollee is making progress in the program. If the algorithms determine that certain criteria are not being met, "the case

[is] referred for peer review . . . which could result in a denial of services." *Id.* at 15. Meanwhile, UHC staff told the agency that no comparable additional review process applies to members undergoing outpatient medical/surgical treatment. *Id.* at 16. The state agency therefore determined that the "approval process for outpatient MH/SUD services is not comparable and that [utilization management] review is being applied in a more stringent manner for outpatient MH/SUD services." *Id.*

The use of an algorithmic process to trigger additional levels of review could explain why Ryan S.'s claims were not denied for a single stated reason. If the ALERT system triggers a more intensive review process for MH/SUD claims, reviewing staff might subsequently deny each individual claim for any number of reasons. Even if all those denials were independently valid, the mere fact that the reasons to deny coverage were identified only because the MH/SUD claims were subjected to an additional layer of scrutiny could violate the Parity Act.

UnitedHealthcare asserts that the report's findings have an insufficient nexus to Ryan S.'s claims, as he relies on the inference that such practices could explain his experiences with UnitedHealthcare.[3] Such an inference is not unwarranted on a motion to dismiss, however, where the court must construe all allegations in the light most favorable

[3] UnitedHealthcare also characterizes ALERT as relevant only to the pre-authorization process, which it argues Ryan S. does not have standing to challenge. However, as described above, the agency report's findings were not so limited. The report suggests that UHC uses ALERT *throughout* the process of a beneficiary's MH/SUD outpatient treatment, and that ALERT can lead to the denial of a benefits claim at any point. FINAL REPORT at 15-16. The conclusions regarding ALERT pertain to claims which Ryan S. has standing to bring.

to the plaintiff. The report was the result of a government investigation conducted concurrently with the benefit denials that form the basis of Ryan S.'s claims. The report suggests that, at least at the time, UnitedHealthcare subjected *all* MH/SUD outpatient claims to a more restrictive review process. That is enough to connect the report's findings to Ryan S.'s denial of benefits and is therefore sufficient to place Ryan S.'s allegations "in a context that raises a suggestion of" wrongdoing. *Twombly*, 550 U.S. at 557.

The report is much more thorough than any pre-lawsuit investigation that a typical Parity Act plaintiff could be expected to conduct on his or her own. It directly analyzes UnitedHealthcare's review process for MH/SUD claims and compares it to the plan's review process for other claims in the same classification. A pleading standard under which such a comprehensive investigation is insufficient would make it inordinately difficult for a plaintiff to challenge an internal process, given the likelihood that an individual claimant's own administrative record would not shed light on the internal processes to which the claims were subjected. The plausibility pleading standard is not that unreachable. In short, Ryan S.'s allegations, in conjunction with the agency report, are more than sufficient to allege a plausible violation of the Parity Act.

B. Breach of Fiduciary Duty

The district court primarily rejected Ryan S.'s breach of fiduciary duty claims for the same reasons that it dismissed his Parity Act claim: a failure to allege the existence of a violative practice. As we conclude that Ryan S. sufficiently alleged that UnitedHealthcare implemented a more stringent process for determining MH/SUD benefit claims in violation of the Parity Act, we conclude he also alleged a breach of

fiduciary duty.[4] ERISA specifies that fiduciaries must discharge their duties solely in the interests of plan beneficiaries and participants "in accordance with the documents and instruments governing the plan *insofar as such documents and instruments are consistent with the provisions of*" ERISA. 29 U.S.C. § 1104(a)(1)(D) (emphasis added). This language suggests that a violation of 29 U.S.C. § 1185a is a breach of fiduciary duty. *See, e.g.*, *Doe v. United Behav. Health*, 523 F. Supp. 3d 1119, 1127 (N.D. Cal. 2021) (denying defendant's motion for summary judgment in a breach of fiduciary duty suit predicated on a violation of the Parity Act).

C. Violation of Plan Terms

A plaintiff bringing a claim based on a violation of plan terms "must identify a specific plan term that confers the benefit in question." *Steelman v. Prudential Ins. Co. of Am.*, 2007 WL 1080656, at *7 (E.D. Cal. 2007) (quoting *Stewart v. Nat'l Educ. Ass'n*, 404 F. Supp. 2d 122, 130 (D.D.C. 2005)). Even though Ryan S. has plausibly alleged the existence of a more stringent review process for MH/SUD claims, such a process would not automatically violate the terms of his plan. To succeed on this claim, Ryan S. must identify a term of his plan that Defendants violated, such as a term that promised an identical review process for all claims.

[4] UnitedHealthcare argues that if any of Ryan S.'s claims proceed, they should do so against only United Behavioral Health, Inc., as Ryan S. has not adequately alleged that any other defendant was a fiduciary. The district court has not addressed this question, and it seems to us premature to do so at this point in the proceedings. Further, the agency report indicated that at least UHC had direct involvement in the implementation of the ALERT system. FINAL REPORT at 16.

As the district court concluded, Ryan S. has not done so. Instead, he rests on the assertion that "it is hard to fathom how Defendants' failure to decide many of Ryan's claims could possibly be consistent with Plan terms requiring UnitedHealthcare to decide and pay claims for medically necessary substance use disorder treatment." The question is not whether it is "hard to fathom" that a plan did not include a specific requirement, but whether the plan actually included such a requirement that Defendants then violated. Ryan S. fails to make such a showing.

III. Conclusion

We affirm the district court's dismissal of Ryan S.'s claims based on a violation of the terms of his plan. We reverse the district court's dismissal of Ryan S.'s claims for violation of the Parity Act and breach of fiduciary duty, and we remand for further proceedings consistent with this opinion.

Each party shall bear its own costs on appeal.

AFFIRMED in part; REVERSED in part; REMANDED for further proceedings.

DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

FOCUSED SURVEY OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) IMPLEMENTATION

OF

UHC OF CALIFORNIA
DBA: UNITEDHEALTHCARE OF CALIFORNIA

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JULY 18, 2018

Final Report
Focused Survey of Mental Health Parity and Addiction Equity Act Implementation
UHC of California dba: UnitedHealthcare of California
July 18, 2018

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EXECUTIVE SUMMARY

On October 24, 2016, the California Department of Managed Health Care (Department) notified UHC of California dba: United HealthCare of California (Plan) that the Focused Survey for compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76 had commenced, and requested the Plan submit information regarding its healthcare delivery system.

The survey team conducted the onsite portion of the survey from January 10, 2017 to January 12, 2017. For the survey review period of January 1, 2016 to October 24, 2016, the Department identified one finding requiring corrective action summarized below.

The Preliminary Report was issued to the Plan on December 7, 2017. The Plan had 45 days to file a certification document that bears the signature of one of the Plan's principal officers to certify the Report's accuracy.

This Final Report describes the Focused MHPAEA Survey of the Plan.

MHPAEA does not require health plans to offer mental health and substance use disorder (MH/SUD) benefits, but plans that do so are required to provide covered MH/SUD benefits in parity with medical/surgical (M/S) benefits. The Knox-Keene Health Care Service Plan Act of 1975,[1] specifically California Health and Safety Code section 1374.76, directs group and individual plans to provide all covered MH/SUD benefits in compliance with MHPAEA no later than January 1, 2015, and authorizes the Department to issue guidance to plans concerning MHPAEA compliance.

