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NO. 68726-3-I

IN THE COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION I

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PREMERA BLUE CROSS and  
LIFEWISE OF WASHINGTON,

Petitioners-Defendants,

v.

A.G., by and through his parents, J.G. and K.G.,  
on his own behalf and on behalf of  
all similarly situated individuals,

Respondent-Plaintiff.

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**RESPONDENT'S OPPOSITION TO  
PETITIONERS' MOTION FOR DISCRETIONARY REVIEW**

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## I. INTRODUCTION

Washington State has two statutes that mandate health insurance coverage for neurodevelopmental therapies. The Neurodevelopmental Therapy Mandate requires that certain insured group health plans provide neurodevelopmental therapies for insureds through the age of six. RCW 48.44.450. The Mental Health Parity Act requires coverage for neurodevelopmental therapies in all health plans when the therapy is designed to treat a qualified mental health condition irrespective of age. RCW 48.44.341.

Premera argues that that the two mandates “conflict” such that the Neurodevelopmental Therapy Mandate overrides the Parity Act. Premera asks for discretionary review of the trial court’s decision otherwise, arguing that its position is “potentially meritorious.” Premera Mot., p. 9.

Premera’s argument is not meritorious – not even close. As Judge Lasnik held in addressing this identical argument in a case against Group Health, an insurer can – and must – comply with both statutes:

By its plain terms, RCW 48.44.450 evidences legislative intent to establish a minimum mandatory level of “coverage for neurodevelopmental therapies for covered individuals age six and under.” Equally plain, however, is that RCW 48.44.450 does not preclude providers from extending that same coverage to individuals older than six. ***The statute establishes a floor, not a ceiling.***

When it enacted [the Mental Health Parity Act], Washington raised the minimum standard by ***further***

requiring that mental health coverage “be delivered under the same terms and conditions as medical and surgical services.” ***This new burden does not conflict with RCW 48.44.450.*** Defendant can readily comply with both statutes simply by comporting with the parity requirements of RCW 48.46.291 for all covered individuals, keeping in mind that RCW 48.44.450 confers a more specific and more onerous requirement upon Defendants to provide “neurodevelopmental therapies for covered individuals age six and under” without regard for parity. This “construction gives significance to both acts of the legislature.”

*Z.D. v. Group Health*, 829 F. Supp. 2d 1009, 1014 (W.D. Wash. 2011) (citations omitted, emphasis added). As a result, when Group Health asked Judge Lasnik to certify this issue to the Washington State Supreme Court, he refused:

... [T]he Court sees no justification for certifying. As the Court concluded in its previous Order, ***this is not a close question.*** Applying common and well-accepted principles of statutory construction, the Court readily concluded that no conflict exists between the Neurodevelopmental Therapy Mandate, RCW 48.44.450, and the Mental Health Parity Act, RCW 48.46.291.

Plaintiff-Respondent’s Appendix (“P.A.”) 218-19, *Z.D. v. Group Health*, Dkt. No. 36, dated December 20, 2011. *See also* P.A. 10, *Z.D. v. Group Health*, 2012 WL 1997705, \*10 (W.D. Wash. 2012) (same). In fact, every state and federal court judge to consider this issue has concluded that the Neurodevelopmental Therapy Mandate does not conflict with the Mental Health Parity Act. *See* P.A. 10, *Z.D.*, 2012 WL 1997705, \*10, fn. 11 (“A litany of Washington state courts have held the same.”).

The reason is simple. When two statutes govern the same subject matter, effect will be given to both to the extent possible. *Walker v. Wenatchee Valley Truck & Auto Outlet, Inc.*, 155 Wn. App. 199, 208, 229 P.3d 871 (2010). Only where two statutes conflict to the extent that they cannot be harmonized will a more specific statute supersede a general one. *Id.* When simultaneous compliance is possible, there simply is no statutory conflict—both statutes will be enforced as written:

Where two legislative enactments relate to the same subject matter and are not actually in conflict, they should be interpreted to give meaning and effect to both. Such construction gives significance to both acts of the legislature.

*Davis v. King County*, 77 Wn.2d 930, 933, 468 P.2d 679 (1970). *See also* *Z.D.*, 2011 WL 5299592, \*4 (citing to same cases); *Mortell v. State*, 118 Wn. App. 846, 849, 78 P.3d 197 (2003). Applying those longstanding rules of construction is straightforward—there is simply no irreconcilable conflict between the statutes:

The Court does not have to invalidate RCW 48.44.450, the Neurodevelopmental Therapy Act, to reach this result. RCW 48.44.450 only creates a minimum level of required coverage. Both the Neurodevelopmental Therapy Act and the Mental Health Parity Act can be read together and harmonized. Defendants must meet the requirements of both Acts.

See Appellants' Exhibits ("A.E."), p. 433, ¶ 4. Where, as here, Premera can comply with both statutes, it must do so. It is not permitted to pick and chose which statute to follow, ignoring the other.

Permitting discretionary review of such a straightforward issue makes no sense. There are, to be sure, more complex issues currently pending in this putative class action case which will likely be appealed. To allow discretionary appeal now on just one aspect of the Parity Act is the definition of a piecemeal appeal. Premera's appeal only delays, not advances the case, and should be denied.

## II. ISSUES PRESENTED

Should the Court of Appeals deny Premera's Motion for Discretionary Review because the RAP 2.3(b) grounds for review are not met and interlocutory review will delay the resolution of the litigation?

## III. CASE OVERVIEW<sup>1</sup>

### A. **Premera/LifeWise deny A.G. coverage for neurodevelopmental therapies to treat his autism.**

A.G. is a 13-year-old diagnosed with autism. A.E., p. 433, Order, ¶¶ A.1-2. He was referred to Valley Medical Center's Children's Therapy

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<sup>1</sup> Premera does not challenge the trial court's findings of fact and conclusions of law related to the injunctive relief sought for Plaintiff A.G. "Unchallenged findings of fact are verities on appeal." *224 Westlake, LLC v. Engstrom Properties LLC*, 169 Wn. App. 700, 281 P.3d 693, 704 (2012).

Program (“Valley”) for neurodevelopmental evaluation and therapy. *Id.* The therapists at Valley recommended that he receive weekly occupational and speech therapy to treat his autism. *Id.* A.G. has received speech and occupational therapy from Valley since 2007.

A.G. is, and has been, insured under an individual policy issued by LifeWise Health Plan of Washington since at least January 1, 2006. *Id.*, ¶ A.5. A.G.’s policy contains an express exclusion of neurodevelopmental therapies. *Id.*, ¶ A.8. Valley submitted bills for A.G.’s speech and occupational therapies to LifeWise, which paid for the services, at least for the first twenty visits, despite the express neurodevelopmental therapy exclusion. *Id.*, ¶ A.6.

In July 2011, A.G.’s parents received an envelope with forms called “Explanations of Benefits” (EOBs) from LifeWise. *Id.*, ¶ A.7. The EOBs revealed that LifeWise had conducted a retrospective review of the therapy provided to A.G. since January 1, 2010 and determined that all of the therapy was incorrectly covered. In sum, LifeWise determined that nearly \$24,000 in neurodevelopmental therapies had been improperly paid and that A.G.’s parents were financially responsible for all of the treatment. *Id.*

A.G.’s father called LifeWise to object to the determination and to request an explanation. *Id.*, ¶ A.8. On August 12, 2011, LifeWise sent

A.G.'s father a letter confirming the decision. LifeWise maintained that there was no coverage for neurodevelopmental therapies because of an explicit exclusion in its policy:

This letter is being issued to provide confirmation the following listed of claims [*sic*] were processed incorrectly and will be adjusted as Neurodevelopment[al] therapy is not a covered benefit under the above listed policy.

*Id.* LifeWise included a copy of the relevant section of A.G.'s contract which contained the only exclusion it relied upon:

**EXCLUSIONS**

This section of the contract lists those services, supplies or drugs [that] are not covered under this plan.

...

**Learning Disorders and Neurodevelopmental Therapy**

Services, therapy and supplies related to the treatment of learning disorders, cognitive handicaps, dyslexia, *developmental delay or neurodevelopmental disabilities.*

*Id.* Once LifeWise retroactively denied coverage of A.G.'s therapy services, his parents were forced to eliminate his speech therapy. *Id.*,

¶ A.9. A.G. was also at risk of losing access to his occupational therapy.

*Id.* A.G.'s parents began to receive collections notices and calls from Valley regarding the nearly \$24,000 in outstanding bills. *Id.*

**B. Premera/LifeWise has a standard policy of excluding neurodevelopmental therapy services.**

Premera's official policy excludes coverage of neurodevelopmental therapy services, either entirely in their individual

policies, or for persons over the age of six in their group policies. P.A. 124-27, Hamburger Decl. (1/13/12), *Exh. A* (WEA Premera group policy); A.E., pp. 255-56, 261 (A.G.'s LifeWise policy). Premera does not dispute this. *See* A.E., p. 386, Decl. of Chelle Moat, M.D., ¶ 5 (“Premera covers neurodevelopmental therapy in some but not all of its health plans.”). As Premera admits, it maintains these blanket exclusions despite the plain language of the Mental Health Parity Act. *See* Premera Mot., p. 7. To date, only A.G. is effected by the trial court’s order. *See* A.E., p. 437, Order p. 8.

#### IV. ARGUMENT

##### A. Standard for review—discretionary appeal

Interlocutory review was not intended to allow trial courts to “abandon the final judgment doctrine and embrace the principle of piecemeal appeals.” *U.S. v. Woodbury*, 263 F.2d 784, 788 n.11 (9th Cir. 1959) (quoting *Deepwater Exploration Co. v. Andrew Weir Co., Ltd.*, 167 F. Supp. 185, 188 (E.D. La. 1958); *see also Right-Price Recreation v. Connells Prairie Cmty. Council*, 146 Wn.2d 370, 380, 46 P.3d 789 (2002) (discretionary review is disfavored because it lends itself to “piecemeal, multiple appeals”). Discretionary review of appeals arising from the denial of summary judgment, in particular, are rarely granted precisely because they tend to create piecemeal litigation. *DGHI Enters. v. Pac.*

*Cities, Inc.*, 137 Wn.2d 933, 949, 977 P.2d 1231 (1999). Consequently, certification should be limited to only extraordinary cases. Interlocutory appeal is not a means for avoiding protracted and expensive litigation. It is not a vehicle to obtain expedited review of a difficult or even important case. *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 475 (1978); *U.S. Rubber Co. v. Wright*, 359 F.2d 784, 785 (9th Cir. 1966) (certification is “not intended merely to provide review of difficult rulings in hard cases.”).

None of the RAP 2.3(b) grounds for interlocutory review exist here. Although the trial court certified for discretionary review the legal question of whether the Mental Health Parity Act requires coverage of neurodevelopmental therapies to treat DSM-IV conditions, despite the Neurodevelopmental Therapy Mandate, the trial court’s certification alone does not compel the Court of Appeals to accept review. *See* RAP 2.3(b) (“discretionary review *may be accepted* only in the following circumstances.”) (emphasis added).<sup>2</sup> Where, as here, there is no “obvious”

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<sup>2</sup> The decision to accept review is always discretionary, and requires consideration of the practical effect and need for an immediate appeal:

Although a certification or stipulation may increase the chances of discretionary review, the certification or stipulation is not binding on the appellate court. Discretionary review remains what the name implies—discretionary.

2A WASHINGTON PRACTICE, *Rules Practice*, RAP 2.3 (7<sup>th</sup> Ed.).

or “probable” error or even a “substantial ground for a difference of opinion,” discretionary review should be rejected.

**B. There is no obvious or probable error or even a substantial ground for a difference of opinion.**

The sole legal issue certified by the trial court is whether the Mental Health Parity Act mandates coverage of medically necessary neurodevelopmental therapies to treat DSM-IV conditions, such that Premera’s express exclusion in the named plaintiff’s policy is invalid and void. As every single court to consider this issue has concluded and as described below, the Parity Act prohibits such blanket exclusions of covered mental health services.

**1. The Mental Health Parity Act mandates coverage of mental health services including neurodevelopmental therapies to treat DSM-IV Conditions.**

In landmark legislation known as the “Mental Health Parity Act,” the Washington State legislature mandated two basic rights: coverage and parity. This interlocutory appeal only addresses whether the Parity Act’s coverage mandate invalidates Premera’s blanket exclusion of coverage for neurodevelopmental therapies. The express language of the Parity Act mandates *coverage*:

*All health service contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:*

*(a) ... coverage for:*

*(i) Mental Health Services....*

RCW 48.44.341(2) (emphasis added). *See Z.D.*, P.A. 89 (“Thus, the Act plainly imposes *a baseline coverage requirement* requiring Group Health [to] ‘provide ... coverage for’ Z.D.’s ‘medically necessary’ treatment for her DSM-IV-TR mental health conditions, without any regard for whether that treatment is restorative or non-restorative.”) (emphasis in original). The Act precludes an insurer from imposing a blanket exclusion because “that would defeat the very purpose of the statute: *providing coverage.*” *Id.* (emphasis added). Thus, if Premera provides coverage for medical and surgical services to insureds generally—and it certainly does—then it is prohibited from completely excluding *any* medically necessary mental health service.

For developmentally disabled individuals like A.G., Premera’s blanket exclusion of neurodevelopmental therapies, including those therapies treat DSM-IV conditions covered by the Parity Act, illegally eliminates their access to medically necessary mental health services. The Mental Health Parity Act was specifically designed to root out this discrimination. Premera’s denial of plaintiff A.G.’s neurodevelopmental therapies is, in fact, a perfect example of how Premera’s blanket exclusion improperly exclude coverage of medically necessary mental health services to developmentally disabled persons.

Plaintiff A.G. is autistic. A.E., p. 433, Order, ¶ A.1; A.E., P. 85, Decl. of J.G., ¶ 3. Autism, because it is a DSM-IV condition, is a “mental disorder” as defined by the Parity Act. P.A. 202-205, Hamburger Decl. (1/13/12), *Exh. I*. The disorder can be treated with neurodevelopmental therapy. P.A. 133-37, 139-40, 142-46, 148-66, Hamburger Decl. (1/13/12), *Exhs. C, D, E, F*. Under the Parity Act, the *only* reason Premera can wholly exclude coverage of A.G.’s neurodevelopmental therapies to treat his DSM-IV condition of autism is medical necessity. It cannot impose a blanket exclusion of the service. A.E., p. 432, Order, p. 3 (“Since neurodevelopmental therapies may be medically necessary to treat autism, Defendants cannot use a blanket exclusion to deny coverage for those therapies.”).

**2. The Mental Health Parity Act and the Neurodevelopmental Therapy Act do not conflict.**

To avoid the straightforward analysis under the Parity Act, Premera claims that the Neurodevelopmental Therapy Mandate conflicts with and trumps the Parity Act’s broad coverage mandate. *See* Premera Mot. pp. 12-14. Premera’s argument has been rejected by every single court to consider it. P.A. 10, *Z.D.*, 2012 WL 1997705, \*10, fn. 11.

The two statutes are easily read together and harmonized. “The primary objective of statutory construction is to carry out the intent of the

Legislature, which must be determined primarily from the language of the statute itself.” *Roberts v. Johnson*, 137 Wn.2d 84, 91, 969 P.2d 446, 449 (1999). “Where the language of the statute is plain and unambiguous, the meaning should be discovered from the wording of the statute itself.” *Id.* Premera can—and must—follow both statutes. *Walker*, 115 Wn. App. at 208 (“In the case of multiple statutes or provisions governing the same subject matter, effect will be given to both to the extent possible.”). Here, the Neurodevelopmental Therapy Mandate “established a coverage floor, not a ceiling.” P.A. 84, *Z.D.*, Dkt. No. 77, pp. 17. “[T]he subsequently enacted Mental Health Parity Act merely imposed an additional, distinct coverage requirement.” *Id.* As a result, “[t]here does not exist even a close question as to whether there is a conflict between the statutes under established Washington law.” *Id.*

Ignoring the plain language of the Parity Act, Premera claims that subsequent legislative efforts to expand the age limit of Neurodevelopmental Mandate is proof that the Legislature never intended to include neurodevelopmental therapies within the broad reach of the

Parity Act. Premera's Mot., p. 14.<sup>3</sup> But under Washington's "plain meaning" rule, legislative intent is derived, first and foremost, from the language of the statute itself.<sup>4</sup> *State Dept. of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 9-10, 43 P.3d 4, 9 (2002). Legislative history is irrelevant if the language of the statute is unambiguous:

If the plain language is subject to only one interpretation, our inquiry ends because plain language does not require construction. "Where statutory language is plain and unambiguous, a statute's meaning must be derived from the wording of the statute itself."