The Department's Focused Surveys evaluated plans' MHPAEA compliance, for the survey review period specific to each plan, by reviewing the two general categories of MHPAEA treatment limitations which are Nonquantitative Treatment Limitations (NQTLs) and Quantitative Treatment Limitations (QTLs). MHPAEA states that treatment limitations are applicable to both NQTLs and QTLs.[2]

- NQTLs are types of treatment limitations that limit the scope or duration of benefits, but are not quantifiable by a specific number. MHPAEA regulations provide an illustrative list of eight specific NQTLs, but explains the list is not meant to be comprehensive.[3] Medical management standards, one NQTL, is listed and is defined as a NQTL that limits or excludes benefits based on medical

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to Section are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to Rule are to Title 28 of the California Code of Regulations unless otherwise indicated.
[2] 45 CFR 146.136(a)
[3] The illustrative NQTL list at 45 CFR 146.136(c)(4)(ii) includes: (A) medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental; (B) formulary design for prescription drugs; (C) standards for provider admission to participate in a network, including reimbursement rates; (D) refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective; (E) conditioning benefits on completion of a course of treatment; (F) restrictions based on geographic location, facility type, or provider specialty; (G) standards for providing access to out-of-network providers.

necessity, medical appropriateness or whether the treatment is experimental or investigative. The Department's NQTL review focused on medical management standards based on the Plan's utilization management (UM) processes.

For NQTLs, MHPAEA provides a general rule that a health plan may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification[4] unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification.[5]

To determine whether UM processes are comparable between M/S and MH/SUD services, the Department reviewed and compared UM files,[6] to the extent plans were able to produce files, within Inpatient, Outpatient, and Other Findings categories.[7] The Department also conducted interviews with plan staff to assess implementation of processes, strategies, evidentiary standards, and/or other factors used in plans' daily operations when applying UM criteria to both MH/SUD and M/S services. The Department evaluated whether plans' UM processes utilized for MH/SUD services were being applied in a manner that is more stringent than the processes applied for M/S services. Finally, the Department reviewed relevant plan documents such as policies and procedures, and Evidences of Coverage (EOCs) to assess application of UM criteria and other written NQTLs.

- QTLs are typically numeric based treatment limitations. They may include financial requirements such as deductibles and copayments/coinsurance, limits on the total number of hospital days allowed within a year, and other limits or caps on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period.

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[4] Regarding the classification of benefits, the federal rules at 45 CFR 146.136(c)(2)(ii) and 45 CFR 146.136(c)(3)(iii)(C) set forth the following 8 benefits classifications and outpatient subclassifications: 1) Inpatient, in-network; 2) Inpatient, out-of-network; 3) Outpatient office visits, in-network; 4) Outpatient other items and services, in-network; 5) Outpatient office visits, out-of-network; 6) Outpatient other items and services, out-of-network; 7) Emergency care; and 8) Prescription drugs.

[5] 45 CFR 146.136(c)(4)(i)

[6] With regard to approval files, the Department found the files often lacked documentation that identified formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. As a result, the Department reviewed both approval and denial files and assessed factors evident in file review together with information presented during interviews and processes described in policies and procedures.

[7] The categories reviewed by the Department are: 1) Inpatient Hospitalization; 2) Skilled Nursing Facility/Residential; 3) Outpatient Office Visits; 4) Outpatient – Other Items and Services and 5) Other Findings. Although the Department recognizes that MHPAEA identifies Emergency as a separate classification, the Department utilized an Other Findings classification because it determined an Emergency classification, by itself, would not provide meaningful analysis of the Plan's UM processes because plans do not conduct prior authorization of emergency services and few plans conduct retrospective review of emergency services. The Other Findings category allowed the Department to evaluate each Plan's unique operations. Finally, the Department did not review the prescription drug classification in this focused survey.

MHPAEA prohibits a health plan that provides both M/S and MH/SUD benefits from applying a financial requirement and/or other QTL to MH/SUD services in any benefits classification[8] that is more restrictive than the predominant financial requirement or QTL of that type applied to substantially all M/S benefits in the same classification.

The Department assessed plans' QTL compliance by reviewing financial requirements such as co-pays and coinsurance, within specific plan products. The Department also conducted interviews concerning QTL processes and reviewed relevant documents.

FOCUSED SURVEY TABLE OF FINDINGS

NONQUANTITATIVE TREATMENT LIMITATIONS	
1	**The Plan does not ensure that the criteria used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.** Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i)
QUANTITATIVE TREATMENT LIMITATIONS	
2	**The Department identified no MHPAEA issues with respect to the Plan's implementation of financial requirements.** Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A)

PLAN BACKGROUND

The Plan is a full service medical health care plan headquartered in Cypress, California, and received its Knox-Keene license on May 15, 1978. UHC offers commercial HMO plans in the small and large group markets and is a delegated model. UHC provided a list of 106 Medical Groups/Independent Provider Associations (MGs) that conduct UM for M/S requests on behalf of UHC. The Plan reported that, as of November 8, 2016, the total number of enrollees in medical groups to which UM is delegated is 486,183 of the 487,267 total enrollees (99.8%).

Credentialing and routine UM functions are delegated to the Plan's contracted medical groups/IPAs. UHC has a Plan-to-Plan Agreement with U.S. Behavioral Health Plan, California dba: OptumHealth Behavioral Solutions of California (Optum) to provide behavioral health services. Optum performs UM for MH/SUD services requested for Plan enrollees.

[8] The six classifications provided in 45 CFR 146.136(c)(2)(ii).

UM Responsibility Chart

Entity	UM Responsibility
Plan	Resolution of appeals; UM for bariatric surgeries, transplants, and continuity of care
106 Medical Groups/IPAs	Almost all M/S services
U.S. Behavioral Health Plan, California dba: OptumHealth Behavioral Solutions of California	MH/SUD

MHPAEA IMPLEMENTATION OVERVIEW

MHPAEA was enacted by Congress in 2008.[9] Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.[10] The U.S. Departments of Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.[11] The federal government authorized states to ensure compliance with MHPAEA and the final rules within health plan and insurer coverage.

California law mandates that commercial health plans cover specified mental and substance use disorders as well as certain services to treat those disorders.[12] MHPAEA requires health plans to provide covered benefits for MH/SUD in parity with M/S benefits.

The Department's Oversight

To ensure health plan compliance with MHPAEA, the Department has undertaken a two-phased approach.

Phase One began in September 2014 when the Department required 26 licensed full service health plans to submit up to 15 benefit plan designs (BPDs) that were reviewed for MHPAEA compliance.[13] The Department's Office of Plan Licensing, Office of Financial Review, and clinical consultants reviewed each of the health plans' submissions. After extensive discussions with the Department, each plan was required to make corrections and implement changes by January 1, 2016.

Phase Two is the Focused Survey. The purpose of the Focused Survey is to review the Plan's implementation of the required changes made in Phase One, and to further evaluate NQTL and QTL to determine MHPAEA compliance.

The Department's findings for Phase One and Two with respect to UHC of California dba: United Healthcare of California are described in this Report.

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[9] Public Law 110-343, 42 U.S.C. § 300gg-26.
[10] 42 U.S.C. § 300gg-26(a)(1)-(a)(3), as amended by ACA, Title X, subtitle A, § 10107(b)(1); 78 Fed. Reg. 68240-68241, 68251 (Nov. 13, 2013); 45 C.F.R. § 156.115(a)(2).
[11] 45 CFR § 146.136 (2013).
[12] Health and Safety Code section 1374.72 requires plans to cover inpatient, outpatient, and psychiatric hospitalization treatment for nine severe mental illnesses for a person of any age and children with serious emotional disturbances. In addition, Health and Safety Code section 1367.005 applies the Affordable Care Act's essential health benefits to nongrandfathered commercial individual and small group coverage while Rule 1300.67.005 requires plans to cover substance use disorders and almost all mental disorders with a range of medically necessary treatments such as intensive outpatient programs, outpatient counseling, and residential care.
[13] Depending on each plan's participation in the individual, small group and large group commercial markets, plans were required to submit up to a maximum of 15 BPDs for review (5 products for each market served).