*HomeStreet, Inc. v. State*, 166 Wn.2d 444, 451, 210 P.3d 297, 300 (2009)  
(citations omitted).

The *actual* legislative history indicates that the Legislature knew that it was covering all mental health services under the Parity Act,

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<sup>3</sup> The Neurodevelopmental Therapy Mandate applies to those with those with mental health conditions, it does not cover the identical population as is covered by the Parity Act. For that reason, "[t]he fact that the Washington legislature is apparently considering expanding the Neurodevelopmental Therapy Mandate to require coverage up to the age of 18 has no bearing on whether the legislature intended to require parity coverage under RCW 48.46.291—the statute in question." P.A. 219, Pl.'s Resp. to Premera's Mot. to Certify, *App. A*, p. 3.

<sup>4</sup> Contrary to Premera's argument, failed legislation is not evidence of legislative intent. Premera Mot., pp. 14-16; *See State v. Conte*, 159 Wn.2d 797, 813, 154 P.3d 194 (2007); *Spokane County Health Dist. v. Brockett*, 120 Wn.2d 140, 153, 839 P.2d 324 (1992). Even the cases cited by Premera (Mot., p. 15) do not stand for the proposition that subsequent legislative action can override the plain language of a statute. *See Costanich v. Dep't of Soc. And Health Svcs.*, 164 Wn.2d 925, 932, 194 P.3d 988 (2008) (*rejecting* claims that subsequent legislative inaction demonstrates legislative history, and relying instead on the plain language of the relevant statute); *Impeccoven v. Dep't of Revenue*, 120 Wn.2d 357, 363, 841 P.2d 752 (1992) (construing the legislative intent of a statute by analyzing its plain language when read as a whole).

including services designed to treat those with developmental disabilities. P.A. 170, Hamburger Decl. (1/13/12), *Exh. G*, p. 2 (“Therefore the legislature intends to require that insurance coverage be at parity for mental health services, which means this coverage be delivered under the same terms and conditions as medical and surgical services.”); P.A. 189, Hamburger Decl. (1/13/12), *Exh. H*, p. 1 (“***The requirement for mental health coverage is broad—‘all mental disorders included in the diagnostic and statistical manual of mental disorders’***....The requirement for parity in coverage is also broadly worded, so that it applies to both treatment limitations and various forms of financial participation.”). *See also id.* (Parity Act “would require group health plans and the public employees benefit board health plan to (a) provide mental health coverage if they currently do not, and (b) cover mental health at the same level that physical health is covered.”).

Premera’s claim that the Washington Department of Health (DOH) and Office of the Insurance Commissioner (OIC) have interpreted the Parity Act to exclude coverage of neurodevelopmental therapies is wholly without merit. *See* Premera Mot., pp. 15-17. In fact, DOH concluded that coverage of therapies to treat DSM-IV conditions like autism may be mandated by both statutes:

There are existing mandates that should be reviewed that

may provide the coverage that these families are seeking. These are the neurodevelopmental therapy mandate and the mental health parity mandate.

P.A. 227, Supp. Hamburger Decl. (2/24/12), *Exh. J*, p. 16. Premera's claim that the OIC "agrees that the Parity Act does not apply to neurodevelopmental therapy" because the OIC has not taken action against Premera, is unfounded. Premera Mot., p. 17. Inaction is not an agency interpretation. *See* RCW 34.05.010(8). In fact, the OIC just announced its first effort at rulemaking on the Parity Act, stating that "existing regulations do not address" the "general mental health parity requirements established in state law." Washington State Register 12-22-070 (Nov. 7, 2012).

Not surprisingly, every court considering this issue has found that the Parity Act prohibits such contractual exclusions of neurodevelopmental or behavioral services because those services are "mental health services" and can be medically necessary to treat covered DSM-IV conditions. *See Z.D.*, 829 F. Supp. 2d at 1013; P.A. 238, Supp. Hamburger Decl. (2/24/12), *Exh. L*, *D.F. v. Washington Health Care Authority, et al.*, No. 10-2-29400-7 SEA, p. 4 ("specific exclusions ... that exclude coverage of Applied Behavior Analysis therapy, even when medically necessary ... do not comply with Washington's Mental Health Parity Act..."); *Markiewicz v. State Health Benefits Comm'n*, 915 A.2d

553, 560 (App. Div. 2007); *Micheletti v. State Health Benefits Comm'n*, 913 A.2d 842, 851 (N.J. App. 2010).

This is not even a close question. The statute is clear, and Premera can—and must—comply with both the Parity Act and the Neurodevelopmental Therapy Act.

**C. Appellate review of this case should consider all of the relevant legal questions regarding the application of the Mental Health Parity Act.**

The purpose of discretionary review under RAP 2.3(b)(4) is to serve judicial economy and avoid a useless trial. *Shannon v. State*, 110 Wn. App. 366, 369, 40 P.3d 1200 (2002). Where, as here, interlocutory appeal will only address part of the substantive legal questions presented about the effect of the Mental Health Parity Act, judicial economy is not served by having the Court of Appeals consider another closely-related legal issue at some point in the future.

As noted above, the Parity Act mandates two basic requirements: coverage and parity. The legal issue at stake in Premera's Motion for Discretionary Review is whether the Parity Act mandates coverage of neurodevelopmental therapies to treat DSM-IV conditions, when medically necessary. It is a challenge to the breadth of the Parity Act's *coverage* mandate. Plaintiff's pending motion regarding Premera's visit limits invokes the Parity Act's second mandate—the *parity* requirement.

In short, the pending visit limit motion contends that the plain language of the Parity Act prevents Premera from imposing annual visit limits on neurodevelopmental therapies to treat DSM-IV conditions because it does not impose such limitations on medical and surgical services generally. P.A. 16-35, Pl.'s Mot. for Partial Summ. Judgment Re: Visit Limits.

These legal questions are so intertwined that both should be decided together. Otherwise, the Court of Appeals will have to review the same case, the same substantive statute, and related legal and factual issues all over again. Far from hastening the end of litigation, this interlocutory appeal would have the effect of delaying it, and, the potential relief for thousands of developmentally disabled insureds.

**D. The trial court did not commit obvious or substantial error by granting a declaration that Premera's neurodevelopmental therapy exclusion was illegal.**

Premera asserts that the trial court committed obvious or probable error when it granted Plaintiff A.G. declaratory and injunctive relief because A.G. did not prove that neurodevelopmental therapies were medically necessary to treat autism. Premera Mot., pp. 17-18. Premera's argument is without merit for at least four reasons.

*First*, Plaintiff A.G. was only required to show that neurodevelopmental therapies *can* be medically necessary. The undisputed evidence confirms that is the case. *See* P.A. 134, Hamburger

Decl. (1/13/12), *Exh. C*, p. 5; P.A. 139, *Exh. D*, p. 163; P.A. 143-46, *Exh. E*, pp. 7-10. Even Premera's Medical Director admits that neurodevelopmental therapies are covered by Premera, subject to medical necessity review. A.E., p. 386, Moat Decl., ¶ 5 ("***Premera covers neurodevelopmental therapies*** in some, but not all, of its health plans ... subject to review of ***medical necessity***." (emphasis added). After all, Premera only pays for medically necessary services. See A.E., p. 244, A.G.'s LifeWise Plan ("We provide benefits for covered services ... when such services ... meet all of the following conditions: ***They must meet our definition of "medically necessary."***") (emphasis added). Premera's contract expressly excludes payment for services that are ***not*** medically necessary. A.E., p. 262, A.G.'s LifeWise Plan ("Services Not Medically Necessary" listed under the contract's Exclusions). Premera cannot cover neurodevelopmental therapies as medically necessary in some plans, and then claim that the therapies are never medically necessary in others.

***Second***, the only evidence Premera offered to dispute Plaintiff's showing that neurodevelopmental therapies can be medically necessary to treat DSM-IV conditions was Dr. Moat's statement that neurodevelopmental therapies, while covered by Premera subject to medical necessity, are, at the same time, considered "educational" and never medically necessary. Compare A.E., p. 387, Moat Decl., ¶ 5 to ¶ 7.

Dr. Moat's mere characterization of neurodevelopmental therapies as educational rather than medically necessary is insufficient to avoid summary judgment. See *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S. Ct. 1348 (1986) (the nonmoving party "must do more than simply show that there is some metaphysical doubt as to the material facts"); *Grimwood v. Univ. of Puget Sound, Inc.*, 110 Wn.2d 355, 359-61, 753 P.2d 517 (1988) (a party's self-serving statements of conclusions and opinions alone are insufficient to defeat a summary judgment motion).

**Third**, the trial court made no finding as to the medical necessity of A.G.'s particular therapies, or even whether neurodevelopmental therapies were always medically necessary to treat autism. The trial court merely declared that since neurodevelopmental therapies can be medically necessary to treat autism, Premera could no longer use its blanket exclusion to deny coverage for A.G.'s neurodevelopmental therapies. Judge Trickey then ordered Premera to process A.G.'s ongoing claims for therapies without applying the exclusion, *leaving it to Premera to make any required medical necessity determinations.*

**Fourth**, although proof of medical necessity was not necessary, the only evidence before the trial court was that Premera had determined that A.G.'s therapies were medically necessary. For years, Premera covered

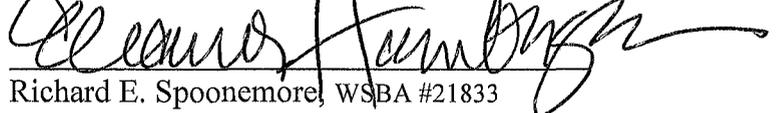
A.G.'s neurodevelopmental therapies, at least up to 20 visits. A.E., p. 87, J.G. Decl., ¶ 9. Even when Premera conducted its retrospective review, the only reason A.G.'s therapies were denied was Premera's neurodevelopmental therapy exclusion. *Id.*, ¶ 10, *Exh. A*. Premera's post-litigation claim that its "auto-adjudication" process does not determine medical necessity is inconsistent with its express contract language. The Court's finding that neurodevelopmental therapies can be medically necessary is not obvious or even probable error.

#### V. CONCLUSION

Premera's Motion for Discretionary Review should be denied. None of the grounds under RAP 2.3(b) are met, except for the certification by the trial court. Despite the certification, Premera's Motion should be denied because interlocutory appeal will not materially advance the conclusion of litigation and may delay the day when developmentally disabled Premera insureds can receive full coverage of their conditions.

DATED: November 14, 2012.

SRIANNI YOUTZ SPOONEMORE



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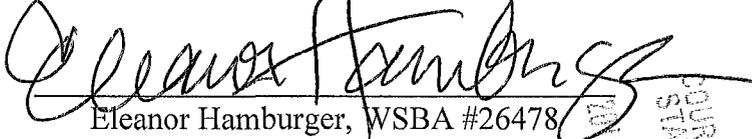
Attorneys for Respondent-Plaintiff A.G.

**CERTIFICATE OF SERVICE**

I certify, under penalty of perjury under the laws of the State of Washington, that on November 14, 2012, a true copy of the foregoing RESPONDENT'S OPPOSITION TO PETITIONERS' MOTION FOR DISCRETIONARY REVIEW was served upon counsel as indicated below:

Barbara J. Duffy	<input checked="" type="checkbox"/>	By United States Mail
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DATED: November 14, 2012, at Seattle, Washington.

  
Eleanor Hamburger, WSBA #26478

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88938-4

NO. 68726-3-I

IN THE COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION I

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PREMERA BLUE CROSS and  
LIFEWISE OF WASHINGTON,

Petitioners-Defendants,

v.

A.G., by and through his parents, J.G. and K.G.,  
on his own behalf and on behalf of  
all similarly situated individuals,

Respondent-Plaintiff.

---

**RESPONDENT'S APPENDIX TO OPPOSITION TO  
PETITIONERS' MOTION FOR DISCRETIONARY REVIEW**

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STATE OF WASHINGTON

**INDEX TO RESPONDENT'S APPENDIX TO OPPOSITION TO  
PETITIONERS' MOTION FOR DISCRETIONARY REVIEW**

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Plaintiffs' Motion for Partial Summary Judgment Regarding Visit Limits, and Motion for Permanent Injunctive Relief Pursuant to CR 65(a)(2), dated October 12, 2012 .....	B (pp. 15-35)
Declaration of Eleanor Hamburger, with Exhibits A-H, dated October 12, 2012.....	C (pp. 36-119)
Declaration of Eleanor Hamburger, with Exhibits A-I, dated January 13, 2012.....	D (pp. 120-205)
Response to Defendants' Motion to Certify Order for Discretionary Review, with Appendix A, dated April 24, 2012.....	E (pp. 206-219)
Supplemental Declaration of Eleanor Hamburger in Support of Motion for Partial Summary Judgment, with Exhibits J-L, dated February 24, 2012 .....	F (pp. 220-244)

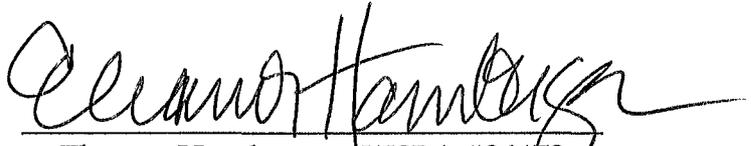
**CERTIFICATE OF SERVICE**

I certify, under penalty of perjury under the laws of the State of Washington, that on November 14, 2012, a true copy of the foregoing RESPONDENT'S APPENDIX TO OPPOSITION TO PETITIONERS' MOTION FOR DISCRETIONARY REVIEW was served upon counsel as indicated below:

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DATED: November 14, 2012, at Seattle, Washington.

  
Eleanor Hamburger, WSBA #26478

# Exhibit A

P.A. 000001

2012 WL 1997705

Only the Westlaw citation is currently available.  
United States District Court, W.D. Washington,  
at Seattle.

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of The Technology Access Foundation Health Benefit Plan, and on behalf of similarly situated individuals, Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, et. al., Defendants.

No. C11-1119RSL. | June 1, 2012.

#### Attorneys and Law Firms

Richard E. Spoonemore, Eleanor Hamburger, Sirianni Youtz Spoonemore, Seattle, WA, for Plaintiffs.

Charles S. Wright, Nigel P. Avilez, Davis Wright Tremaine, Seattle, WA, for Defendants.

#### Opinion

### ORDER GRANTING PLAINTIFFS' MOTIONS FOR SUMMARY JUDGMENT

ROBERT S. LASNIK, District Judge.

\*1 This matter comes before the Court on Plaintiffs' "Motion for Summary Judgment re: Exhaustion of Administrative Remedies" (Dkt.# 43) and "Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and Injunctive Relief under ERISA" (Dkt.# 44). Plaintiffs ask the Court to find as a matter of law that they exhausted their administrative remedies or that those remedies would be futile and to enter a permanent injunction requiring Defendants to comply with the requirements of Washington's Mental Health Parity Act, RCW 48.46.291, which the Court previously found to apply. The Court finds that Plaintiffs have exhausted their administrative remedies. It further finds that Plaintiffs are entitled to a permanent injunction requiring Defendants to adhere to the plain requirements of Washington's Mental Health Parity Act. Accordingly, the Court GRANTS both motions.

#### I. BACKGROUND

This case concerns a dispute over healthcare benefits. Plaintiff Z.D. is the twelve-year-old daughter and dependant of Plaintiffs J.D. (her mother) and T.D. (her father). *See* Dkt. # 45 at ¶ 2. She is a beneficiary of "The Technology Access Foundation Health Benefit Plan" (the "Plan"), an ERISA "employee welfare benefit plan," 29 U.S.C. § 1002(1), underwritten and administered by Defendant Group Health Options, Inc.—a wholly owned subsidiary of Defendant Group Health Cooperative. Amended Complaint (Dkt.# 3) at ¶¶ 1–5.

In 2006, Defendant Group Health diagnosed Z.D. with two DSM-IV-TR mental health conditions: a "moderate-severe receptive language disorder" and "other specific developmental learning disabilities." Dkt. # 45 at ¶ 4; *see also* Dkt. # 49–1 (Exhibit B).<sup>1</sup> At the time of her diagnoses, Z.D. was already a beneficiary of the Plan and began receiving covered non-"restorative"<sup>2</sup> speech therapy treatment for her conditions. Circumstances changed, however, shortly before Z.D.'s seventh birthday. Plaintiff was told that, per the Plan, non-restorative speech therapy treatments were not covered for individuals over the age of six and thus her treatments would no longer be covered once she turned seven. Dkt. # 45 at ¶ 5. As

a result, Z.D. stopped going to outpatient therapy, though she did receive some limited treatment services through her public elementary school. *Id.* at ¶ 6; Dkt. # 49-1 at 21.

<sup>1</sup> The Court notes that this exhibit is sealed and, because it prefers that the present Order be accessible by the public, has not disclosed any information not otherwise available from the parties' public filings. Nevertheless, throughout this Order the Court will cite to sealed documents that it considered but is not publicly disclosing in order to build a more thorough record in the event of an appeal.

<sup>2</sup> The Plan distinguishes between "restorative" treatment, which is intended to restore function and is covered regardless of age, and "non-restorative" treatment, which is intended to improve function and is not covered for individuals older than seven. *E.g.*, Dkt. # 56-1 at 28.

Unfortunately, this limited therapy did not seem to be enough. Six months after Z.D.'s seventh birthday, her mother complained to Z.D.'s doctor that Z.D. was continuing to experience problems at school. In October 2007, Z.D. was evaluated extensively at the University of Washington's LEARN Clinic, which confirmed Group Health's earlier diagnosis. Dkt. # 45 at ¶ 6; *see* Dkt. # 49-1 at 19-37. Group Health covered this evaluation. Dkt. # 57 at ¶ 4; Dkt. # 57-1 at 2.

On November 28, 2007, J.D. phoned Group Health to ask if Group Health would cover speech therapy for Z.D. Dkt. # 50-1 at 83; Opp. (Dkt.# 54) at 8. According to Group Health's records, it told her that Z.D.'s therapy would not be covered because she was over the age of six. Dkt. # 50-1 at 83.

\*2 In 2008, Z.D.'s parents began paying for her to receive treatment at Bellevue Mosaic in 2008. Dkt. # 45 at ¶ 7. In late 2008, Bellevue Mosaic recommended that Z.D. seek a higher level of treatment than it could provide. *Id.* at ¶ 8. Her parents took her to Northwest Language and Learning Center in September 2008. *Id.* Shortly after, J.D. emailed Group Health about coverage. Dkt. # 45-1 at 6-7. After she provided some extra information requested by Group Health, *id.* at 8, she received a formal denial of coverage on December 18, 2008. Group Health explained that "neurodevelopmental speech therapy is not covered beyond the age of 6" and that Northwest Learning and Language was not a provider within the Group Health system."<sup>3</sup>*Id.* at 11. Z.D.'s parents sent her to the center anyway, paying for her treatment out of pocket beginning in January 2009. Dkt. # 45 at ¶ 11.

<sup>3</sup> This rationale is somewhat curious given that Group Health covered Z.D.'s September and October sessions at Northwest. Dkt. # 57-1 at 4.

On September 15, 2010, Z.D. received an evaluation from Dr. Deborah Hill. *Id.* at ¶ 12. On October 15, J.D. sent Group Health another letter informing them of its prior age-based denials of her requests for treatment for Z.D. and asking it to reconsider its position. Dkt. # 45-1 at 18. She explained that she intended to enroll Z.D. at the Northwest Language and Learning Center and added: "Please consider this letter to be an appeal of Group Health's denial of my requests for speech therapy and neurodevelopmental evaluation for my daughter." *Id.* She also included a claim for reimbursement for the September 15 evaluation. *Id.* at 19-21.

Group Health responded in a letter dated November 1, 2010. *Id.* at 23. It stated that it did not have any record of having denied coverage for the September evaluation and would forward her claim to the claims department. *Id.*

J.D. responded via a certified letter dated December 9, 2010. *Id.* at 25. She wrote that she had not heard anything further from Group Health in regard to either her general request for coverage or her specific claim for the September evaluation. *Id.* She explained that because she had not received any explanation of benefits in regard to her request for coverage, she considered Group Health's inaction to be a denial and wished to appeal that denial. *Id.* Group Health states that it never received that letter. Opp. (Dkt.# 54) at 11. It did eventually "cover" the September 15 claim, though. *Compare* Dkt. # 45 at ¶ 17 (stating that Group Health paid the claim), *with* Dkt. # 57 at ¶ 6 (stating that Group Health denied coverage because Plaintiffs had used the maximum number of mental health evaluations to which they were entitled, but that Plaintiffs still received the benefit of Group Health's lower rate).

In any case, Plaintiffs continued to send Z.D. to Northwest, paying for her therapy themselves. Dkt. # 45 at ¶ 17. On July 6, 2011, they filed the instant suit against Defendants, alleging that Washington's Mental Health Parity Act, RCW 48.46.291, requires Defendants to cover Z.D.'s mental health therapy sessions. Complaint (Dkt.# 1). They seek to recover the "benefits due them due to the improper exclusion and/or limitations of behavioral and neurodevelopmental therapy." Amended Complaint (Dkt.# 3) at ¶¶ 36–38 (relying on 29 U.S.C. § 1132(a)(1)(B)). And they seek the recovery of all losses to the Plan for Defendants' alleged failure "to act in accordance with the documents and instruments governing the Plan." *Id.* at ¶¶ 28–35 (relying on 29 U.S.C. § 1132(a) (2) ("breach of fiduciary duty")). Finally, they ask the Court to enjoin Defendants from continuing to process and pay claims in a manner inconsistent with RCW 48.46.291. *Id.* at ¶¶ 39–41 (relying on 29 U.S.C. § 1132(a)(3)).

\*3 After filing suit, Plaintiffs filed a claim for each of Z.D.'s 2011 sessions at Northwest. Dkt. # 45 at ¶ 17. Group Health tendered a check in payment of these claims on November 17, 2011. *Id.* In a subsequent deposition, however, Group Health stated that it had erroneously tendered that payment. Dkt. # 48–1 at 60–61 ("[I]t should not have been paid.").

## II. DISCUSSION

In the present motions, Plaintiffs argue first that they are entitled to a legal finding that they exhausted their administrative remedies or that those remedies would have been futile. Dkt. # 43. Moreover, they ask the Court to enter a permanent injunction against Defendants, enjoining "Group Health from denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM–IV–TR mental health conditions simply because the insured is over six years old." Dkt. # 44.

Notably, the Court may grant Plaintiffs' motions only if it is satisfied that there is no genuine issue of material fact and that judgment is appropriate as a matter of law. Fed.R.Civ.P. 56(c). As the moving party, Plaintiffs bear the initial burden of informing the Court of the basis for summary judgment. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). They must prove each and every element of their claims or defenses such that no reasonable jury could find otherwise. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). In doing so, they are entitled to rely on nothing more than the pleading themselves. *Celotex*, 477 U.S. at 322–24. Only once they make their initial showing does the burden shift to the Defendants to show by affidavits, depositions, answers to interrogatories, admissions, or other evidence that summary judgment is not warranted because a genuine issue of material fact exists. *Id.* at 324.

To be material, the fact must be one that bears on the outcome of the case. A genuine issue exists only if the evidence is such that a reasonable trier of fact could resolve the dispute in favor of the nonmoving party. *Anderson*, 477 U.S. at 249. "If the evidence is merely colorable ... or is not significantly probative ... summary judgment may be granted." *Id.* at 249–50. In reviewing the evidence "the court must draw all reasonable inferences in favor of the nonmoving party, and it may not make credibility determinations or weigh the evidence." *Reeves v. Sanderson Plumbing Prods. Inc.*, 530 U.S. 133, 150, 120 S.Ct. 2097, 147 L.Ed.2d 105(2000).

### A. Exhaustion

"Section 502 of ERISA entitles a participant or beneficiary of an ERISA-regulated plan to bring a civil action 'to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.'" *Chappel v. Lab. Corp. of Am.*, 232 F.3d 719, 724 (9th Cir.2000) (quoting 29 U.S.C. § 1132(a)(1) (B)). Before a beneficiary may bring such a claim, though, "exhaustion, at least to the level of the trustees, is ordinarily required where an action seeks a declaration of the parties' rights and duties under the [ERISA] plan." *Graphic Commc'ns Union. Dist. Council No. 2. AFL–CIO v. GCIU–Emp'r Ret. Benefit Plan*, 917 F.2d 1184, 1187 (9th Cir.1990) (emphasis in original) (citations and internal quotation marks omitted). Suits raising unexhausted claims are barred absent a showing that the relevant unexhausted plan provision is either unenforceable or invalid. *Chappel*, 232 F.3d at 724.

\*4 Plaintiffs' argument in favor of exhaustion in this case is confined to three occasions: specifically, that "Group Health

failed to (1) timely process and respond to Z.D.'s October 25, 2010 pre[-]service request for coverage of speech therapy; (2) institute any appeal or consideration of a pre-service speech therapy claim in response to Z.D.'s December 9, 2010 request to do so; and (3) timely respond to Z.D.'s September 12, 2011 post-service claim for speech therapy benefits."<sup>4</sup>

<sup>4</sup> Accordingly, the Court does not address Defendants' arguments as to other dates.

In response, Defendants raise three arguments. First, they contend that Plaintiff's "pre-service" requests were not true "pre-service" requests at all and that Group Health therefore had no obligation to respond. Second, they contend that Group Health did timely respond to the 2011 claim and that, even if it did not, it has since tendered payment, mooting any claim. Finally, it argues that Plaintiff's administrative remedies would not have been futile. The Court disagrees with each of Defendants' positions and finds that Plaintiff is entitled to judgment as a matter of law. It thus GRANTS the motion (Dkt.# 43).

### 1. Exhaustion of 2010 "Pre-Service" Claims

The facts relevant to Plaintiff's 2010 "pre-service" requests are straightforward and undisputed: On October 15, 2010, J.D. sent Group Health a letter that recounted its prior age-based denials of her requests for treatment for Z.D. and immediately added, "Please consider this letter to be an appeal of Group Health's denial of my requests for speech therapy and neurodevelopmental evaluation for my daughter." Dkt. # 45-1 at 18 (emphasis in original).

She further noted that she had recently had her daughter evaluated again and had been told that she needed to "receive additional medically necessary speech therapy." *Id.* (emphasis omitted). She explained that she intended "to enroll Z.D. at Northwest Language and Learning for the recommended speech therapy" and stated: "I request that Group Health reconsider its exclusion of neurodevelopmental therapy coverage for my daughter and provide her with coverage for neuropsychological evaluation and speech therapy services. Both neurodevelopmental evaluation and speech therapy are medically necessary services to treat my daughter's developmental disabilities and communication disorder." *Id.* (emphasis in original).

In its response, Group Health did not address J.D.'s request for speech therapy, stating only that it had no record of having denied any claims arising from a distinct evaluation not at issue here. *Id.* at 23. J.D. was not dissuaded. She wrote back in a certified letter dated December 9, 2010, stating bluntly that she considered Group Health's non-response to her request for coverage to be a de facto denial of coverage. *Id.* at 25. She then immediately stated again: "Please consider this letter to be an appeal of Group Health's denial of my requests for speech therapy and neurodevelopmental evaluation for my daughter." *Id.* (emphasis in original).

\*5 Moreover, eliminating any reasonable objective potential for ambiguity,<sup>5</sup> she went on to explain that she had "enrolled Z.D. at Northwest Language and Learning for the recommended speech therapy" and then immediately stated again: "I request that Group Health reconsider its exclusion of neurodevelopmental therapy coverage for my daughter and provide her with coverage for neuropsychological evaluation and speech therapy services. Both neurodevelopmental evaluation and speech therapy are medically necessary services to treat my daughter's developmental disabilities and communication disorder." *Id.* (emphasis in original).

<sup>5</sup> To be clear, the Court sees absolutely no factual basis from which to conclude that reasonable minds could disagree as to the import of J.D.'s correspondences. Her letters make it clear beyond any possibility for fairminded disagreement that she was requesting both coverage for future expected treatment at Northwest and reconsideration of prior denials.

In the face of these plain requests for coverage and notices of appeal, Defendants argue simply that no response was required because Plaintiff's requests were not valid "pre-service" claims, as defined under ERISA. *See* Opp. (Dkt.# 54) at 15-18. They contend that ERISA places procedural requirements only on a "claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care." 29 C.F.R. § 2560.503-1(m)(2), and that, because the Plan does not require pre-approval of outpatient speech therapy like Z.D. was requesting, her requests did not constitute pre-service requests. Opp. (Dkt.# 54) at 15-18. Technically speaking, the Court agrees. J.D.'s letters would not appear to fall within the technical definition of "Pre-service claims" set forth in the regulation.

Notably, however, that does not mean that the regulation contemplates that Defendants could merely sit on their hands in the face of her requests. Apart from the specific obligations attached to “pre-service claims,” the regulation precludes claim procedures from being “administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits.” § 2560.503–1(b)(3). It goes on to specifically provide “that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan’s procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, *the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits,*” § 2560.503–1(c)(1)(f) (emphasis added). Compare § 2560.503–1(c)(1)(ii) (noting requirements), with Dkt. # 45–1 at 18 (naming “a specific claimant; a specific medical condition or symptom; and a specific treatment ... for which approval is requested”).

As explained by the Department of Labor, which promulgated the regulation, “a group health plan that requires the submission of pre-service claims, such as requests for preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis for concluding that the inquirer is *attempting to file or further a claim for benefits*, although not acting in compliance with the plan’s claim filing procedures.” U.S. Department of Labor FAQs About the Benefits Claim Procedure Regulations (“DOL FAQs”), available at [http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html) at A–5 (emphasis added). Rather, “the regulation requires the plan to inform the individual of his or her failure to file a claim and the proper procedures to be followed.” *Id.*; see *Barboza v. Cal. Ass’n of Prof’l Firefighters*, 651 F.3d 1073, 1079 (9th Cir.2011) (deferring to the Secretary of Labor’s interpretation of § 2560.503–1 because “[w]hen evaluating conflicting interpretations of an administrative regulation, we are required to give ‘substantial deference’ to the agency’s interpretation of its own regulations”).

\*6 Thus, even assuming that J.D.’s letter was an inappropriate pre-service claim, the Court finds it beyond any possibility for fairminded disagreement that Group Health had “a basis” for concluding that J.D. was “attempting to file or further a claim for benefits.” Compare Dkt. # 45–1 at 18, with DOL FAQs, at A–5. Group Health therefore had an obligation to inform her of the shortcoming of her request—that, as Defendants now contend, it was not an appropriate pre-service claim—and of the proper procedure for filing a claim, i.e., either concurrently or post-service.<sup>6</sup> Compare § 2560.503–1(c)(1)(i), with Dkt. # 48–1 at 80 (noting that Group Health recognizes pre-service, concurrent, and post-service claims). Because it failed to do either, Plaintiffs’ claims are deemed exhausted. § 2560.503–1(1) (“In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.”).

<sup>6</sup> As Plaintiffs point out, Group Health is a fiduciary. The law does not permit it to simply sit on its hands while a beneficiary unsuccessfully attempts to “navigate the byzantine bureaucracy of a health carrier.” Mot. (Dkt.# 43) at 15. It had a duty to aid J.D. in her attempts to present a claim. See § 2560.503–1(c)(1)(i).

Moreover, the fact that the Plaintiffs may not have filed a claim contemplated by § 2560.503–1(m)(2) does not mean that it was not a valid claim under the terms of the Plan itself. As § 2560.503–1(a) states, it “sets forth *minimum requirements* for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries.” *Id.* (emphasis added). It does not preclude a Plan from providing greater protections. See *Chappel*, 232 F.3d at 724 (noting the distinction between rights and benefits accorded “by the statutory provisions of ERISA itself” and rights and benefits provided “by the contractual terms of the benefits plan”). And in this case, the Plan does not expressly incorporate § 2560.503–1(m)(2)’s definition of or otherwise define “pre-service claim.” It simply states:

#### D. Claims

*Claims for benefits may be made before or after services are obtained. To make a claim for benefits under the Agreement, a Member (or the Member’s authorized representative) must contact GHO Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.*

\* \* \*

GHO will generally process claims for benefits within the following timeframes after GHO receives the claims:

\$ Pre-service claims—within fifteen (15) days.

\$ Claims involving urgently needed care—within seventy-two (72) hours.

\$ Concurrent care claims—within twenty-four (24) hours.

\$ Post-service claims—within thirty (30) days.

Timeframes for pre-service and post-service claims can be extended by GHO for up to an additional fifteen (15) days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

\*7 Dkt. # 56–2 at 6 (2010 Plan Benefit Booklet)<sup>7</sup>; accord Dkt. # 56–2 at 59 (2011 Plan Benefit Booklet); see also Dkt. # 56 at ¶ 4 (stating that the 2010 Contract was effective March 1, 2010, and the 2011 Contract was effective March 1, 2011).