SECTION I: PHASE ONE OVERVIEW

For the Phase One review, the Plan submitted 15 BPDs for the Department's review. The Department assessed the BPDs for compliance with parity requirements in the Knox-Keene Act and with MHPAEA requirements. Upon completion of its review, the Department issued the Plan a closing letter (the Phase One Closing Letter) that described cost-sharing changes required for eight of the 15 BPDs submitted in addition to other changes. A copy of the Phase One Closing Letter is attached to this report (see Appendix A.)

SECTION II: DISCUSSION OF FOCUSED SURVEY – PHASE TWO

The Department verified whether the Plan met the conditions set forth in the Department's Phase One Closing Letter. The Department also reviewed Plan documents (Evidences of Coverage, Summaries of Benefits and Coverage, and other disclosure documents), conducted interviews with Plan representatives and delegated entities, and reviewed and compared the UM practices for M/S and MH/SUD in each classification as described in the Plan and delegates' (if applicable) M/S and MH/SUD files.

The Department also reviewed two BPDs[14] that were not previously submitted for the Department's review, and assessed whether these BPDs demonstrated appropriate cost-sharing and financial requirements.

FINDINGS

A. NONQUANTITATIVE TREATMENT LIMITATIONS

#1 The Plan does not ensure that the criteria used to apply utilization management to mental health/substance use disorder benefits are comparable to, and applied no more stringently than the criteria used to apply utilization management to medical/surgical benefits in the same classifications.
Health and Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).

Statutory/Regulatory Reference: Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26). Plans offering benefits to individuals and small groups must also comply with Section 1367.005.

45 CFR 146.136(c)(4)(i) requires that the processes, strategies, evidentiary standards, or other factors used by a health plan in applying a nonquantitative treatment limitation to mental health or substance use disorder benefits within a classification be comparable to, and 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 same classification.

Supporting Documentation or Evidence:

- Review of 140 UM files total in the following categories: Inpatient, Skilled Nursing Facility (SNF)/Residential, Outpatient Office Visit, Other Outpatient, Other Findings (Retrospective Review) (see Table 1)
- Plan policies and procedures
- Interviews with plan staff conducted January 10, 2017 through January 12, 2017

[14] Except for Plans that only offer IHSS coverage.

Assessment:

File Review

In order to assess MHPAEA parity between the Plan's MH/SUD and M/S benefits, the Department requested the Plan and delegates submit UM files. The Department reviewed the Plan's approval files and found the files often lacked documentation that identified the formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. However, the Department's purpose in reviewing these files was not to ensure the Plan documented the basis for approval.

MHPAEA and the Knox-Keene Act do not require plans to document criteria/guidelines in approval files. Rather, the Department reviewed UM files to gather information about the Plan's processes for approving requested services. In reviewing the files, the Department assessed the following within each classification of benefits:

- the nature, frequency of use and application of UM factors, criteria and processes utilized for M/S and MH/SUD services;
- application of clinical rationales and;
- file documentation of the UM processes and/or clinical rationale, and variation in application of UM processes by the Plan and/or its delegated entities.

The Department randomly selected 30 M/S delegates for inclusion in the file logs. Twenty delegates were ultimately represented in the selected files. The chart below lists the total number of files reviewed by the Department:

Table 1- Total Number of Files Reviewed

Category of Benefits	Number of Medical/Surgical Files Reviewed	Number of Mental Health Files Reviewed	Number of Substance use Disorder Files Reviewed
Inpatient	10	10	10
SNF/ Residential	16	10	10
Office Visit	14	6	0
Other Outpatient	10	10	10
Other (Retrospective)	10	13	1
Total	**60**	**49**	**31**

1. Inpatient

A. File Review

(i) Inpatient Hospitalization

Medical/Surgical:

The Department reviewed 10 M/S files involving inpatient hospitalization. The delegates approved all of the requested services. Six of the 10 files involved ER admissions for various issues such as pneumonia, anasarca, chest pain, unsteady gait, and altered mental status. All of the 10 files involved requests for in-network services. Nine of the files demonstrated application of formal criteria. Four files demonstrated application of Milliman Care Guidelines (MCG). Five files demonstrated application of InterQual[15] criteria. One file demonstrated application of clinical reasoning. Concurrent review was conducted on four files.

Mental Health:

The Department reviewed 10 MH files for services such as involuntary admissions, schizoaffective disorder, eating disorder, and recurrent episode of major depression. Nine of the ten files demonstrated application of the Optum Level of Care Guidelines. One of the files demonstrated application of the American Society of Addiction Medicine (ASAM) Guidelines. All services requiring prior authorization were approved. Concurrent review was performed on eight of the files, leading to one modification.

Substance Use Disorder:

The Department reviewed 10 SUD files that predominantly involved inpatient detoxification services. Eight of the files demonstrated application of the Optum Level of Care Substance Abuse Inpatient Detoxification Guidelines. Two files demonstrated application of the Optum Level of Care Guidelines. The requests for prior authorization resulted in five approvals, two modifications, and one denial. Concurrent review was performed on five of the files with all services approved.

(ii) SNF/Residential

Medical/Surgical SNF:

The Department reviewed 16 files involving approvals for skilled nursing facility (SNF) services. One delegate file demonstrated application of its own medical group criteria. Eleven of the files demonstrated application of clinical information and/or clinical judgment in making the approval decision; four used MCG, and one used medical group guidelines. While preparing files for this survey, the Plan found that two medical groups had discovered “inconsistent application and use of the MCG Guidelines” and the medical groups began “rigorous correction with training, new job aids and tools with decision tree matrix.” This was reflected in four of the files.

File review demonstrated that the medical groups deferred to inpatient hospitalists’ decisions concerning the members need for SNF services. Where the inpatient hospitalist recommended SNF services, the medical group performed no additional UM, and SNF benefits were approved. Eleven of the 16 files reviewed showed the final decision to authorize the SNF admission occurred after the members were discharged. The authorizations were for the entire length of stay, which ranged from three to 59 days.

[15] InterQual is a standardized medical review tool to establish level of care.

Mental Health Residential:

The Department reviewed 10 MH residential treatment files. All 10 files reviewed demonstrated application of Optum Level of Care Guidelines. Eight of the ten admissions to MH residential treatment centers reviewed underwent initial review by Optum UM staff for authorization on the day of admission. One file was reviewed the day after admission and another was reviewed within a week of admission. The initial authorizations placed limitations on number of days authorized, ranging from two to six days. All 10 files reviewed documented concurrent reviews by UM staff for the purpose of authorizing additional days of residential treatment, which ranged from one to eight days. Five files showed physician peer-to-peer reviews that led to denial of continued stay.

Substance Use Disorder Residential:

The Department reviewed 10 SUD files. All 10 files demonstrated application of the Optum Level of Care guidelines used to make the determinations. Nine out of 10 admissions to substance use disorder residential treatment centers reviewed underwent initial review by UM staff for authorization the day of admission. One request was reviewed within two days of admission. The initial authorizations placed limitations on number of days authorized, ranging from three to seven days. All 10 files reviewed documented concurrent reviews by UM staff for the purpose of authorizing additional days of residential treatment, which ranged from two to seven days.

Table 2 – Inpatient Hospitalization and SNF/Residential Summary

File Type	Number of Files	Basis for UM Determination
Inpatient M/S Files	10	MCG (4) InterQual (5) Clinical Reasoning (1)
Inpatient MH Files	10	Optum LOC Guidelines (9); ASAM (1)
Inpatient SUD Files	10	Optum LOC SA Inpatient Detoxification (8); Optum LOC Guidelines (2)
M/S SNF	16	MG Guidelines (1); Clinical Factors (11); MCG (4)
MH Residential	10	Optum LOC Guidelines Residential Treatment (10)
SUD Residential	10	Optum LOC SA Guidelines Residential (10)

B. Inpatient Interviews

The Department conducted interviews with Plan staff to understand the Plan's operational processes when applying UM criteria in the Inpatient classification. The Plan delegates almost all of the UM review for M/S services to the various medical groups. Plan staff stated that when approving M/S services, each of the medical groups utilized differing UM processes and varied UM criteria including national guidelines as well as specific medical group criteria.

The Plan was asked what M/S services require prior authorization. The Plan's Sr. Medical Director for Clinical Services responded that there are "thousands of codes" that are auto-approved. The Plan's Chief Medical Officer stated that 95% of utilization management is conducted by the delegated medical groups. The medical groups may develop their own list of services requiring prior authorization as well as their own evidence-based criteria. Therefore, some services will require prior authorization by some medical groups but not by other medical groups. The Plan stated it does not monitor the prior authorization lists produced by each medical group or the level of scrutiny used by each medical group in the UM decision-making process.

The Regional Medical Director for Optum stated that facility-based care (e.g., inpatient, residential treatment, partial hospitalization, and intensive outpatient services) requires prior authorization. Further, Optum's Level of Care (LOC) Guidelines and the medical judgement of physician reviewers are used to review requests that require prior authorization. Optum staff detailed the process for authorization of mental health and substance use disorder, which involved a Treatment Milestone Authorization (TMA) "Quick-Cert" process for the most frequent requests. The Quick-Cert process involves a brief review of Age, Diagnosis, Level of Care Guidelines, and three or fewer prior admissions to provide an automatic authorization. If the service is not a TMA, more information is collected and undergoes an initial review for authorization using Optum Level of Care Guidelines. In some instances, the request goes through peer review by the Medical Director or other medical professionals to provide authorization and/or suggest an alternate level of care. The Optum Level of Care Guidelines are used at every step of the authorization process. If authorized, the members all go to facility based care where concurrent review is performed. The Department's file review did not find any files that utilized the Quick-Cert process. All files demonstrated application of Optum Level of Care Guidelines.

Inpatient Conclusion:

In the Inpatient classification, while the Department found evidence enrollees had obtained necessary M/S and MH/SUD services,[16] the file review results and the information obtained during interviews demonstrated that the processes and evidentiary standards used in applying UM to MH/SUD services were not comparable to those used when applying UM to M/S services. Furthermore, the results from the file review in this classification established the Plan applied UM criteria more stringently to MH/SUD services than for M/S services.

[16] The NQTL analysis does not focus on whether the final result in terms of obtaining services is the same. Rather, MHPAEA compliance depends on parity in application of the underlying processes and strategies. See FAQ #3 from the October 27, 2016 Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury.

The Department found that the strict use of Optum Level of Care Guidelines by Optum to authorize MH/SUD services is not comparable to the range of criteria such as MCG, InterQual, medical group specific criteria, and/or clinical rationale used by the numerous medical groups to authorize M/S services. MH/SUD files documented that only Optum Level of Care Guidelines were applied. However, M/S files documented that a range of UM criteria were applied, including InterQual and MCG evidence-based criteria used by health care plans, insurers, hospitals, and companies nationally, as well as criteria developed by the Plan itself, and/or criteria developed by the Plan's contracted medical groups. While the Department did not thoroughly compare the Optum Level of Care Guidelines to the varied criteria utilized by the various medical groups, the Department nevertheless has concerns that the criteria may not be comparable. For instance, the criteria developed by companies such as InterQual and/or MCG, which are used by health care organizations nationally, were developed and implemented based on clinical evidence and peer-reviewed literature without consideration to a specific plan or medical group's day to day operations. Thus, the use of a single set of criteria by Optum for authorizing MH/SUD services does not appear comparable to the various criteria developed by the Plan and/or its medical groups for authorizing M/S services. Interviews with the Plan confirmed there is no uniformity in the development and/or application of UM criteria when reviewing and approving M/S services.

For M/S SNF files, the hospitalists who were the attending physicians for members while in the hospital made the decisions to transfer without needing to undergo additional reviews for authorizations from UM staff. The delegated medical groups deemed the attending physicians' medical judgments/decisions as equivalent to authorizations. However, the MH and SUD residential files showed that the treating psychiatrists' clinical judgments/decisions were not deemed as equivalent to authorizations. In addition, no concurrent review was performed on the M/S SNF files reviewed. The file review demonstrated that both an initial review and concurrent review were performed on 10 out of 10 MH files and nine out of 10 SUD files. The Department therefore determined the UM review and approval processes were not comparable between M/S and MH/SUD services and that UM review was being applied more stringently to MH/SUD services.

2. Outpatient

A. File Review

(i) Outpatient Office Visits

Medical/Surgical:

The Department reviewed 14 M/S outpatient office visit files. Three of the files demonstrated application of UHC Guidelines. One file demonstrated application of medical group guidelines. One file demonstrated application of clinical reasoning to make the UM determination. Eight of the files involved services that were auto-authorized by several different medical groups. One demonstrated application of MCG.

Mental Health:

The Department reviewed six MH outpatient office visit files. All six files demonstrated application of the Optum Level of Care Guidelines. In addition, five files demonstrated use of Optum's ALERT algorithm (see discussion of ALERT system below.)

Substance Use Disorder: No Substance use Disorder files were available to be reviewed by the Department.

(ii) Outpatient – Other Items and Services

Medical/Surgical:

The Department reviewed 10 files involving requests for outpatient, non-office visit M/S services from the Plan and various delegates. Six of the files demonstrated application of MCG criteria in making the UM decision. Three files demonstrated application of clinical information and reasoning to make the determination. One file was an auto-authorization for an extremity study to rule out deep vein thrombosis. There was no concurrent review in any of the 10 files.

Mental Health:

The Department reviewed 10 MH outpatient - other items and services files. The Plan utilized Optum Level of Care Guidelines in eight of the 10 files. The Plan utilized Optum Psychological/Neurological Testing Guidelines in two of the files. Concurrent review was performed in two of the 10 files.

Substance Use Disorder:

The Department reviewed 10 SUD files in the outpatient-other items and services classification. All 10 files utilized Optum's Level of Care Guidelines. Concurrent review was performed on five of the 10 files.

Table 3 – Outpatient Office Visit and Outpatient Other Summary

File Type	Number of Files	Basis for UM Determination
M/S Office Visits	14	UHC Guidelines (3); Clinical Reasoning (1); Medical Group Guidelines (1); Auto-Authorization (8); MCG (1)
MH Office Visits	6	Optum Level of Care Guidelines (6)
SUD Office Visits	0	N/A
M/S Outpatient - Other	10	MCG (6); Clinical Reasoning (3); Auto-Authorization (1)
MH Outpatient - Other	10	Optum Level of Care Guidelines (8); Optum Psychological/Neurological Testing Guideline (2)
SUD Outpatient - Other	10	Optum Level of Care Guidelines (10)

B. Outpatient Interviews

The Department's review of policies, procedures, and files found that Optum uses the Algorithms for Effective Reporting and Treatment (ALERT) system for outpatient office-based visits. Optum staff described ALERT as a "patient advocacy system that identifies members' risks. When a risk is identified, Optum reaches out to the member's clinician to discuss the case."