<sup>7</sup> The Court recognizes that the Supreme Court has distinguished between summary documents and Plan terms. *CIGNA Corp. v. Amara*, —U.S. —, —, 131 S.Ct. 1866, 1878, 179 L.Ed.2d 843 (2011) (“[S]ummary documents, important as they are, provide communication with beneficiaries about the plan, ... their statements do not themselves constitute the terms of the plan for purposes of § 502(a)(1)(B).” (emphasis omitted)). Noting that the “GHO Booklets” relied upon by the parties themselves state they are “not the contract itself,” e.g., Dkt. # 56–2 at 2, 51, the Court directed the parties to file the actual contracts. Dkt. # 69. The parties subsequently filed those documents, pointing out, however, that the contracts themselves do not provide specific terms. Instead, they incorporate as Plan terms the provisions set forth in the GHO Booklets. E.g., Dkt. # 70 at 34 ¶ 1. The Court therefore treats the Booklet terms as the Plan terms.

Undoubtedly recognizing the lack of textual support for its litigation position, Defendants argue that Group Health nonetheless applies the ERISA definition of “pre-service” claim. In support, they offer only the deposition testimony of Carroll Candace, one of their Rule 30(b)(6) deponents, arguing that she testified that “such claims need to be ‘contractually contingent’ on Group Health’s advance approval.” Opp. (Dkt.# 54) at 18 (citing Dkt. # 48–1 at 80). The Court finds no support for that assertion.

The entirety of the relevant exchange between Ms. Carroll and Plaintiffs’ counsel was as follows:

Q: Do you also deal with situations where there is a pre-service request for authorization?

A: Yes.

Q: And that’s a situation where somebody is asking Group Health under the contract to approve benefits before the service has been provided, right?

A: Exactly.

Q: And that would then be sort of contractually contingent upon Group Health saying, yes, we bless this for payment in advance?”

A: Yes

Q: I tend to call those pre-service claims. Is that what Group Health calls them as well?

A: We call them—yes, I technically call them that, but Group Health doesn’t necessarily do that. That’s a health care reform term.

So yes, I do use the word claim because ERISA uses the word claim.

\* \* \*

A: It's a claim against benefit pre-service versus a claim to pay.

\* \* \*

Q: How does Group Health determine whether an individual is making a request for a pre-service claim ?

A: The request comes in prior to the delivery of care.

Dkt. # 48-1 at 80 (emphasis added). As the whole conversation makes clear, Ms. Carroll not only fails to ever condition her understanding of the Plan term on the *need* for pre-approval, she expressly distinguishes Group Health's understanding of its terms from the statutory definitions. *Id.* Furthermore, when asked point blank to identify how Group Health determines if "an individual is making a request for a pre-service claim," she relies on only one condition: the timing of the claim. *Id.* Accordingly, the Court finds that Defendants have failed to offer any evidence sufficient to give rise to a genuine issue as to the import of Group Health's terms. *Anderson*, 477 U.S. at 249-50 ("If the evidence is merely colorable ... or is not significantly probative ... summary judgment may be granted."). The October 25 letter served as "a claim for benefits under the Agreement" to which Group Health was obligated to respond.

And, of course, Group Health did respond. Moreover, it did so *within the 15-day period set forth by the Plan for "processing" pre-service claims* rather than the 30-day post-service review period, further reinforcing its understanding of its own terms' requirements. Dkt. # 45-1 at 23. It informed J.D. that it had no record of a denial and advised her that it had "forwarded her information to the claims department for processing." *Id.* Dissatisfied with Group Health's response, J.D. again wrote to appeal Group Health's apparent de facto denial, wisely mailing her letter via certified mail. Group Health concedes it never responded to that letter, claiming that it never even received it. Opp. (Dkt.# 54) at 11. That claim is ultimately insufficient to overcome Plaintiffs' exhaustion contention, however. Plaintiffs have presented evidence of both their mailing and Group Health's receipt of their December 9, 2010 letter. Dkt. # 45-1 at 25, 27-28. In response, Defendants merely assert non-receipt. And it is settled law that "[m]erely stating that the document isn't in the addressee's files or records ... is insufficient to defeat the presumption of receipt." *Huizar v. Carey*, 273 F.3d 1220, 1223 n. 3 (9th Cir.2001).

\*8 Thus, in sum, the Court finds that, in addition to being able to claim the benefit of the automatic exhaustion provision of § 2560.503-1(1), Plaintiffs fulfilled their exhaustion obligations under the Plan itself. They both presented their 2010 claims to Group Health as the Plan terms required and subsequently appealed Group Health's de facto denial. Accordingly, under either theory, the Court finds that Plaintiffs 2010 claims are exhausted. *See Barboza*, 651 F.3d at 1076 ("[T]he 'applicability *vel non* of exhaustion principles is a question of law' that 'we consider ... de novo.'").

## 2. Exhaustion of the 2011 Claim

Next, the Court whether Plaintiffs exhausted their 2011 post-service claim.

Notably, Group Health tendered a check in partial payment of these claims on November 12, 2011—60 days after the claim was filed. *See* Dkt. # 57-2 at 4 (noting that Group Health paid \$609.00 of the \$810.00 claimed). The only amount it declined to pay was Plaintiffs' Plan-designated co-pay amount. Accordingly, Defendants assert that there is no adverse benefit determination to appeal. Plaintiffs disagree. They assert that Group Health's decision not to pay the entirety of the claim constituted an "adverse benefit determination." Dkt. # 62 at 10-11. And, because Group Health did not provide them with notice of that adverse decision within 30 days of its receipt of their claim as required by § 560.503-1(f)(2) (iii)(B), the

automatic exhaustion provisions of § 2560.503-1(1) were triggered.<sup>8</sup> The Court agrees.

<sup>8</sup> Plaintiffs also complain that Group Health has since indicated that it should not have paid any of the claim. See Dkt. # 48-1 at 50-61 (statement by one of Defendants' Rule 30(b)(6) deponents, Dean Solis, the acting associate of "Western Washington Health Plan Operations," that Group Health should not have paid the claim). As a result, Plaintiffs rightly fear that Group Health could seek to clawback those funds at any time.

While Defendants are correct in their assertion that "the regulation does not address the periods within which payments that have been granted must be actually paid or services that have been approved must be actually rendered," DOL FAQs, at A-10, that is not the crux of Plaintiffs' claim. To the contrary, Plaintiffs note that the regulation defines "adverse benefit determination" as any "failure to provide or make payment (*in whole or in part*)." § 2560.503-1(m)(4) (emphasis added). They argue that this includes even denials based on the imposition of co-pays, pointing out that this is the official position of the Department of Labor. DOL FAQs, at C-12 (answering the question, "If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan's limits on co-payment, deductibles, etc., pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination?" in the affirmative because "[i]n any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses."). The Court sees no reason not to defer to this interpretation. See *Barboza*, 651 F.3d at 1079.

Thus, the undisputed fact that Group Health did not pay the entirety of the claim constituted a partial denial of benefits and thus an adverse benefits determination. § 2560.503-1(m)(4). Accordingly, Group Health was required to inform Plaintiffs of this partial denial within 30 days of receiving the claim. § 560.503-1(f)(2)(iii)(B). Plaintiffs assert that it failed to do so, and, in response, Defendants essentially concede the point. Accordingly, the Court finds that Plaintiffs' 2011-based claim is exhausted.

### 3. Futility

\*9 Because the Court finds that Plaintiffs exhausted both of the claims that are the subject of this motion, it does not reach the issue of futility.

Notably, though, the Court wishes to point out that Defendants' position on futility—that administrative remedies may not have been futile because, despite the fact that the Plan does not permit coverage of non-restorative mental health therapies for individuals over the age of six,<sup>9</sup> Group Health sometimes paid them anyway—is troubling. As Plaintiffs point out, ERISA fiduciaries are not permitted to process claims on a whim. Rather, they are required to do precisely the opposite: "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and ... 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). Moreover,

<sup>9</sup> To be clear, the Court agrees with Plaintiffs that Defendants' official position throughout this litigation has been that the Plan "required Group Health to deny neurodevelopmental therapy benefits for claimants over six years old," Dkt. # 19 at 7, and that the record is replete with examples of Defendants asserting Group Health's official position. See, e.g., Mot. (Dkt.# 43) at 21-27 (summarizing the many instances in which Group Health asserted its official position); Reply (Dkt.# 62) at 5-8 (same). Certainly, Defendants filed two motions premised on that position. Dkt. # # 7, 31. It is the entire reason this case exists.

The claims procedures for a plan will be deemed to be reasonable only if ... [t]he claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

29 C.F.R. § 2560.503-1(b)(5).

Thus, in attempting to win the exhaustion battle, Defendants essentially concede the war by representing to this Court that Group Health deviates from the Plan's terms to pay claims not permitted under the Plan contract. E.g., Opp. (Dkt.# 54) at 23

“Notwithstanding Group Health’s policy limiting speech benefits to children under 7, the record shows that in Z.D.’s case Group Health paid speech therapy claims when she submitted them.... But even though those payments may have been ‘error’ in the sense that they were inconsistent with the TAF Contract, that ‘error’ has benefitted Plaintiffs every time....”). The Court has no choice but to treat this representation as a concession that Group Health is administering the Plan in an arbitrary and capricious fashion, i.e., that it is wholly failing to act as a fiduciary.

### B. Injunctive Relief

The Court next considers Plaintiffs’ motion for “an order and judgment under ERISA clarifying that neurodevelopmental therapy to treat insureds with DSM–IV–TR mental health conditions may not be denied simply because the insured is over the age of six” and “enjoin[ing] Group Health from denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM–IV–TR mental health conditions simply because the insured is over six years old.” Mot. (Dkt.# 44) at 7.

In opposition, Defendants raise three arguments: First, that “Group Health treats all neurodevelopmental disorders the same”; second, that “Plaintiffs’ own experience demonstrates the lack of an actual or imminent injury”; and third, that “the Neurodevelopmental Therapies Mandate specifically permits terminating speech therapy at age 7.” Opp. (Dkt.# 53) at 15. The Court finds none persuasive. Rather, it finds that no genuine issue of material fact exists and that Plaintiffs are entitled to judgment as a matter of law under 29 U.S.C. § 1132(a)(1)(B) and (a)(3). It thus GRANTS Plaintiffs’ motion (Dkt. # 44).

### 1. Revisiting the Neurodevelopmental Therapies Mandate Issue

\*10 The Court thinks it prudent to start with Defendant’s third argument: their third attempt to convince this Court that “the Neurodevelopmental Therapies Mandate specifically permits terminating speech therapy at age 7” and that the Mental Health Parity Act must therefore be interpreted in such a fashion that it does not require neurodevelopmental therapy coverage. Opp. (Dkt.# 53) at 15. As the Court stated in its prior resolution of this *same argument*,<sup>10</sup> the issue is not whether the Mandate requires coverage. Plainly it does not. Neither is there any dispute as to whether the Mental Health Parity Act repealed the Mandate. Again, plainly it did not. The only issue is whether the two statutes conflict, and as the Court has found on two separate occasions, they do not. Order (Dkt.# 30) at 8; Order (Dkt.# 36) at 2–3.

<sup>10</sup> The Court disagrees with Defendants’ representations regarding the “newness” of their argument. As before, Defendants contend that the Neurodevelopmental Therapies Mandate does not require coverage after an individual turns seven. As before, they argue that the Mental Health Parity Act did not repeal the Neurodevelopmental Therapies Mandate. And, as before, they contend that the two statutes conflict and that the Mandate trumps the Parity Act. There is nothing materially new about Defendants’ argument.

The previously enacted Mandate required “coverage for neurodevelopmental therapies for covered individuals age six and under.” RCW 48.44.450(1). It established a coverage floor, not a ceiling. Thus, the subsequently enacted Mental Health Parity Act merely imposed an additional, distinct requirement that mental health coverage “be delivered under the same terms and conditions as medical and surgical services.” H.B. 1154, 59th Leg., Reg. Sess., ¶ 1 (Wash.2005); *see, e.g.*, Order (Dkt.# 30); Order (Dkt.# 36). There does not exist even a close question as to whether there is a conflict between the statutes under established Washington law.<sup>11</sup>

<sup>11</sup> A litany of Washington state courts have held the same. *See, e.g., D.F. v. Wash. State Health Care Auth.*, No. 10–2–294007 SEA; Dkt. # # 74, 74–1 (listing decisions).

In any case, as it appears that the message has yet to be received, the Court wishes to be clear: The coverage at issue in this case is the product of RCW 48.46.291, not the Neurodevelopmental Therapies Mandate. The Mandate continues to apply, requiring “coverage for neurodevelopmental therapies for covered individuals age six and under.” RCW 48.44.450(1). And while the Mandate no longer applies after a child turns seven, RCW 48.46.291 does. By its plain terms, it requires health maintenance organizations like Group Health to provide coverage for “mental health services” at increasing levels of parity with the coverage such entities provide for medical and surgical services. *See* RCW 48.46.291(2)(a)-(c).

## 2. Statutory Treatment Requirements

The Court next considers Defendants' contention that, since January 2011, they have brought their policies in conformity with the Mental Health Parity Act and that an injunction is therefore unnecessary.<sup>12</sup> Opp. (Dkt.# 53) at 17. The Court disagrees.

<sup>12</sup> The Court notes that Defendants mischaracterize Plaintiffs' request. To be clear, Plaintiffs do not request that the Court find that an age limit is never appropriate under any circumstance. Opp. (Dkt.# 53) at 15–16. They assert only that Group Health cannot impose an age-based treatment limitation on neurodevelopmental therapies unless it generally imposes that same limit on “medical and surgical services.”

The Court notes at the outset that Defendants paint a much rosier picture of their policies in their briefs than they apply in practice. For example, Defendants argue that they are in compliance with RCW 48.46.291(2)(c) because Group Health applies the same treatment limitations to mental health therapy services that it applies to all therapies services. Opp. (Dkt.# 53) at 16 (“Group Health imposes a treatment limit (age seven) on a limited set of therapies (speech therapy, physical therapy and occupational therapy) that treat medical and mental conditions alike.”). In actuality, however, Group Health does not apply an age-based treatment limitation across the board to all therapies related to medical and surgical services. *See* Dkt. # 56–2 at 82 (2011 terms).<sup>13</sup> It applies an age-based limitation only to a narrow subcategory of medical and surgical services, namely, non-rehabilitative therapies—“therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member’s level of functioning,” as opposed to “restore function following illness, injury or surgery.” *Id.* (emphasis added). Thus, in reality, Group Health applies its age-based limitation to only a sub-category of a sub-category of its covered services: non-rehabilitative, therapy services.

<sup>13</sup> The Plan states:

### G. Rehabilitation Services.

1. Rehabilitation services are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; massage therapy; and speech therapy to restore function following illness, injury or surgery. Services are subject to all terms, conditions and limitations of the Agreement including the following:

- a. All services require a prescription from either a MHCN or community physician and must be provided by a MHCN-approved or Community Provider rehabilitation team that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.
- b. Under the Community Provider option, inpatient rehabilitation services must be authorized in advance by GHO.
- c. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the Member’s condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.
- d. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: inpatient Residential Treatment services; specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member’s level of functioning (except as set forth in subsection 2. below); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

2. **Neurodevelopmental Therapies for Children Age Six (6) and Under.** Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member’s condition would result without the services. Coverage for inpatient and outpatient services is limited to the Allowances set forth in the Allowances Schedule.

Excluded: inpatient Residential Treatment services; specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; recreational, life-enhancing, relaxation or palliative therapy, implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

Dkt. # 56–2 at 82 (some emphasis omitted).

\*11 In any case, the end result of Group Health's actions is simple. As Defendants concede, "Group Health's 'official policy' " remains to terminate "neurodevelopmental therapies at age seven." Opp. (Dkt.# 53) at 16 ("The plain language of the TAF Contract makes this equal treatment clear: the Neurodevelopmental Therapies benefit does not distinguish between types of conditions, but simply grants coverage for neurodevelopmentally disabled children (regardless of whether the neurodevelopmental disability is "mental" or "physical"), subject to common treatment limitations (e.g., no coverage after age six)."). They defend this practice by pointing to a single line of RCW 48.46.291(2)(c): "Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services...." They contend that because Group Health essentially excludes all non-restorative "rehabilitative therapies related to medical and surgical services," it may similarly exclude all coverage for similar non-restorative mental health or neurodevelopmental disorders. *See* Opp. (Dkt.# 53) at 17.

The Court finds two problems with this interpretation. First, Defendant's interpretation ignores the full text of RCW 48.46.291. Even the subsection containing the clause relied upon by Defendants states plainly:

(2) *All health benefit plans offered by health maintenance organizations that provide coverage for medical and surgical services shall provide:*

(c) For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, *coverage for:*

(i) *Mental health services.* The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services....

RCW 48.46.291(2)(c)(i) (emphasis added). And the statute defines "mental health services" as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association," with exceptions not at issue here. RCW 48.46.291(1). Thus, the Act plainly imposes a *baseline coverage requirement* requiring Group Health "provide ... coverage for" Z.D.'s "medically necessary" treatment for her DSM-IV-TR mental health conditions without any regard for whether that treatment is restorative or non-restorative. RCW 48.46.291(2)(c)(i); *see* RCW 48.46.291(2)(a)(i), (b)(i).<sup>14</sup>

<sup>14</sup> This interpretation is also supported by the Washington Senate Bill Report for the Parity Act, which states: "**Background:** Current Washington law does not require health carriers to include mental health coverage in any benefit plan.... **Summary of Bill:** Beginning January 1, 2006 [ ] a health benefit plan that provides coverage for medical and surgical services must provide coverage for mental health services and prescription drugs to treat mental disorders." Dkt. # 9 at 40-41.

\*12 Second, Defendants' focus on the final clause of subsection (c) (i) ignores the history and structure of the statute. As enacted, the statute is meant to impose increasingly stringent requirements on entities like Group Health every two years. RCW 48.46.291(2)(a)-(c). Thus, the addition of the treatment limitation is not meant to weaken or supplant the baseline coverage requirement; it is meant to bolster it by further limiting the conditions an entity like Group Health can impose on its coverage of mental health conditions like Z.D.'s. *Id.* In short, the clause precludes Group Health from imposing precisely the sort of tailored limitations at issue here—limitations that would defeat the very purpose of the statute: providing coverage.

In sum then, the Court finds that RCW 48.46.291(2)(c)(i) requires Group Health to provide coverage for "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association," with those limited exceptions set forth in the statute, RCW 48.46.291(1). And it finds that the final clause of subsection (c)(i) only further precludes Group Health from imposing treatment limitations it does not generally "impose [ ] on coverage for medical and surgical services." RCW 48.46.291(2)(c)(i). Accordingly, because Group Health does not exclude individuals over the age of six from coverage for medical and surgical services or even impose an age-based

limitation on its therapy coverage in general, it may not impose that limitation on non-restorative mental health therapy coverage.<sup>15</sup>

<sup>15</sup> Accordingly, it would also seem that Group Health cannot condition coverage on the availability of treatment through “programs offered by public school districts.” *Cf.* Dkt. # 56-2 at 82 (2011 terms).

### 3. Actual or Imminent Injury

Finally, the Court turns to Defendants’ contention that Plaintiffs cannot show a likelihood of irreparable injury.

The crux of Defendants’ position is, again, that regardless of Group Health’s actual policies, they may in fact pay future claims.<sup>16</sup> As Defendants state: “Apart from Group Health’s policies, Plaintiffs’ actual experience with Group Health’s claims practice belies their claim that Group Health ‘systematic [ally] violates ... plan terms’ or will do so in the future.” *See* Opp. (Dkt. # 53) at 17.

<sup>16</sup> Defendants also contend that Plaintiffs conceded that they have no plans to start speech therapy again. Opp. (Dkt.# 53) at 19. As they concede, though, that is no longer the case. *Id.* Moreover, as the entirety of the record in this case makes clear, every doctor who has evaluated Z.D. has recommended that she get treatment. And her parents’ desire to follow doctor’s recommendations is the impetus for this case.

First and foremost, this contention is patently deficient as a matter of law. As stated, ERISA requires “a fiduciary [to] discharge his duties with respect to a plan solely ... in accordance with the documents and instruments governing the plan.” 29 U.S.C. § 1104(a)(1)(D). Accordingly, it is no excuse for Defendants to represent that the Plan precludes the coverage sought, and yet simultaneously argue that, “[w]hile there may be some discrepancy between Group Health’s practice and its official policy toward neurodevelopmental therapies, ... its practice has changed in Plaintiffs’ favor, suggesting a strong likelihood of future coverage.” Opp. (Dkt.# 53) at 20. The Court will not leave Plaintiffs at the mercy of Group Health’s plainly arbitrary application of its own Plan terms or its ever-evolving understanding of Plaintiffs’ entitlement to coverage.

\*13 Moreover, Group Health’s boots on the ground clearly do not share the same impression as its lawyers as to Plaintiffs’ likelihood of future coverage. As one of its regional managers, Tomi McVay, testified in her role as Rule 30(b)(6) deponent:

Q: So if a person comes to you who is age seven, has a neurodevelopmental problem, disorder—let’s go even further and say that they have diagnosed DSM-IV-TR diagnoses as well.

\* \* \*

The person then comes to you and says, “I understand that I’m not covered under the neurodevelopmental benefit because I’m age seven, am I covered under the rehab benefit?”

And the first thing you do [is] determine whether they are trying to improve their function or restore function? Is that what goes on clinically?

A: I do an evaluation and I send it to clinical review.

Q: And if the evaluation concludes that they’re seeking speech therapy to not just restore previous function but to improve function, your expectation is that Group Health would determine that to be not medically necessary?

\* \* \*

A: Typically, yes.

Q: And that's your current understanding up to today, is that correct?

A: Yes....

Dkt. # 64 at 27. Furthermore, she goes on to note that there have been “[l]ess than seven” cases in which treatment has continued to be covered after the individual turned seven. *Id.* It thus appears that both Defendants’ policies and its practices do not favor Plaintiffs’ chances of obtaining the coverage to which she is entitled absent an injunctive order—acutely demonstrating the need for the Court “to clarify [Plaintiffs’] rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B).

\* \* \*

In sum, the Court finds (1) that RCW 48.46.291 is effective against Group Health, (2) that neither Group Health’s policies nor its practices adhere to the statute’s mandates, and (3) that Plaintiffs have more than demonstrated a substantial likelihood of harm absent injunctive relief. Accordingly, the Court GRANTS Plaintiffs’ motion for declaratory and injunctive relief under § 1132(a)(1)(B) and (a)(3). The Court ORDERS Defendants to cease denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM–IV–TR mental health conditions simply because the insured is over six years’ old. Moreover, the Court ORDERS Defendants to cease their application of any treatment limitations that are not generally “imposed on coverage for medical and surgical services.” RCW 48.46.291(2)(c)(i). The Court will not look kindly on failures to immediately implement its directive.

### III. CONCLUSION

For all of the foregoing reasons, the Court GRANTS Plaintiffs’ “Motion for Summary Judgment re: Exhaustion of Administrative Remedies” (Dkt.# 43) and “Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and Injunctive Relief under ERISA” (Dkt.# 44).

Plaintiffs exhausted their 2010 and 2011 claims and have demonstrated as a matter of law that Group Health’s policies and its actions fail to comport with the plain requirements of Washington’s Mental Health Parity Act. Accordingly, they are entitled to declaratory relief. Moreover, because they have demonstrated a strong likelihood of future irreparable injury absent injunctive relief, the Court ORDERS Defendants to immediately cease denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM–IV–TR mental health conditions simply because an insured is over six years old. Defendants must immediately cease their application of any treatment limitations that are not generally “imposed on coverage for medical and surgical services.” RCW 48.46.291(2)(c)(i).

#### Parallel Citations

53 Employee Benefits Cas. 2190

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# Exhibit B

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HON. MICHAEL J. TRICKEY  
Noted for Hearing: November 9, 2012 at 9:30 a.m.  
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G., and K.N. and T.N., by and through their parents P.N. and L.N., each on his or her own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON, Washington corporations,  
Defendants.

NO. 11-2-30233-4 SEA

PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT REGARDING VISIT LIMITS

AND

MOTION FOR PERMANENT INJUNCTIVE RELIEF PURSUANT TO CR 65 (a)(2)

I. INTRODUCTION

Since April 26, 2012, Premera has ignored the Court's declaratory judgment that under the Mental Health Parity Act, neurodevelopmental therapies to treat DSM-IV conditions must be covered as "mental health services." The insurer continues to violate the law in two ways: (1) Premera continues to exclude coverage of neurodevelopmental therapies entirely in its contracts and coverage policies; and (2) for some limited diagnoses (including autism), the insurer covers the therapies as "rehabilitation services," not mental health services, and *lumps speech, occupational physical and massage therapies together to apply an aggregate annual visit limit cap.*

Plaintiffs ask the Court to take the following action to protect the rights of Plaintiffs K.N. and T.N. and proposed class members: *First*, the Court should order Premera to cease its application of its neurodevelopmental therapy exclusion to class

1 members and to cover neurodevelopmental therapies to treat DSM-IV conditions as  
2 "mental health services."

3           *Second*, the Court should further rule that Premera's "lump and cap"  
4 visit limits also violate the Mental Health Parity Act. This arbitrary cap is not applied  
5 generally to medical and surgical services. It has nothing to do with the medical  
6 necessity of the therapy - it is automatically imposed on medically necessary care once  
7 the arbitrary cap is reached. The "lump and cap" provision violates the plain language  
8 of the Mental Health Parity Statute. Of course, it also violates the plain language of this  
9 Court's April 26 Order:

10                           Under the Mental Health Parity Act, *Defendants must*  
11 *provide coverage for all medically necessary "mental health*  
12 *services" to the same extent as they provide coverage for*  
13 *other medical and surgical services.* Neurodevelopmental  
14 therapies are "mental health services" designed to treat  
15 autism, a mental disorder listed in the DSM-IV. Since  
16 neurodevelopmental therapies may be medically necessary to  
17 treat autism, Defendants cannot use a blanket exclusion to  
18 deny coverage for those therapies.

19 Order Granting Plaintiff's Motion for Partial Summary Judgment and Injunctive Relief  
20 and Denying Defendants' Motion to Dismiss, April 26, 2012, p. 3 (emphasis added).

21           The relief sought here is identical to that ordered by Judge Robert Lasnik  
22 in *Z.D. v. Group Health Cooperative*:

23                           In sum, the Court finds (1) that RCW 48.46.291 [Mental  
24 Health Parity Act] is effective against Group Health, (2) that  
25 neither Group Health's policies nor its practices adhere to the  
26 statute's mandates, and (3) that Plaintiffs have more than  
demonstrated a substantial likelihood of harm absent  
injunctive relief. Accordingly, the Court GRANTS Plaintiffs'  
motion for declaratory and injunctive relief under §  
1132(a)(1)(B) and (a)(3). The Court ORDERS Defendants to  
cease denying coverage for medically necessary  
neurodevelopmental therapy to treat insureds with DSM-IV-

1 TR mental health conditions simply because the insured is  
2 over six years old. Moreover, *the Court ORDERS Defendants*  
3 *to cease their application of any treatment limitations that*  
4 *are not generally "imposed on coverage for medical and*  
5 *surgical services."* RCW 48.46.291(2)(c)(i). The Court will not  
6 look kindly on failures to immediately implement its  
7 directive.

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Hamburger Decl., (10/12/12), *Exh. F, Z.D. v. Group Health Cooperative*, No. 2:11-cv-01119-RSL, Dkt. No. 77, pp. 24-25 (emphasis added).

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1 Starting July 1, 2010, all Lifewise Health Plan of Washington  
2 Individual and Family Plans are changing to comply with  
3 Washington state mental health parity laws. All current and  
4 closed plans, as well as group conversion plans will have  
5 *unlimited mental health limits*.

6 *Id.*, Exh. B; LifeWise Connections, April 2010, pp. 8-9; See also Exh. C, Premera Pulse,  
7 April 2010, p. 10 (starting July 1, 2010, both small group and individual Premera plans  
8 had "*unlimited mental health benefits*" due to final implementation of the Parity Act).

9 Premera now seeks to impose the very limits that it acknowledged were  
10 illegal on mental health services that treat neurodevelopmental mental health  
11 conditions. Premera should be ordered to immediately cease its lump and cap visit  
12 limit on medically necessary neurodevelopmental therapies to treat DSM-IV  
13 conditions. Those services must be covered as "mental health services" without any  
14 visit limits, just as Premera does for other mental health, medical and surgical services.

## 15 II. RELIEF REQUESTED

16 Plaintiffs and the class, if certified, respectfully request that the Court:

17 (1) Order Premera to immediately cease applying all visit limits to  
18 neurodevelopmental therapies to treat DSM-IV conditions, since there are no  
19 corresponding visit limitations imposed on medical and surgical services generally;

20 (2) Order Premera to immediately alter its Certificates of Coverage or  
21 contracts to (a) expressly cover medically necessary neurodevelopmental therapies to  
22 treat DSM-IV conditions as "mental health services" and (b) eliminate all exclusions  
23 and treatment limitations imposed on services to treat developmental DSM-IV  
24 conditions, where such exclusions and limitations are not generally imposed on  
25 medical and surgical services; and  
26

1 (3) Order Premera to immediately provide corrective Notice to all  
2 class members regarding its obligation to cover neurodevelopmental therapies to treat  
3 DSM-IV conditions as "mental health services."<sup>1</sup>

4 III. FACTS

5 The facts of this case have been described in detail in the Court's April 26,  
6 2012 Order and are incorporated herein by reference. The following additional facts  
7 relate to Premera's continued use of exclusions and treatment limitations on  
8 neurodevelopmental therapies to treat autism and other DSM-IV conditions after the  
9 Court's April 26, 2012 ruling:<sup>2</sup>

10 Since the Court's order, Premera has apparently processed A.G.'s  
11 neurodevelopmental therapies under the mental health benefit of his policy, without  
12 the application of any combined visit limits. Hamburger Decl. (10/12/12), ¶3. Premera  
13 has not, however, changed its policies for other affected non-ERISA insureds. See P.N.  
14 Decl., ¶13; Hamburger Decl. (10/12/12), Exhs. D and E. For example, new Plaintiffs  
15 K.N. and T.N. were never informed by Premera that neurodevelopmental therapies to  
16 treat their DSM-IV conditions would be covered as "mental health services" under  
17 their policy. P.N. Decl., ¶13. Although Premera has covered some of K.N. and T.N.'s  
18 neurodevelopmental therapy services under the rehabilitation benefit (see P.N. Decl.,  
19 ¶8), they are at risk for a "clawback" just like A.G. experienced. Moreover, Premera's  
20

21  
22 <sup>1</sup> Judge Lasnik ordered Group Health to issue a Court-approved Notice to every ERISA beneficiary,  
23 not just class members, in *Z.D. v. Group Health Cooperative*. See Hamburger Decl. (10/12/12), Exh. H, Dkt.  
24 No. 88, p. 2.

25 <sup>2</sup> After the Court's April 26, 2012 ruling, Premera moved for interlocutory appeal of the Court's  
26 Order. Hamburger Decl. (10/12/12), ¶2. Shortly thereafter, the parties engaged in protracted  
settlement negotiations, meeting together with Judge George Finkle (ret.) on three occasions, as well as  
in many more informal conversations between negotiations. *Id.* On September 27, 2012, however, the  
settlement negotiations broke down and the parties returned to actively litigating this case. *Id.*

1 denials of K.N. and T.N.'s ongoing therapies, and their administrative appeals, shows  
2 that Premera persists in treating neurodevelopmental therapies to treat DSM-IV  
3 conditions as something other than "mental health services." *Id.*

4 Premera's Certificates of Coverage in its non-ERISA plans still contain the  
5 very language that the Court ruled was void and against public policy. Plaintiffs'  
6 counsel requested copies of all contracts filed with the Office of the Insurance  
7 Commissioner (OIC) after April 26, 2012. Hamburger Decl. (10/12/12), ¶4. The  
8 policies provided by the OIC did not reflect any changes as a result of the Court's  
9 order. For example, in one individual policy provided by the OIC, Premera's illegal  
10 exclusions persist:

11 **EXCLUSIONS**

12 This section of the contract lists those services, supplies  
13 or drugs that are not covered under this plan.

14 ...

- 15 • Habilitation, education, or training services or  
16 supplies for dyslexia, for attention deficit  
17 disorders, and for disorders or delays in the  
18 development of a child's language, cognitive,  
19 motor or social skills including evaluations thereof

20 ...

21 **Learning Disorders and Neurodevelopmental Therapy**

22 Services, therapy and supplies related to the treatment of  
23 learning disorders, cognitive handicaps, dyslexia,  
24 developmental delay or neurodevelopmental disabilities.

25 *Id.*, *Exh. D*, p. 29.

26 In another non-ERISA group contract, (coverage of graduate appointees  
at the University of Washington), Premera retained all of the exclusions that this Court  
had declared illegal:

1 WHAT'S NOT COVERED

2 ...