Optum staff explained that ALERT uses clinical data and algorithms to trigger outreach to providers for clinical updates based on the results of the enrollee's completed Wellness Assessments and history of claims data. For both outpatient and extended outpatient services, enrollees are asked to complete a Wellness Assessment at the first visit, which are returned to Optum for review. Enrollees are asked to complete a second Wellness Assessment, usually at the time of the third visit, which is also reviewed by Optum.

Optum uses claims data to identify the frequency of enrollee visits and in turn identifies risk. Plan staff provided the following example: If an enrollee is seen once per week for six months, the need for a Wellness Assessment would be triggered and the Assessment reviewed. Enrollees may opt out of completing the Wellness Assessment, but a review of claims for that enrollee would still occur. If the Wellness Assessment indicates the enrollee is progressing in treatment, the enrollee's clinician would be contacted by Optum for a clinical update. Optum staff stated ALERT does not issue denials; however, if criteria is not met, the case would be referred for peer review and which could result in a denial of services. Further, concurrent clinical review is triggered

by the high frequency algorithm to determine whether criteria is being met. Plan staff admitted that the ALERT system is effectively using claims to conduct UM.

The Plan was asked if a similar program is used for M/S reviews. Plan staff responded that claims data is used to identify gaps in care (e.g., an overdue preventive service) and to identify enrollees that could benefit from case management. However, Plan staff stated that the Plan does not review enrollees' claims as part of the UM review process. In addition, members utilizing M/S services are not burdened with having to fill out a Wellness Assessment at the initial visit and a second Wellness Assessment at a third visit.

Outpatient Conclusion:

A review of UM files confirmed Optum's use of the ALERT system in the UM process. The file review further revealed that Optum places limitations on the frequency of MH office visits due to information obtained through the ALERT system. The ALERT system, via established algorithms, utilizes claims in addition to clinical information in the UM decision process for MH/SUD services. Interviews with Optum staff revealed that the ALERT system may trigger the initiation of a peer review, which could result in denials of requested services. The Department's file review verified the Plan implemented this process, which resulted in limitations being placed upon ongoing MH treatment. However, the Department found no such comparable system or process existed when the Plan reviewed and approved M/S services, and that there was no comparable process for conducting concurrent review for M/S services. Therefore, the Department finds that the UM approval process for outpatient MH/SUD services is not comparable and that UM review is being applied in a more stringent manner for outpatient MH/SUD services.

Finally, file review demonstrated, and interviews confirmed, that a number of M/S services were reviewed and approved by auto-authorization. However, no auto-authorizations were present in the MH and SUD files reviewed.

3. Other Findings

A. Retrospective File Review

Medical/Surgical:

The Department reviewed 10 files involving retrospective authorization for previously rendered services. Three files demonstrated application of nationally recognized guidelines. One file demonstrated application of UHC Guidelines. Five files demonstrated application of clinical judgment in making the UM decision. One file was an auto-authorization.

Mental Health:

The Department reviewed 13 MH files. Eleven of the files were approvals, one was an administrative denial, and one was a partial denial. Nine of the requests were for in-network services. Seven files demonstrated application of Optum Level of Care Guidelines. Four files demonstrated application of clinical information/factors in making

the UM decision. One file was an administrative approval and one file was an administrative denial.

Substance Use Disorder:

The Department reviewed one post service approval for residential treatment for substance use detoxification. The file demonstrated application of Optum Level of Care Guidelines.

Table 4 – Other Findings (Retrospective Review)

File Type	Number of Files	Basis for UM Determination
M/S Retrospective	10	National Guidelines (3- Apollo and CareWeb); UHC Guidelines (1); Clinical Judgment (5); Auto-Authorization (1)
MH Retrospective	13	Optum Level of Care Guidelines (7); Clinical Judgment (4); Administrative approval (1); Administrative Denial (1)
SUD Retrospective	1	Optum Level of Care Guidelines (1)

The Department's file review found that retrospective UM review for M/S and MH/SUD service requests was conducted using nationally recognized clinical guidelines or clinical judgment. There was no indication that criteria or clinical judgment was applied more stringently for MH or SUD services as compared to M/S services. In interviews, Optum representatives stated that, for retrospective review of mental health services, if any part of a requested service cannot be authorized under the applicable guidelines, the case is forwarded to a peer reviewer to review the episode of care and make a determination. Additionally, the Optum *UM Program Description* states that requests for outpatient benefits previously delivered may be administratively authorized up to the number of visits available under the enrollee's specific contract, provided there are extenuating circumstances that prevented the physician/clinician from obtaining authorization prior to or within the dates the service was delivered. The Department found no similar approval for extenuating circumstances provision with respect to M/S services.

Other Findings Conclusion:

In analyzing files and documents, together with information obtained during interviews, the Department found that the criteria and processes applied in performing retrospective UM review for MH and SUD benefit requests were comparable to, and applied no more stringently than, the UM standards and factors used by the Plan and its delegates to retrospectively reviewed M/S benefits.

Conclusion:

Health and Safety Code section 1374.76 requires the Plan to comply with MHPAEA requirements. MHPAEA, at 45 CFR 146.136(c)(4)(i), requires processes, strategies and factors used to apply NQTLs to MH/SUD benefits to be comparable and no more stringent than the processes, strategies and factors used in applying the NQTLs to M/S benefits. Based on file review, interviews, and document review, the Department found that the Plan's processes, strategies and other factors used to conduct UM review were not MHPAEA compliant in the Inpatient and Outpatient classifications.

In the inpatient classification, the Department found that the Plan's reliance on its M/S delegates and the various criteria and processes used for M/S determinations is not comparable to the single set of criteria utilized by Optum for authorizing MH/SUD services. Additionally, the UM processes applied to MH/SUD benefits were more stringent than those applied to M/S benefits because for SNF decisions the delegated medical groups deemed the attending physicians' medical judgments/decisions as equivalent to authorizations with no concurrent review while MH/SUD residential decisions were subjected to initial and concurrent review. The Department also determined that the processes and factors used in making outpatient M/S UM determinations were not comparable to the processes, factors and strategies predominantly used in making inpatient MH/SUD UM determinations because there is nothing comparable to the MH/SUD ALERT system on the M/S side. Additionally, the UM processes applied to MH/SUD benefits were more stringent than those applied to M/S benefits because the UM approval process for outpatient MH/SUD services is more restrictive than the outpatient UM process for M/S UM reviews. Accordingly, the Department finds that the above processes result in a MH/SUD UM process that is not comparable and more stringent than the process utilized to authorize MS services.

Plan Response:

Inpatient:

The Plan asserted that its UM review process for an enrollee's inpatient admission is comparable between MH/SUD and M/S services, but that the files reviewed by the Department during the survey did not contain sufficient documentation to establish the review processes were comparable. The Plan explained that the decision to admit an enrollee for inpatient services is not the sole decision of the hospitalist/attending physician for both MH/SUD and M/S services. In support, the Plan provided four examples of policies and procedures from its delegated medical groups to establish that the decision to admit an enrollee for inpatient services occurs after the medical group's UM staff performs clinical review, which includes a discussion with the admitting physician.