- 3 • Habilitation, education, or training services or  
4 supplies for dyslexia, for attention deficit disorders,  
5 and for *disorders or delays in the development of a*  
6 *child's language, cognitive, motor or social skills*  
7 *including evaluations thereof.* However, this  
8 exclusion doesn't apply to treatment of  
neurodevelopmental disabilities in children age 6 and  
under as state under the Neurodevelopmental  
Therapy rider.

9 *Id.*, Exh. E, p. 26 (emphasis added).

10 Premera's actual practices haven't changed either. Just as with A.G.,  
11 Premera apparently covers some neurodevelopmental therapies to treat DSM-IV  
12 conditions (including autism) as rehabilitation services, not mental health services.  
13 When it does, it lumps the therapies together with other rehabilitative services to  
14 impose a combined cap on coverage. New Plaintiffs K.N. and T.N. are sisters, both of  
15 whom are diagnosed with autism and other developmental DSM-IV conditions. P.N.  
16 Decl., ¶¶3-4. In 2012, both submitted claims for speech and occupational therapies to  
17 Lifewise/Premera. *Id.*, ¶8. Both had their therapies covered, up to 20 combined visits,  
18 under their rehabilitation therapy benefit. *Id.*

19 But K.N. and T.N. need more therapy than just 20 visits, which ran out in  
20 April and June 2012 respectively. *Id.* Their mother appealed Premera's denial of  
21 coverage once the 20-visit limit was reached. *Id.*, ¶11, Exhs. A, B, C, and D. At both  
22 levels of internal administrative review, Premera denied coverage simply because the  
23 plan's visit limit had been reached. *Id.*, ¶12, Exhs. E, F, G, and H. Premera refused to  
24 consider the therapies to be "mental health services" - even though P.N.'s appeal was  
25 filed after this Court's Order declaring that such therapies should be covered under  
26 Premera's mental health benefit. *See id.* Premera never denied the claims based upon

1 medical necessity. The only reason provided for Premera's denial was that the plan's  
2 annual visit limit for the therapies had been reached.

3 K.N. and T.N. and the proposed class need ongoing therapy in order to  
4 improve their condition and development. See P.N. Decl., ¶10; Glass Decl., ¶¶5-9.  
5 These therapies are the essential health benefit for children with developmental  
6 disabilities and are instrumental in reducing the impact of their disabilities on their  
7 health and safety:

8 Children who need these therapies, but do not receive  
9 them (or do not receive them in a timely manner and at the  
10 required intensity) are likely to lose the opportunity to have  
11 the impact of their developmental deficits reduced to the  
12 maximum degree or, to enjoy the prospects of their  
13 development being restored to normal functioning, or at the  
14 very least, as near to normal functioning as possible. The  
15 harm attendant in the delay to provide EI [Early  
16 Intervention] services is real and substantial. Especially for  
17 the very young child, losing access to needed therapies in a  
18 timely manner can make reversible or treatable  
19 developmental conditions more severe, of greater long-term  
20 functional impact and at times, devastating, and unneeded,  
21 consequences may be seen.

22 Glass Decl., ¶8. Without the neurodevelopmental therapies provided by Cascade  
23 Children's Clinic, K.N. and T.N. continue to experience severe communication deficits  
24 and behavioral problems. P.N. Decl., ¶10.

#### 25 IV. LAW AND ARGUMENT

##### 26 A. **Premera May Not Lump and Cap Outpatient Neurodevelopmental Mental Health Services Because the Insurer Does Not Similarly Lump and Cap Outpatient Medical and Surgical Services**

The Parity Act makes that clear that visit limits are illegal if they are not  
also imposed on general medical and surgical services:

*Treatment limitations* or any *other* financial requirements on  
coverage for mental health services are only allowed if *the*

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*same limitations or requirements* are imposed on coverage for *medical and surgical services*.

RCW 48.46.291(2)(c)(i) (emphasis added). The word "other" directly modifies "treatment limitations" and reveals that the legislature intended that any such limitations be considered a form of financial requirement, such as a visit limit, age limit, or annual or lifetime financial cap.

Ending discriminatory visit limits was at the heart of the Parity Act. Historically, as the legislative Sunrise Review noted, "most health plans ... do cover mental health services but nearly all do so with limits on *visits*, days, cumulative cost, or other parameters." Hamburger Decl., (1/14/12), *Exh. H*, p. 1 (emphasis added). The Act was therefore specifically designed to require that those treatment limitations and financial limits on mental health services be the same as those generally applied to all medical and surgical services. As the Sunrise Review explained:

The requirement for parity is also broadly worded, so that it applies to both treatment limitations and various other forms of financial participation. ... For example, if there is a \$10 co-pay for office visits, the co-pay for mental health visit must not be more than \$10. In addition, *there could be no maximum number of visits on either an inpatient or outpatient basis, unless similar requirements were imposed on coverage for medical and surgical services.*

*Id.* (emphasis added). This Court agreed:

Under the Mental Health Parity Act, Defendants must provide coverage for all medically necessary "mental health services" to the same extent as they provide coverage for other medical and surgical services. Neurodevelopmental therapies are "mental health services" designed to treat autism, a mental disorder listed in the DSM-IV. Since neurodevelopmental therapies may be medically necessary to treat autism, Defendants cannot use a blanket exclusion to deny coverage for those therapies.

...

1            *Defendants shall review any new claims* submitted by  
2            Plaintiff A.G. and/or his providers *for neurodevelopmental*  
3            *therapy as a mental health benefit* and consistent with all  
4            other provisions in Plaintiff A.G.'s contract, including  
5            medical necessity

6            April 26, 2012 Order pp. 3, 8 (emphasis added). Thus, no treatment limitations,  
7            including visit limits, can be imposed on neurodevelopmental therapies to treat DSM-  
8            IV conditions, if such limits are not imposed on medical and surgical services  
9            generally.

10            This is not news to Premera. Premera understood that full  
11            implementation of the Parity Act would eliminate all visit limits imposed on mental  
12            health services. Premera removed visit limits from its large group plans in November  
13            2009. *See* Hamburger Decl. (10/12/12), *Exh. C*, p. 10. It removed all visit limits from its  
14            mental health benefits in small group and individual plans in July 1, 2010. *Id.*; *see also*  
15            *id.*, *Exh. C*, pp. 8-9. The sole reason given for these changes was "to comply with  
16            Washington state mental health parity laws." *Id.* Even in this litigation, Premera  
17            conceded that the state Parity Act requires the elimination of treatment limitations  
18            where such services are not imposed on medical and surgical services generally:

19            The Parity Act was first enacted in 2005, but did not include  
20            individual health plans until 2007. 2007 Laws, ch. 8. The Act  
21            requires plans that cover medical and surgical services to also  
22            provide coverage for "mental health services" to individuals  
23            diagnosed with a condition listed in DSM-IV (*sic*). The Parity  
24            Act mandates this coverage in phases. For plans issued or  
25            renewed after January 1, 2008, the Act generally requires only  
26            that the co-pay for mental health services be no more than the  
             co-pay for medical and surgical services. RCW 48.44.341  
             (2)(b)(ii). *For plans issued or renewed after July 1, 2010, the*  
             *Act also requires that treatment limitations on coverage for*  
             *mental health services be the same as those imposed on*  
             *coverage for medical and surgical services.* RCW 48.44.341  
             (2)(c)(i).

1 Premera's Mot. to Dismiss, (10/5/11), pp. 6-7 (emphasis added).

2 This exact issue was addressed by Judge Lasnik in *Z.D. v. Group Health*  
3 *Cooperative* when he rejected Group Health's age-limit for coverage of  
4 neurodevelopmental therapies to treat DSM-IV conditions. In that case, Group Health  
5 provided coverage of neurodevelopmental therapies, but only up to age 6. All  
6 coverage after age 6 was excluded. Judge Lasnik determined that the age-limitation  
7 was an impermissible treatment limit because it was not imposed on medical and  
8 surgical services generally:

9 In short, the clause precludes Group Health from imposing  
10 precisely the sort of *tailored limitations at issue here*—  
11 limitations that would defeat the very purpose of the statute:  
12 providing coverage.

13 In sum then, the Court finds that RCW 48.46.291(2)(c)(i)  
14 requires Group Health to provide coverage for "medically  
15 necessary outpatient and inpatient services provided to treat  
16 mental disorders covered by the diagnostic categories listed  
17 in the most current version of the diagnostic and statistical  
18 manual of mental disorders, published by the American  
19 psychiatric association," with those limited exceptions set  
20 forth in the statute, RCW 48.46.291(1). And it finds that the  
21 *final clause of subsection (c)(i) only further precludes Group*  
22 *Health from imposing treatment limitations it does not*  
23 *generally "impose[] on coverage for medical and surgical*  
24 *services."* RCW 48.46.291(2)(c)(i).

25 Hamburger Decl. (10/12/12), *Exh. F*, pp. 22-23 (emphasis added).

26 This is not a close question. The Parity Act prevents Premera from  
imposing visit limits on mental health services, including neurodevelopmental  
therapies to treat DSM-IV conditions, since it does not impose visit limits on medical  
and surgical services generally. Despite the clear prohibition, Premera now singles out  
just one type of mental health therapy for visit limits - neurodevelopmental therapy -

1 which is the predominant therapy to treat developmentally disabled enrollees. It is the  
2 essence of discrimination. It is precisely what the Parity Act prohibits.

3 **B. Premera May Not Impose Visit Limits Simply Because It Also**  
4 **Imposes Visit Limits on Rehabilitation Services**

5 Premera may claim that it can impose a visit limit on a subset of mental  
6 health services -- neurodevelopmental therapies to treat DSM-IV conditions -- because  
7 it imposes a similar visit limit on rehabilitation therapies. Of course, Group Health  
8 made - and lost -- this argument when it asked Judge Lasnik to approve its age limit  
9 for neurodevelopmental therapies. In *Z.D.*, Group Health claimed that it could impose  
10 an age limit on all neurodevelopmental therapies, whether provided to treat DSM-IV  
11 conditions or medical conditions, because the age limit applied the same to both  
12 medical or mental health conditions. *Id.*, *Exh. F*, p. 21 ("They contend that because  
13 Group Health essentially excludes all non-restorative "rehabilitative therapies related  
14 to medical and surgical services," it may similarly exclude all coverage for similar non-  
15 restorative mental health or neurodevelopmental disorders.").

16 The *Z.D.* court rejected Group Health's attempt to use a special parity  
17 "comparator" just for neurodevelopmental therapy services to treat DSM-IV  
18 conditions. Judge Lasnik concluded that the Parity Act's regulation of treatment limits  
19 was designed to "preclude[ ] Group Health from imposing precisely the sort of  
20 *tailored limitations at issue here.*" *Id.*, p. 22 (emphasis added). The Court continued  
21 that such limitation "would defeat the very purpose of the statute: providing  
22 coverage." *Id.*

23 [B]ecause Group Health does not exclude individuals over  
24 the age of six from coverage for medical and surgical services  
25 or even impose an age-based limitation on its therapy  
26 coverage in general, it may not impose that limitation on  
non-restorative mental health therapy coverage.

1 *Id.*, pp. 22-23. Premera's visit limits for neurodevelopmental mental health services  
2 violate the Parity Act in the exact same manner.

3           The Parity Act unambiguously prohibits treatment limitations for all  
4 "mental health services" if a health benefit plan does not similarly limit "coverage for  
5 medical and surgical services." RCW 48.46.291(2)(c)(i) (emphasis added). As the  
6 Senate Bill Report explained, "Beginning January 1, 2010: ... treatment limitations or  
7 any other financial requirements on coverage for mental health services are only  
8 allowed if the *same limitations* or requirements are imposed on coverage for medical  
9 and surgical services." Hamburger Decl. (10/12/12), *Exh. G*, p. 2 (emphasis added).  
10 The mandate is not linked to any specific medical or surgical benefit, but to the  
11 existence of those services generally. If Premera does not impose a visit limit on  
12 coverage for outpatient medical services and surgical services generally -- which it  
13 does not--then it is prohibited from imposing such a visit limit on any outpatient  
14 mental health service, even neurodevelopmental mental health services.

15           Washington's Parity Act is consistent with the federal Mental Health  
16 Parity Act, which likewise requires that any exclusions imposed on a mental health  
17 service be applied to "substantially all" medical and surgical benefits. *See* 29 U.S.C. §  
18 1185a (a)(3); *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health*  
19 *Parity and Addiction Equity Act of 2008*, 75 FR 5410-01, p. 5413 ("[A]ny treatment  
20 limitations applied to mental health or substance use disorder benefits may be no more  
21 restrictive than the *predominant treatment limitations applied to substantially all*  
22 *medical/surgical benefits.*") (emphasis added); 26 C.F.R. § 54.9812-1T(b)(plans may not  
23 impose limits on mental health services if those limits do not also apply to at least two-  
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1 thirds of all medical and surgical benefits).<sup>3</sup> The Washington Parity Act is also  
2 consistent with that of other states. *See e.g., Harlick v. Blue Shield of California*, 686 F.3d  
3 699, 711-12 (9th Cir. 2012) (California’s Parity Act requires health insurers to apply the  
4 same financial conditions that are applied to coverage for physical illnesses generally  
5 to covered mental conditions).

6 Using general medical and surgical services as the comparator for parity  
7 prevents disparate impacts, such as where (as here) a specific benefit is primarily – but  
8 not exclusively – utilized to treat persons with mental health conditions. The  
9 requirement prevents insurers from gaming true parity by selecting the “skinniest”  
10 medical/surgical benefit as the comparator. *See* 75 FR 5410-01, 5412 (February 2, 2010)  
11 (“This requirement is included to ensure that a plan does not misclassify a benefit in  
12 order to avoid complying with the parity requirements.”). That is why the federal Act,  
13 like Washington’s Parity Act, forbids limiting parity to a comparison between one  
14 single type of mental health service and another type of medical service.

15 The result, an effective prohibition on visit limits in mental health, is the  
16 “largest benefit” associated with the federal Parity Act. *Id.*, p. 5422. The regulators  
17 explained that the federal Act’s use of broad categories of medical and surgical services  
18 for the parity comparison was designed to add substantial “teeth” to the 1996 Parity  
19 Act:

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23 <sup>3</sup> Premera admits that it must comply with the federal Mental Health Parity and Addiction Equity  
24 Act Parity Act’s requirements for its group plans covering 51 or more enrollees, including many of the  
25 class members in this case. Hamburger Decl., *Exh. C*, p. 10 (“Since November of 2009, Premera group  
26 plans for 51 or more employees ... have unlimited mental health and chemical dependency benefits at  
enrollment or renewal to comply with this legislation”); *see also* 26 C.F.R. § 54.9812-IT (e). As a matter of  
both state and *federal law*, Premera cannot impose visit limits on neurodevelopmental mental health  
services in its large group plans.

1 [A] major shortcoming of [the prior federal Mental Health  
2 Parity Act of 1996] was its failure to apply parity to visit  
3 limitations. *Applying parity to visit limitations will help*  
4 *ensure that vulnerable populations -- those accessing*  
5 *substantial amounts of mental health and substance use*  
6 *disorder services -- have better access to appropriate care. ...*  
7 The most common visit limits under current insurance  
8 arrangements are those for 20 visits per year. That means  
9 assuming a minimal approach to treatment of one visit per  
10 week, people with severe and persistent mental disorders  
11 will exhaust their coverage in about five months. This often  
12 results in people foregoing outpatient treatment and a higher  
13 likelihood of non-adherence to treatment regimes that  
14 produce poor outcomes and the potential for increased  
15 hospitalization costs.<sup>4</sup>

16 *Id.* (emphasis added).

17 That is exactly what happened to K.N. and T.N. Both are diagnosed with  
18 autism, a severe, life-long disorder for which the only evidence-based, effective  
19 treatment is early, intensive intervention. Such intensive interventions are designed to  
20 quickly return children with autism to a normal or as near normal developmental  
21 trajectory as possible at the time in their lives when such recovery is possible. Glass  
22 Decl., ¶8. Timely and adequate speech and occupational therapy are a critical  
23 component of this early intervention approach. *Id.*, ¶¶6-8.

24 Both K.N. and T.N. received speech and occupational therapies 2012 that  
25 were covered by Premera. P.N. Decl., ¶8. Coverage for those therapies, however, was  
26 exhausted by April for K.N. and June for T.N. *Id.* Without continued therapy, their  
progress slowed. *Id.* ¶10. When Premera's plan covers only 20 combined visits,

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24 <sup>4</sup> The federal Department of Health and Human Services found that requiring parity of visit limits  
25 would likely reduce out-of-pocket expenses for services that were needed but not covered, thereby  
26 reducing bankruptcy, financial distress for families, cost-shifting of those services to the public sector,  
and increase productivity of persons with mental disorders at work, as well as the quality of mental  
health care provided. 75 FR 5410-01, pp. 5422-5423.