The Plan reviewed the same files as the Department and determined these files lacked adequate documentation of the elements necessary to show: (a) the delegated medical group followed the inpatient admission review process documented in the policies and (b) the actions taken by the Plan during its review process was comparable to the process applied to MH/SUD inpatient admissions.

To address the Department's finding that the Plan's files lacked adequate documentation of its processes, the Plan proposed a corrective action plan (CAP) that included the following:

1. The Plan will conduct a review of documentation standards for inpatient admissions for each medical group and emphasize the need to document the request, the criteria applied by the delegate, the parties making the request (the hospitalist/attending physician) and the delegated staff reviewing the request (e.g., case manager, medical director, and/or delegate medical management staff, etc.); and

2. The Plan will request that delegate policies and procedures are updated for inpatient utilization review that will emphasize the need to document the elements above in the records maintained by the delegate; and

3. The Plan will update its delegate oversight, audit processes, procedures and tools to ensure that its review of each delegate's inpatient utilization management comply with the documentation standards discussed in 1 and 2 above.

In addition, the Plan also proposed a CAP to address the Department's finding that the Plan's files demonstrated a lack of documented oversight/audit review of the delegated medical groups' processes in order to demonstrate comparability of the UM processes with the Plan. To address this finding, the Plan proposed the following CAP:

1. To ensure Plan and delegate compliance with MHPAEA, the Plan will update the Plan's delegate oversight, audit tools, and processes and procedures to specifically require review and documentation of such review in applicable Plan records demonstrating MHPAEA compliance for each delegated Plan process and procedure; and

2. Update the Plan's contracts with delegates and delegation agreements to stipulate the following elements:

    (a) The Plan will:
        i. Confer with delegates, through its delegation oversight and audit process and review the delegate's process to select medical necessity criteria for the conduct[ing] of UM;

        ii. Identify and review with the delegate the process that the Plan uses to select the medical necessity criteria for the conduct[ing] of UM for Plan benefits in the applicable MHPAEA benefits classifications; and

        iii. Ensure, through the delegation oversight and audit process, that the delegate uses a comparable process for the selection of medical necessity criteria to conduct UM for Plan benefits in the applicable MHPAEA benefits classifications and within the scope of the delegate's delegation; and

(b) Delegate covenants that it shall use a process for the selection of medical necessity criteria to conduct UM for Plan benefits in the applicable MHPAEA benefits classifications, and within the scope of the delegation, when the delegate applies UM to Plan benefits in applicable benefits classifications. The delegate will provide the Plan documentation of that process and criteria as necessary through the Plan's delegation oversight and audit process.[17]

Outpatient:

In response to the Department's finding regarding the use of auto-authorizations by delegated medical groups for outpatient services with no corresponding auto-authorizations for MH/SUD, the Plan states there are no prior authorization requirements at all for routine MH/SUD outpatient benefits such as psychotherapy and counseling services, which is a less stringent UM review process than auto-authorization applied to M/S services. In addition, the Plan stated that for the few non-routine outpatient MH/SUD services that are subject to prior authorization, such as partial hospitalization and intensive outpatient program services, the Plan uses an auto-authorization process known as the Treatment Milestone Approach.

Concerning the ALERT system finding, the Plan proposed the following CAP:

1. The Plan will direct its behavioral delegate to cease and desist from applying the ALERT process to medical necessity criteria for outpatient MH/SUD services in the absence of any comparable process for the delegated medical/groups.

2. To ensure Plan and delegate compliance with MHPAEA, the Plan will update its delegate oversight, audit tools, and processes and procedures to specifically require review and documentation of the MHPAEA compliance elements for each Plan process and procedure delegated for both M/S and MH/SUD benefits.

Status:

In items #2(a) and (b) above, the Plan proposed updates to its contracts with delegates to ensure "a comparable process for the selection of" various described criteria. The Plan submitted the same text to the Department's Office of Plan Licensing (OPL) in eFile number 20180114 to update several template capitation agreements currently under review. The Department finds the proposed text misstates the legal requirements for nonquantitative treatment limitations set forth in General Rule 45 CFR 146.136(c)(4)(i). Therefore, the Plan's proposed response is inadequate, and OPL will be requiring revisions to this text from the Plan through the eFiling review.

The Plan provided four examples of delegated medical group policies and procedures to demonstrate that with regard to inpatient admissions, the delegated medical groups do not allow the hospitalist to make a unilateral admission decision without further utilization review. However, the Department's interviews with Plan staff and file review contradicted this assertion. The Plan has failed to provide evidence that the inpatient

[17] The proposed language in this CAP is inadequate and currently under review by the Office of Plan Licensing, Filing No. 20180114.

admission process with regard to *all* M/S delegates' involves a review by the medical group's UM staff and/or someone other than the admitting physician. The Plan has also concurred with the Department's finding that the Plan's files lacked documentation of its UM processes sufficient to establish MHPAEA compliance.

To address these findings, the Plan has proposed a CAP to provide sufficient documentation in its files of UM processes to demonstrate MHPAEA compliance and has directed its behavioral health delegate to cease using the ALERT system. In addition, the Plan will update the Plan's delegate oversight and audit tools. However, as of the date of the Plan's response, the Plan has not yet fully implemented its CAPs, and has not presented sufficient evidence to establish it has made policy and process changes to ensure that processes, strategies and factors used to apply NQTLs to MH/SUD benefits are comparable and no more stringent than the processes, strategies and factors used in applying the NQTLs to M/S benefits. The Department will assess the Plan's CAP efforts during the Plan's next routine survey, no later than 1st Quarter 2020.

B. QUANTITATIVE TREATMENT LIMITATIONS

#2 The Department identified no MHPAEA issues with respect to the Plan's implementation of financial requirements.
Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A).

Statutory/Regulatory Reference: Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) and Section 1367.005.

45 CFR 146.136(c)(2)(i) requires that plans providing both medical/surgical benefits and mental health or substance use disorder benefits 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 CFR 146.136(c)(2)(ii) provides that if a plan provides mental health or substance use disorder benefits in any classification of benefits described in paragraph (c)(2)(ii),[18] mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

[18] See footnote 4 for a description of the classifications.

45 CFR 146.136(c)(3)(i)(A) provides that a financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

Supporting Documentation or Evidence:

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets[19]
- 2016 Evidence of Coverage and Summary of Benefits

Assessment: The Department reviewed and analyzed two Plan BPDs not previously submitted to the Department to assess whether Plan methodologies for determining cost-sharing amounts are MHPAEA compliant. The Department reviewed BPD #2: UHC Small Group Gold Plan J47 and BPD #3: UHC Large group Plan Z5K. The Department's review of these BPDs determined whether the Plan's financial requirements, as applied to MH/SUD benefits, are in parity with the financial requirements applied to its M/S benefits.

In furtherance of this review, the Plan filed an Exhibit J-11-A worksheet for the two BPDs that included the services identified by the Plan as belonging in each classification of benefits, for M/S and MH/SUD benefits, along with the applicable cost-sharing requirements for each classification as calculated by the Plan. The Department reviewed the Plan's Exhibit J-11-A for MHPAEA compliance and found that the Plan appropriately covers all required benefits in the two BPDs reviewed.

The Plan submitted its Exhibit J-12 worksheet that included calculations demonstrating its predominant financial requirement in each classification of benefits that applies to substantially all benefits within the classification. The Department's Office of Financial Review reviewed the Plan's calculations and determined that the Plan correctly calculated the financial requirements for the two BPDs.

The results of the Department's review of United Healthcare of California's BPD #2 and BPD #3 showed that the Plan appropriately determined cost-sharing for MH/SUD benefits in each category, as compared with M/S benefits in the same category. The Department determined the Plan correctly calculated the financial requirements and properly applied the federal rules concerning cost-sharing to ensure that it is acting within parity in what it charges enrollees receiving MH/SUD benefits.

Conclusion:

[19] Exhibit J-11-A and J-12 are worksheets developed by the Department to guide the plans (use is optional) in demonstrating compliance with MHPAEA. Exhibit J-11-A addresses the classification of benefits requirement of MHPAEA. Exhibit J-12 is utilized to demonstrate compliance with the financial requirements of MHPAEA.

Based on the Department's review of the Plan's Exhibit J-11-A worksheet and Exhibit J-12, as well as review of the EOC and information from staff interviews, the Department identified no MHPAEA issues for the BPDs reviewed in the Focused Survey.

Plan Response: The Plan responded timely to the Preliminary Report. The Plan's response offered no comment with respect to the Department's findings in this section.

Status: No MHPAEA QTL issues were identified during this Focused Survey.

SECTION III: PLAN EXPERIENCE IN IMPLEMENTING MHPAEA

The Department's Focused Survey also included inquiry into the Plan's experience implementing MHPAEA and maintaining parity.

1. Delegation Oversight

The Department determined that the Plan must improve the oversight of its delegated medical groups. As described in the Inpatient classification file review section above, Plan staff could not specify the UM criteria used by each delegate.

The Plan must improve its annual delegate audit. When asked how the Plan ensures that the UM processes used by the medical groups are not more restrictive than UM processes used on the MH/SUD side, the Plan pointed to its annual delegation oversight audit which ensures that UM plans are compliant with regulatory requirements and that delegates are using evidence-based criteria. The Plan stated that the contracts with the medical groups require the groups to use nationally reviewed medical guidelines. However, the file review showed that guidelines developed by the medical groups were being used in some instances. Moreover, the medical groups may also develop their own lists of services that require prior authorization and there is no consistency between medical groups regarding services that are auto-approved. The Plan stated that as part of its annual review, it only determines if the medical groups are using guidelines. Medical groups may develop their own guidelines and criteria, but the Plan does not validate the comparability of guidelines developed by medical groups against nationally developed guidelines such as MCG and does not have a process in place to determine whether guidelines developed by medical groups are comparable to national guidelines.

Plan staff described the Plan's annual delegation oversight audit process as a mechanism used to ensure parity, utilizing performance and quality standards to measure the medical groups. The Plan stated that it conducts annual delegation oversight audits using the same process for M/S delegates and the MH/SUD delegate. The Plan created a performance dashboard to monitor delegates, but Plan staff admitted it was not currently being used in its audit process. The Plan stated its file pull of delegate's files uses NCQA's 8/30 methodology. If the first eight files have no issues, no additional files are reviewed. Plan staff stated that the medical groups send reports to the Plan that are presented to the Quality Improvement Committee. A review of the QIC minutes from March 24, 2016, included only a report from Optum regarding complaints, grievances, and appeals. The report did not contain any UM information from Optum, and no other UM reports from medical groups were in the QIC minutes. The Plan contract with medical groups requires the medical groups to establish measures, monitor and analyze relevant data and correct patterns of potential or actual inappropriate under- or over-utilization, using quantitative and qualitative data analysis. Accordingly, the medical groups are required to self-report under- and/or over-utilization data and implement corrective actions when indicated.

One example of delegation oversight problems was brought to the Department's attention during file review. Several files contained an e-mail to the Plan from two medical groups that informed the Plan that the medical groups had identified

inconsistent application of MCG criteria and had implemented a corrective action plan in September of 2016. The Plan confirmed that this email was their first indication that these medical groups were not applying MCG criteria consistently, and the issue was only discovered upon preparing the delegates' files for this survey. Plan staff stated that as a result of the email, the Plan was going to perform an ad hoc follow-up review. Plan staff explained that the delegates should have notified the Plan when the issue was first discovered. However, the Plan completed the annual delegation oversight review of the medical groups in November of 2016 and did not identify any issues in the medical records that were reviewed. When asked if this issue raised any concerns that the inconsistent application of criteria could have impacted parity, the Plan responded that it had no concerns.

SECTION IV: SURVEY CONCLUSION

The Plan's operations were not found to be compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76. The Plan's compliance will be further assessed at the Plan's next Routine Medical Survey, scheduled for the third quarter of 2018.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**.

Once logged in, follow the steps shown below to submit the Plan's response to the Preliminary Report:

- Click the eFiling link.
- Locate the MHPAEA Filing.
- Submit the Plan's response to the Final Report as an Amendment to the MHPAEA filing, as an Exhibit J-12-D MHPAEA Survey, Plan Response to the Final Report.

Plan Response to the Final Report

APPENDIX A PHASE ONE CLOSING LETTER

Edmund G. Brown Jr.,
Governor State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

May 20, 2016

VIA ELECTRONIC MAIL

UHC of California
5701 Katella Avenue, MS CA120-0368
Cypress, California 90630

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by UHC of California (Plan) for compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended,[1] and with The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act[2] and federal final rules.[3]

The Department has completed review of the Amendment, and at this time has no further objection to implementation of the changes as described in the Amendment, as amended, subject to the following conditions:

1. The Plan shall implement the revisions and disclosures to the cost-sharing for mental health and substance use disorder benefits (MH/SUD) that have been reviewed and not objected to by the Department within the Amendment. Those revisions and disclosures are summarized in the chart below. Cost-sharing for MH/SUD benefits within nongrandfathered or grandfathered on- or off-Exchange individual and small group coverage shall first comply with MHPAEA for 2016 coverage and secondly comply with the regulations of Covered California for 2016 coverage.[4] Hence, the Plan may need to further modify the revised MH/SUD cost-sharing summarized below within standard benefit plan design coverage for 2016.

[1] California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to California Code of Regulations, title 28.
[2] Public law 110-343, 42 U.S.C. § 300gg-26.
[3] 45 CFR § 146.136 (2013).
[4] Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e), and 10 CCR section 6460.

Benefit Plan Design	Type of Service and Specific Benefits Impacted	Current (2015) Cost-Sharing	Cost-Sharing 1/1/2016[5]
QHP Platinum Plan Signature Value Alliance 20-40/10%, Benefit Plan Design #8	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$250 per day Copayment applies to a maximum of 5 days per stay	$0
QHP Gold Plan - Signature Value Alliance 35-55/20%, Benefit Plan Design #9	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$600 per day Copayment applies to a maximum of 5 days per stay	$0
Silver HMO Plan - Signature 45-65/40%/2000 ded, Benefit Plan Design #10	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	25% Copayment after Deductible	$0
Bronze HMO Plan - Signature 55-85/0%/6600 ded, Benefit Plan Design #11	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	30% Copayment after Deductible	$0
Platinum HMO Plan - Signature 20-40/30%, Benefit Plan Design #12	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$250 Copayment per day. Copayment applies to a maximum of 4 days per stay	$0

[5] Cost-sharing within individual and small group nongrandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