1 Premera effectively denies most coverage of the essential treatment for children with  
2 autism such as K.N. and T.N. This Court should not countenance a visit limit on  
3 neurodevelopmental mental health therapies when Premera does not generally limit  
4 visits for medical or surgical services or even for other mental health services.

5 **C. The Court Should Issue a Permanent Injunction Against Premera to**  
6 **Eliminate All Exclusions and Limitations Imposed on Coverage for**  
7 **Neurodevelopmental Mental Conditions**

8 An injunction is appropriate where a plaintiff does not have a plain,  
9 complete, speedy and adequate remedy at law. *Kucera v. State, Dept. of Transp.*, 140  
10 Wn.2d 200, 209, 995 P.2d 63 (2000). If that is the case, the plaintiff must "demonstrate  
11 that (1) he has a clear legal or equitable right, (2) he has a well-grounded fear of  
12 immediate invasion of that right, and (3) that the acts he is complaining of have or will  
13 result in actual and substantial injury." *DeLong v. Parmelee*, 157 Wn. App. 119, 150-51,  
14 236 P.3d 936, 951-52 (2010).

15 A permanent injunction may be issued when all parties have notice that  
16 the trial on the merits related to the injunctive relief sought will be advanced and  
17 consolidated with the hearing. CR 65 (a)(2); *Nw. Gas Ass'n v. Washington Utilities &*  
18 *Transp. Comm'n*, 141 Wn. App. 98, 113, 168 P.3d 443 (2007). That is exactly what  
19 occurred in *Z.D. v. Group Health Cooperative*. After extensive briefing and argument,  
20 Judge Lasnik issued a permanent injunction against Group Health, ordering the insurer  
21 to cease applying *all treatment limitations* on neurodevelopmental mental health  
22 services, since there were no similar limitations generally imposed on medical and  
23 surgical services. See Hamburger Decl. (10/12/12), *Exh. F*, pp. 24-25. This Court  
24 should do so as well. All of the factors for permanent injunctive relief are met.

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1. Plaintiffs K.N. and T.N. and the Proposed Class Have No Speedy, Adequate Remedy at Law

Plaintiffs K.N. and T.N. are entitled to legal relief arising out of Premera's wrongful denial of coverage for their neurodevelopmental mental health services. Those claims include reimbursement for treatment that Plaintiffs and proposed class members have paid out-of-pocket. Legal relief, however, is far from adequate. Plaintiffs K.N. and T.N. have been without speech and occupational therapy treatment since May and July 2012, respectively. Their parents cannot afford to pay for these services and wait for monetary relief. P.N. Decl., ¶9. This precise problem was identified by the Department of Health:

Many children with ASD go without necessary treatments and services because the costs are so high and insurance coverage is not generally available. Many families simply cannot afford to pay for the necessary early, intensive treatments.

Hamburger Decl., (1/14/12), *Exh. C*, p. 10. Premera could have implemented the Court's declaratory order without further judicial action, but it has not done so. Permanent injunctive relief is required to ensure that all non-ERISA enrollees receive access to neurodevelopmental therapies, just like as A.G. has.

2. Clear Legal Right

As demonstrated above and as determined by this Court in its April 26, 2012 Order, Plaintiffs and the proposed class have a clear legal right to medically necessary neurodevelopmental therapies to treat their DSM-IV conditions. Those therapies must be covered as "mental health services" under their Premera contracts, and covered, when medically necessary, without visit limits, so long as Premera does not impose visit limits on medical and surgical services generally.

1                   3.     Premera's Actions Invade The Legal Rights of Plaintiffs  
2                                   and the Proposed Class

3                   Premera's ongoing refusal to cover neurodevelopmental therapies to treat  
4     DSM-IV conditions as "mental health services" and its application of illegal contract  
5     exclusions and limitations is an invasion of their legal rights. See Hamburger Decl.  
6     (10/12/12), *Exh. F*, p. 24 ("It thus appears that both Defendants' policies and its  
7     practices do not favor Plaintiffs' chances of obtaining the coverage to which she is  
8     entitled absent an injunctive order").

9                   4.     Actual and Substantial Injury/Irreparable Harm

10                  As this Court found on April 26:

11                  The loss of speech and occupational therapy services will  
12                  harm Plaintiff A.G.'s health and continued development. See,  
13                  e.g., *LaForest v. Former Clean Air Holding Co., Inc.*, 376 F.3d 48,  
14                  55 (2d Cir. 2004). Money damages are insufficient to  
15                  compensate A.G. for the resulting developmental loss. See  
16                  *Washington Fed'n of State Employees (WSFE), Council 28, AFL-*  
                    *CIO v. State*, 99 Wn. 2d 878, 891, 665 P.2d 1337 (1983) (It is  
                    "well nigh irrefutable" that a cancellation of health insurance  
                    is an injury that has no remedy at law).

17     Order, p. 7. The harm suffered by A.G. when his speech and occupational therapy  
18     services were threatened, is the same harm currently suffered by Plaintiffs K.N., T.N.  
19     and the proposed class. All either face or already suffer irreparable harm from the loss  
20     of medically necessary neurodevelopmental therapies to treat their DSM-IV conditions.

21                  Dr. Glass confirms that actual and substantial harm is inflicted on the  
22     class the longer they wait for coverage of medically necessary neurodevelopmental  
23     mental health services. With timely services, children are less disabled, have fewer  
24     long-term care needs, and may avoid costly, complex and risk-laden treatment or  
25     procedures. Glass Decl., ¶9. Without the services, children with conditions *that could*  
26     *have been reversed or treated*, end up more impaired, with greater long-term functional

1 disabilities, and, at times, experiencing devastating and avoidable consequences. *Id.*,  
2 ¶8.

3  
4 V. CONCLUSION

5 Despite the Court's April 26, 2012 Order, Premera continues to  
6 systematically impose exclusions and limitations that deny coverage of medically  
7 necessary neurodevelopmental therapies to treat DSM-IV conditions. Premera's visit  
8 limits are as illegal as its developmental disability exclusion. The Court should  
9 permanently enjoin Premera from applying exclusions and visit limitations to  
10 neurodevelopmental mental health services because it does not apply the same  
11 exclusions and limitations to medical and surgical services.

12 DATED: October 12, 2012.

13 SIRIANNI YOUTZ SPOONEMORE

14 /s/ Eleanor Hamburger

15 Eleanor Hamburger (WSBA #26478)

16 Richard E. Spoonemore (WSBA #21833)

17 Attorneys for Plaintiffs  
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CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on October 12, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

Barbara J. Duffy	<input checked="" type="checkbox"/>	By United States Mail
Gwendolyn C. Payton	<input type="checkbox"/>	By Legal Messenger
Ryan P. McBride	<input checked="" type="checkbox"/>	By Email
LANE POWELL PC		Tel. 206.223.7000
1420 Fifth Avenue, Suite 4100		<a href="mailto:duffy@lanepowell.com">duffy@lanepowell.com</a>
Seattle, WA 98101		<a href="mailto:payton@lanepowell.com">payton@lanepowell.com</a>
<i>Attorneys for Defendants</i>		<a href="mailto:mcbri@lanepowell.com">mcbri@lanepowell.com</a>

DATED: October 12, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger  
Eleanor Hamburger (WSBA #26478)

# Exhibit C

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HON. MICHAEL J. TRICKEY  
Noted for Hearing: November 9, 2012 at 9:30 a.m.  
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G., and K.N. and T.N., by and through their parents P.N. and L.N., each on his or her own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON, Washington corporations,  
Defendants.

NO. 11-2-30233-4 SEA

DECLARATION OF  
ELEANOR HAMBURGER

I, Eleanor Hamburger, declare under penalty of perjury and in accordance with the laws of the State of Washington that:

1. I am a partner at Sirianni Youtz Spoonemore and am one of the attorneys for plaintiff in this action.

2. After this Court granted Plaintiff's Motion for Partial Summary Judgment and Preliminary Injunction as to Plaintiff A.G., defendants moved for interlocutory appeal of the Court's Order. Shortly thereafter, the parties engaged in settlement discussions, mediated by Ret. Judge George Finkle. The parties met three times and engaged in a number of informal conversations. On September 27, 2012, however, the settlement negotiations broke down.

3. Since the Court's Order, A.G.'s claims for neurodevelopmental therapies have been covered by defendants. Premera has not applied visit limits to A.G.'s neurodevelopmental therapies.

1                   4.     I submitted a public disclosure request to the Washington Office of  
2 the Insurance Commissioner for copies of all certificates of coverage or contracts filed  
3 with the regulator since this Court's April 26, 2012 Order. *Exhibits D* and *E* below are  
4 two of the documents I received as a result of the request.

5                   5.     Attached are true and correct copies of the following documents,  
6 with underlining where appropriate for the Court's convenience:

Exhibit	Description
A	LifeWise Washington Individual Contract Endorsement dated July 1, 2010.
B	"LifeWise Connections" dated April 2010, found at <a href="https://www.lifewisewa.com/lwwa/groups/public/documents/xcpproject/b_comm_bulletins.asp">https://www.lifewisewa.com/lwwa/groups/public/documents/xcpproject/b_comm_bulletins.asp</a> (10/12/12).
C	"Premera Pulse" dated April 2010, found at <a href="https://www.premera.com/stellent/groups/public/documents/xcpproject/bwa_bulletins.asp">https://www.premera.com/stellent/groups/public/documents/xcpproject/bwa_bulletins.asp</a> (10/12/12).
D	LifeWise Health Plan of Washington, WiseEssentials 6 (\$1,880 Deductible) for Individuals and Families Residing in Washington, obtained from the Washington Office of the Insurance Commissioner (10/9/12).
E	Policy Specification, University of Washington Policy No. GAIP UW (06-2012), for Policy Coverage Dates Oct. 1, 2012-Sept. 2013, obtained from the Washington Office of the Insurance Commissioner (10/11/12).
F	Order Granting Plaintiffs' Motions for Summary Judgment in <i>Z.D., et al. v. Group Health Cooperative, et al.</i> (U.S. District Court for the Western District of Washington at Seattle, No. C11-1119RSL), dated June 1, 2012.
G	Senate Bill Report, SHB 1154, March 3, 2005.
H	Order Approving Substance of Proposed Class Notice, Requiring Direct Mail Delivery in <i>Z.D., et al. v. Group Health Cooperative, et al.</i> (U.S. District Court for the Western District of Washington at Seattle, No. C11-1119RSL), dated July 6, 2012.

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I declare under penalty of perjury of the laws of the State of Washington  
and the United States of America that the foregoing is true and correct.

DATED: October 12, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger  
Eleanor Hamburger (WSBA #26478)



# EXHIBIT A

P.A. 000041



## Washington Individual Contract Endorsement

Applies to the following LifeWise of Washington individual health care plans:

WiseChoices 0/20 Plan, Form #016809(01-2007)  
WiseChoices 0/30 Plan, Form #016988(01-2007)  
WiseChoices 20 Plan, Form #016812(01-2007)  
WiseChoices 30 Plan, Form #016989(01-2007)  
WiseSavings 20 Plan, (\$1,820 Deductible), Form #017968(07-2007)  
WiseSavings 20 Plan, (\$3,000 Deductible), Form #016990(01-2007)  
WiseSimplicity Plan, (\$10,000 Deductible), Form #019829(06-2009)  
WiseChoices Prime Plan, (\$1,500 Deductible), Form #020881 (08-2009)  
WiseChoices Prime Plan, (\$3,000 Deductible), Form #020884 (08-2009)

Dear Subscriber:

This contract endorsement describes changes to your LifeWise individual health care contract.

Mental Health Care benefits of your plan will be revised to comply with the new state requirements for equivalent benefits for mental health care treatment. Under this law, member cost-sharing requirements (deductibles, copays, and coinsurance), benefit limits, including network restrictions, may not be more restrictive than the common or most frequent cost-sharing requirements, benefit limits, or network restrictions that apply to medical or surgical benefits.

This individual contract endorsement is effective July 1, 2010.

The contract has been revised as follows:

### ■ Mental Health Care

Effective July 1, 2010 your contract is amended to reflect coverage for Mental Health Care services as stated above. Benefits for Mental Health Care will be subject to the same calendar year deductible, coinsurance or copays as you would pay for inpatient services and outpatient visits for other covered medical conditions and do not have an annual or separate benefit limit.

The following sections of your contract have been revised.

Under the "Summary of Benefits" section and "Benefits With Annual Maximums" subsection, we have deleted the following:

Mental Health Care.	Inpatient: Up to 6 days per calendar year
	Outpatient: Up to 6 visits per calendar year.

Under the "Specific Benefits" section we have deleted and replaced the Mental Health benefit as follows:

#### Inpatient Services

See Hospital Inpatient Care for benefits for inpatient treatment.

#### Outpatient Professional Visits

See Professional Visits for benefits for office visits.

Benefits for treatment of a mental health condition including treatment of eating disorders (such as anorexia

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P.A. 000042

nervosa, bulimia or any similar condition), are covered on the same basis as other covered medical services and are provided as shown below. Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice. Benefits for covered Mental Health Care services are not subject to an annual benefit limit.

Covered services must be furnished by one of the following types of providers:

- Hospital
- Washington state-licensed community mental health agency
- Licensed Physician (M.D. or D.O.)
- Licensed Psychologist (Ph.D.)
- Any other provider listed under the definition of "Provider" (please see the "Definitions" section in this contract) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license

Covered services may also be furnished by a state hospital operated and maintained by the State of Washington for the care of the mentally ill.

**This benefit doesn't cover:**

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment

#### **Mental Health Services And Your Rights**

LifeWise and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you want a more detailed description of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact LifeWise at one of the following telephone numbers:

Local and toll-free number: 1-800-592-6804

Local and toll-free TDD number for the hearing-impaired: 1-800-842-5357

If you want to know more about your rights under the law, or if you think anything you received from us may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 360-236-4010."

**All other provisions of your contract remain unchanged. This contract endorsement forms a part of your contract. It should be kept with your contract for future reference.**

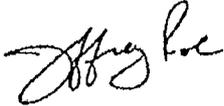
DEF0000082

P.A. 000043

If you have any questions regarding the information contained in this contract endorsement, please contact our Customer Service Department:

Toll Free: 1-800-592-6804  
Hearing Impaired TDD 1-800-842-6357

LifeWise Health Plan of Washington



Jeffrey Roe  
President and Chief Executive Officer  
LifeWise Health Plan of Washington

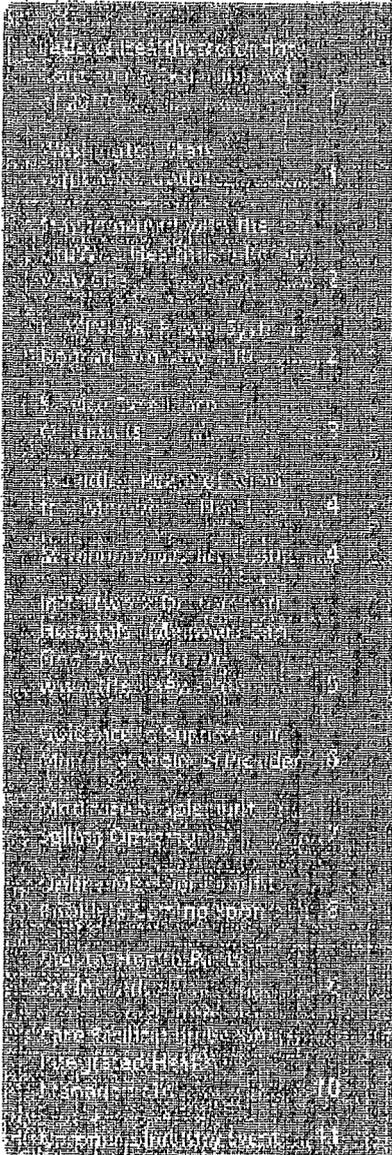
ENDORSEMENT

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P.A. 000044

# EXHIBIT B

P.A. 000045



## Federal Healthcare Update: Continuing Extension Act of 2010

On April 15, President Obama signed into law H.R. 4851, the *Continuing Extension Act of 2010* which extends the eligibility period for the COBRA premium subsidy to May 31, 2010. The previous extension expired on March 31. The COBRA premium subsidy program was originally created in the American Recovery and Reinvestment Act (ARRA) in February 2009 and extended in subsequent legislation. It provides a 65% premium subsidy for COBRA continuation coverage for 15 months.