Benefit Plan Design	Type of Service and Specific Benefits Impacted	Current (2015) Cost-Sharing	Cost-Sharing 1/1/2016[6]
QHP Platinum Plan Signature Value Alliance 20-40/10%, Benefit Plan Design #8	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$250 per day Copayment applies to a maximum of 5 days per stay	$20 Office Visit Copayment
QHP Gold Plan - Signature Value Alliance 35-55/20%, Benefit Plan Design #9	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$600 per day Copayment applies to a maximum of 5 days per stay	$30 Office Visit Copayment
Silver HMO Plan - Signature 45-65/40%/2000ded, Benefit Plan Design #10	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	25% Copayment after Deductible	$30 Office Visit Copayment
Bronze HMO Plan - Signature 55-85/0%/6600 ded, Benefit Plan Design #11	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	30% Copayment after Deductible	$40 Office Visit Copayment

[6] Cost-sharing within individual and small group nongrandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

Benefit Plan Design	Type of Service and Specific Benefits Impacted	Current (2015) Cost-Sharing	Cost-Sharing 1/1/2016[7]
Platinum HMO Plan - Signature 20-40/30%, Benefit Plan Design #12	Mental Health and Substance Use Disorder Services: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$250 Copayment per day. Copayment applies to a maximum of 4 days per stay	$40 Office Visit Copayment
Large Group Commercial, SV 10/100%, Benefit Plan Design #13	Mental Health: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$0	$10
Large Group Commercial, SV 10/100%, Benefit Plan Design #13	Substance Use Disorder: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$0	$0
Large Group Commercial, SV20-40/500A/100DED, Benefit Plan Design #14	Mental Health: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$500 per admit after deductible	$40
Large Group Commercial, SV20-40/500A/100DED, Benefit Plan Design #14	Substance Use Disorder: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$0	$0
Large Group Commercial, 10/100% SCSVEBA, Benefit Plan Design #15	Mental Health: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$0	$10

[7] Cost-sharing within individual and small group nongrandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

Benefit Plan Design	Type of Service and Specific Benefits Impacted	Current (2015) Cost-Sharing	Cost-Sharing 1/1/2016[8]
Large Group Commercial, 10/100% SCSVEBA, Benefit Plan Design #15	Substance Use Disorder: All Other Outpatient Treatment (Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment)	$0	$0

2. The Plan shall utilize nonquantitative treatment limits that have been reviewed and not objected to by the Department in the Amendment, including but not limited to the following revised policies and procedures: Concurrent Review, Insufficient Information for Benefit Determination, and Psychological and Neuropsychological Testing Criteria and Authorization Process. Plan will submit revisions to its Table 5 and policies and procedures regarding Concurrent Review for the Department's review under a new Amendment filing within thirty (30) days of the closing of filing #20142162 as described in Department's May 16, 2016, comment letter and affirmed in Plan's Exhibit E-1 in filing #20142162-34.

3. The Plan shall revise its EOCs, cost-sharing summaries, Summaries of Benefits and Coverage (SBCs), and other disclosure documents for enrollees to disclose MHPAEA-compliant cost- sharing, quantitative treatment limits, and non-quantitative treatment limits, and other revisions to disclosure text that have been reviewed and not objected to by the Department in the Amendment. These revisions include, but are not limited to:

    a. United HealthCare of California EOC revisions:
        i. Revisions to the benefit descriptions of Inpatient Hospital Mental Health Services.
        ii. Revisions to the benefit descriptions of Inpatient Substance-Related and Addictive Disorder Services including Transitional Recovery Services Rendered at a Treatment Center.
        iii. Revisions to the benefit descriptions of Mental Health Services (Outpatient Benefits).
        iv. Revisions to the benefit descriptions of Substance-Related and Addictive Disorder Services (Outpatient Benefits) and clarification pertaining to the requirement of prior authorization.
        v. Language added to clarify the mental health and substance use disorder benefits that require prior authorization.
        vi. Revisions to the benefit descriptions of Other Behavioral Health Services.

[8] Cost-sharing within individual and small group nongrandfathered standard benefit plan design coverage may need to be further revised to comply with Covered California regulations for 2016 coverage.

vii. Revisions to the exclusion list under Exclusions and Limitations of Benefits to clarify the inpatient and outpatient mental health and substance use disorder benefits covered by Plan.
viii. Revisions to the Overseeing Your Healthcare Decisions section regarding submitting a complaint related to Mental Health and Substance-Related and Addictive Disorder.
ix. . Definitions section: Additions or revisions to the definition of Behavioral Health Treatment for PDD or Autism, Day Treatment Center, Inpatient Treatment Center, Mental Disorder, Mental Health Services, Medical Detoxification, Partial Hospitalization/Day Treatment Program and Intensive Outpatient Treatment, Participating Qualified Autism Service Provider, Participating Qualified Autism Service Professional, Participating Qualified Autism Service Paraprofessional, Psychological and Neuropsychological Testing, Serious Emotional Disturbances of a Child, Severe Mental Illness, Substance-Related and Addictive Disorder, Substance-Related and Addictive Disorder Inpatient Treatment Program, and Substance-Related and Addictive Disorder Services.

b. U.S. Behavioral Health Plan, California EPOC:
   i. Revisions to the description of Mental Disorder.
   ii. Revisions to the description of accessing Behavioral Health Services.
   iii. Revisions to the description of "What is an Emergency?"
   iv. Revisions to the benefit descriptions of Covered Behavioral Health Services, including language clarifying the Exclusions and Limitations.
   v. Revisions to the description of Authorization, Modification and Denial of Behavioral Health Services including language pertaining to concurrent and retrospective review pertaining to mental health and substance-related and addictive disorder.
   vi. Definitions section: Additions or revisions to the definition of Behavioral Health Treatment for PDD or Autism, Medical Detoxification, Mental Disorder, Mental Health Services, Outpatient Treatment Center, Partial Hospitalization/Day Treatment Program and Intensive Outpatient Treatment, Participating Facility, Psychiatric Emergency Medical Condition, Psychological and Neuropsychological Testing, Serious Emotional Disturbances of a Child, Substance-Related and Addictive Disorder, and Transitional Residential Recovery Services.

c. Changes to Cost-Sharing in the Schedule of Benefits: the revisions in cost-sharing for the plans listed in the chart above.

4. The Plan shall use the classification of benefits standards, the methodology for calculating financial requirements and quantitative treatment limits, and the factors used to apply nonquantitative treatment limits that have been reviewed and not objected to by the Department within the Amendment to provide all covered mental health and substance use disorder benefits in compliance with MHPAEA within the Plan's individual and group commercial plan coverage.[9]

[9] California Health and Safety Code § 1374.76.

5. The Plan shall implement the changes to comply with MHPAEA delineated above according to the Department's guidance in the July 17, 2015, All Plan Letter concerning January 1, 2016, final implementation of MHPAEA compliance and the August 7, 2015, email update to the July 17 All Plan Letter.[10]

This letter does not constitute a waiver of any compliance issues that may be identified on subsequent review and analysis of the Amendment, whether or not highlighted to reflect a change, or of any other Plan documents or operations, whether or not disclosed in the Amendment.

The revisions necessary to correct the compliance concerns identified by the Department in this Amendment apply to all Plan documents that contain similar language or provisions, whether previously filed or not. Plan documents and operations that do not reflect compliance with the Act, Rules, and MHPAEA in accordance with the Department's determinations regarding this Amendment are not approved. Accordingly, please review and revise all Plan documents as necessary to identify and correct similar compliance concerns where they may exist. If language approved in the context of this Amendment is the only change made by the Plan to its existing variations of the same forms of documents as submitted in this Amendment, the Plan need not file those revised documents. The Department reserves the right to require additional revisions to the Plan's operations and documents, including but not limited to subscriber and provider documents, and written policies and procedures, as further review may indicate is necessary for compliance with the Act.

Please contact the Department if there are any questions regarding the above.

[10] Ibid