The COBRA subsidy program is extended to individuals who were involuntarily terminated from September 1, 2008 through May 31, 2010. It also clarifies that existing rules and requirements apply for individuals who had a qualifying event of an involuntary termination on or after April 1, 2010 through April 15 (prior to enactment of this law).

The law also defers the 21% Medicare physician payment cuts to May 31, 2010. ■

## Washington State Legislative Update

The March edition of LifeWise CONNECTIONS included a summary of the 2010 Washington State regular legislative session, along with bills that passed and were signed into law by Governor Gregoire. On March 15, the Governor called the legislature into a special session to last no longer than 30 days. The following is a summary of that session and the bills that were signed into law by the Governor.

### Special Session

The Washington State Legislature adjourned its special session April 12. This 28-day special session was called by the Governor to continue work and finalize the budget. The budget was finalized with a tax proposal that would generate the almost \$800 million in revenue needed to balance the 2010 biennium budget.

### Legislation

Below is a list of legislation addressed by the Governor during the special session.

**SSB 6280 - East Asian Medicine** modifies state professional designation of acupuncturist to East Asian Medicine practitioner. Governor signed on April 1, 2010.

**ESSB 6538 - Definition of Small Group or Small Employer** for insurance purposes is changed to a group that has between one and 50 employees contingent on federal reform legislation being signed into law and confirmed by the Insurance commissioner (Effective September 29th, 2010, as certified by the Insurance Commissioner). Defines census date for purposes of calculating small group rates. (Effective January 1, 2011). Governor signed on April 1, 2010.

(more next page)

### Online Member Benefits Coming Soon

LifeWise group plans will soon have administrative costs and support the plan. LifeWise Health Plan of Washington members will soon have access to their benefits and plan information on [www.lifewise-wa.com](http://www.lifewise-wa.com). Starting in June 2010, all LifeWise Health Plan members will have electronic access to their benefits and plan information on [www.lifewise-wa.com](http://www.lifewise-wa.com).

Once the website is up and running, members will be able to follow these steps to access their information:

1. Go to [www.lifewise-wa.com](http://www.lifewise-wa.com).

2. Click on "Member Information".

3. On the "My Account" page, click on "My Information". Look for the "My Benefits" link and click on it.

4. Click on "My Benefits" and click on "View My Benefits".

5. The website will display your benefits information in a searchable format, and you will be able to view your benefits and plan information of their health on [www.lifewise-wa.com](http://www.lifewise-wa.com).

6. You will be able to view your benefits information in a searchable format, and you will be able to view your benefits and plan information of their health on [www.lifewise-wa.com](http://www.lifewise-wa.com).

If you have any questions, please contact the Health Plan of Washington at [www.lifewise-wa.com](http://www.lifewise-wa.com).

### Mental Health Parity for Individuals

The Federal Mental Health Parity and Addiction Equity Act of 2008 requires health plans offering mental health or substance use disorder benefits to provide financial requirements or treatment limitations that are no more restrictive than the most common or frequent limitations that apply to medical and surgical benefits. Since November of 2009, LifeWise group plans for 51 or more employees in Clark County have unlimited mental health and chemical dependency benefits at enrollment or renewal, to comply with this legislation.

Starting July 1, 2010, all LifeWise Health Plan of Washington Individual & Family plans are changing to comply with Washington state mental health parity laws. All current and closed plans, as well as group conversion plans will have unlimited mental health limits. In most cases, the mental health cost shares for these plans will remain as they are today. Three plans will change effective July 1 with regard to cost shares for the outpatient benefits. See the table on the following page for details.

(more next page)



continued:  
Mental Health Parity  
 for Individuals

Plan	Current Mental Health Cost Shares	New Mental Health Cost Shares
WiseEssentials Rx	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - Deductible waived, then 25%</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - Deductible waived first 6 visits PCY then coinsurance (25%), with subsequent visits subject to deductible then coinsurance (25%)</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>
WiseEssentials Copay	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - \$25 copay;</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - Deductible waived first 3 visits PCY then copay (\$25), with subsequent visits subject to deductible then coinsurance (25%)</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>
WiseEssentials 25 (CLOSED)	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - Deductible waived then 25%</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>	<p>In-Network:                      Inpatient - Deductible, then 25%                      Outpatient - Deductible waived first 6 visits PCY then coinsurance (25%), with subsequent visits subject to deductible then coinsurance (25%)</p> <p>Out-of-Network:                      Inpatient and Outpatient – subject to out-of-network deductible and coinsurance</p>

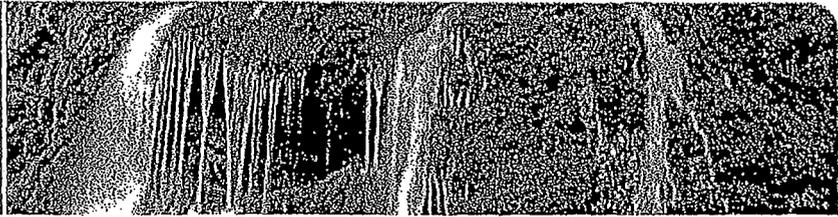
Members will receive an endorsement mailing in late May to notify them of these changes. A sample copy of the endorsement is included with this bulletin.

If you have questions, please contact your LifeWise Health Plan of Washington sales representative. ☒



# EXHIBIT C

P.A. 000049



April 2010

Federal Healthcare Update  
Continuing Extension Act  
of 2010 ..... 1

Washington State  
Legislative Update ..... 1

Stay Informed with the  
Premera Healthcare Reform  
Web Site ..... 2

REMINDER: Power System  
Upgrade on May 7-10 ..... 2

Service Excellence -  
Q1 Results ..... 3

Providing Peace of Mind  
to a Member in Need ..... 4

Memorial Day Office Closure ... 4

In-Network Doctors and  
Hospitals - Members Can  
Find Them Fast on  
www.premera.com ..... 5

Guidance to Support our  
Members' Choice of Provider .... 6

Medicare Reporting  
Requirements for Premera  
Employer Groups ..... 8

Updated Medigap Policy  
Guide Now Available ..... 9

Mental Health Parity for  
Small Groups & Individuals 10

(more next page)



## Federal Healthcare Update: Continuing Extension Act of 2010

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The COBRA subsidy program is extended to individuals who were involuntarily terminated from September 1, 2008 through May 31, 2010. It also clarifies that existing rules and requirements apply for individuals who had a qualifying event of an involuntary termination on or after April 1, 2010 through April 15 (prior to enactment of this law).

The law also defers the 21% Medicare physician payment cuts to May 31, 2010. ❏

## Washington State Legislative Update

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### Special Session

The Washington State Legislature adjourned its special session April 12. This 28-day special session was called by the Governor to continue work and finalize the budget. The budget was finalized with a tax proposal that would generate the almost \$800 million in revenue needed to balance the 2010 biennium budget.

### Legislation

Below is a list of legislation addressed by the Governor during the special session.

**SSB 6280 - East Asian Medicine** modifies state professional designation of acupuncturist to East Asian Medicine practitioner. Governor signed on April 1, 2010.

**ESSB 6538 - Definition of Small Group or Small Employer** for insurance purposes is changed to a group that has between one and 50 employees contingent on federal reform legislation being signed into law and confirmed by the Insurance commissioner (Effective September 29th, 2010, as certified by the Insurance Commissioner). Defines census date for purposes of calculating small group rates. (Effective January 1, 2011). Governor signed on April 1, 2010.

(more next page) 1

## Mental Health Parity for Small Groups and Individuals

The Federal Mental Health Parity and Addiction Equity Act of 2008 requires health plans offering mental health or substance use disorder benefits to provide financial requirements or treatment limitations that are no more restrictive than the most common or frequent limitations that apply to medical and surgical benefits. Since November of 2009, Premera group plans for 51 or more employees in Clark County have unlimited mental health and chemical dependency benefits at enrollment or renewal, to comply with this legislation.

Starting July 1, 2010, all Premera Blue Cross Individual & Family plans and Small Group plans with 2-50 employees are changing to comply with Washington state mental health parity laws.

### Small Group

The Premera Balance and the Premera Value plans have been changed to provided unlimited mental health benefits. The benefit cost shares remain the same. Sales Materials have been updated and contract booklets will be issued as groups enroll or renew their coverage.

### Individual & Family

Changes will take effect for individual and family members on July 1 as part of the annual renewal. All Heritage plans and group conversion plans will have unlimited mental health benefits. The mental health benefit cost shares remain the same.

Members will receive an endorsement mailing in late May to notify them of these changes. A sample of the endorsement is included with this bulletin.

If you have questions, please contact your Premera Blue Cross sales representative. ☒



24-Hour  
NurseLine

Remind your clients that they can get answers to their questions free and quickly. In-network and out-of-network. By calling the Premera Blue Cross 24-Hour NurseLine at 1-800-361-8349.

PREMERA | 

BLUE CROSS  
An Independent Licensee of the Blue Cross Blue Shield Association

## Online Member Benefit Booklets for Individual and Medicare Supplement Coming Soon

As part of our ongoing campaign to manage administrative costs and support the environment, Premera Blue Cross Individual and Medicare Supplement members will soon have access to their benefit booklet online at [www.premera.com](http://www.premera.com). Starting June 1, all Individual & Family plan members and Medicare Supplement members with a June 1 or later effective date will have electronic access to their booklets in the secure member section of the Premera web site.

Once the booklets are released online, members will be able to follow these easy steps to access their information:

- Log in to the member web site at [www.premera.com](http://www.premera.com).
- Click on "My Plan Information."
- On the "Overview" tab, under "Personal Information" look for the open book icon with Current Plans listed below.
- Choose PDF to open, view, and print.

This 24/7 access to their personal information, in a simple, searchable format, allows members to manage their benefits and take charge of their health on their own schedule.

By January, electronic booklets will be the default distribution method. Members will have the option of requesting a paper copy.

If you have questions, please contact your Premera Blue Cross individual sales representative. ■

# EXHIBIT D

P.A. 000053



# LifeWise Health Plan of Washington

## WiseEssentials 6 (\$1,880 Deductible)

For Individuals And Families Residing in Washington

**PLEASE READ THIS CONTRACT CAREFULLY** This is a contract between the subscriber and LifeWise Health Plan of Washington and shall be construed in accordance with the laws of the State of Washington. Please read this contract carefully to understand all of your rights and duties and those of LifeWise Health Plan of Washington.

**GUARANTEED RENEWABILITY OF COVERAGE** Coverage under this contract will not be terminated due to a change in your health. Renewability and termination of coverage are described under the **ELIGIBILITY, ENROLLMENT AND TERMINATION** section of this contract.

In consideration of timely payment of the full subscription charge, LifeWise Health Plan of Washington agrees to provide the benefits of this contract subject to the terms and conditions appearing on this and the following pages, including any endorsements, amendments, and addenda to this contract which are signed and issued by LifeWise Health Plan of Washington.

LifeWise Health Plan of Washington has issued this contract at Mountlake Terrace, Washington.

Jeffrey Roe  
President and Chief Executive Officer  
LifeWise Health Plan of Washington

### PORTABILITY NOTICE

This health care plan is a "catastrophic health plan" as defined by Washington State law. A catastrophic health plan may not be portable if you later enroll on another individual health plan. "Portable" means that you will receive credit for a plan's pre-existing condition waiting period based on prior coverage. Catastrophic health plans generally are not portable, and by enrolling on this plan, you may lose portability rights.

### YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

If, after examining this contract, you are not satisfied with it for any reason, you may return it to LifeWise Health Plan of Washington or the producer through whom it was purchased, within ten days of delivery for a full refund of your subscription charge payment. We will consider the date of delivery to be five days from the postmark date. We will refund your payment within 30 days of the date that LifeWise Health Plan of Washington or our producer received the returned contract, or we will pay an additional ten percent penalty which will be added to your refund. If you return this contract within the ten-day period, it will be void and considered as never effective. We reserve the right to recover any benefits paid by us prior to such action, and deduct such amounts from the subscription charge refund.

025065 (04-2012)

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as intravenous therapy) is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements. Benefits are also not provided for prescription drugs dispensed by a pharmacy for self-administration except for oral chemotherapy drugs. Please see the Oral Chemotherapy Medication Benefit.

**Mastectomy and Breast Reconstruction Services**

**LifeWise Preferred (Network) Providers:**

Benefits are subject to the calendar year deductible of \$1,880 and coinsurance of 25% of allowable charges.

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of

mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

**Mental Health Care**

Benefits are subject to the calendar year deductible and coinsurance.

**Inpatient Services**

See Hospital Inpatient Care for benefits for inpatient treatment.

**Outpatient Professional Visits**

**LifeWise Preferred (Network) Providers:**

The calendar year deductible will be waived for the first six (6) office or home visits each calendar year from LifeWise Preferred (Network) providers. Benefits for the first six visits are only subject to the coinsurance.

Benefits for visits beyond the sixth are subject to the calendar year deductible and coinsurance.

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible and coinsurance.

Benefits for treatment of a mental health condition including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are covered on the same basis as other covered medical services and are provided as shown below. Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice. Benefits for covered Mental Health Care services are not subject to an annual benefit limit.

Covered services must be furnished by one of the following types of providers:

- Hospital

conjunction with a transplant.

#### Oral Chemotherapy Medication

This benefit covers self-administered oral drugs that are dispensed by a pharmacy and can be used to kill or slow the growth of cancerous cells. These drugs are covered for medically necessary uses at 100% of the allowable charge. You pay no deductible, copay or coinsurance.

- **Participating Retail Pharmacies** To avoid paying the retail cost for oral chemotherapy medications that are reimbursed at a lower allowable charge rate, be sure to present your identification card to the pharmacist. When you do, in no case will your out-of-pocket expense exceed the allowable charge for the oral chemotherapy medications being dispensed.
- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the "How Do I File A Claim?" section for more information. Your liability is for any amount above the allowable charge.

If you need a list of participating pharmacies, please call us at the numbers listed on the back page of this contract. You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your LifeWise ID card.

#### Rehabilitation Therapy and Chronic Pain Care

**LifeWise Preferred (Network) Providers:**  
Benefits are subject to the calendar year deductible of \$1,880 and coinsurance of 25% of allowable charges.

**Non-Preferred (Non-network) Providers:**  
Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

Rehabilitation Therapy Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies.

- **Inpatient Care** Benefits for inpatient facility and professional care are available up to 8 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

- **Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:
  - You must not be confined in a hospital or other medical facility
  - Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, or other licensed or certified provider.
  - Massage therapy provided by a licensed massage therapist must be prescribed by a physician

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 20 visits per member each calendar year. This benefit includes physical, speech, and occupational assessments and evaluations related to rehabilitation.

For the purposes of counting outpatient visits, "visit" means a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care Rehabilitation Therapy benefits are also available for medically necessary treatment of intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit maximums stated above. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

This benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of your injury or illness, or from the date of your surgery that made the rehabilitation necessary.
- Neurodevelopmental therapy or treatment of neurodevelopmental disabilities

**Skilled Nursing Facility Services**

**LifeWise Preferred (Network) Providers:**

Benefits are subject to the calendar year deductible of \$1,880 and coinsurance of 25% of allowable charges.

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 45 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a:

- Skilled nursing facility that is a LifeWise Preferred (network) provider

- Medicare-approved skilled nursing facility

**This benefit doesn't cover:**

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

**Spinal and Other Manipulative Treatment**

**LifeWise Preferred (Network) Providers:**

Benefits are subject to a copay of \$25 per visit.

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

Rehabilitation therapy (such as massage or physical therapies) provided in conjunction with manipulative treatment will accrue toward the Rehabilitation Therapy and Chronic Pain Care benefits' annual maximums, even when provided during the same visit.

**Surgical Services**

**LifeWise Preferred (Network) Providers:**

Benefits are subject to the calendar year deductible of \$1,880 and coinsurance of 25% of allowable charges.

**Non-Preferred (Non-network) Providers:**

Benefits are subject to the calendar year deductible of \$3,760 and coinsurance of 50% of allowable charges.

This benefit includes all professional surgical services when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office.

Also included in this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transplanting of blood or blood derivatives.

one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
- Federal or any public health care plan, including state children's health care plans
- Peace Corps Plan
- Government health coverage provided for citizens or residents of a foreign country
- Any other health insurance coverage

"Creditable" coverage doesn't include coverage under a limited policy such as an accident only coverage; disability income insurance; worker's compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplemental policy; or long-term care policy.

The waiting period for transplants **doesn't apply** to:

- A HIPAA eligible individual
- Newborn children born after the subscriber's effective date of coverage under this plan, provided they are covered from birth as explained under the "When Does Coverage Begin?" section.
- Newborn children covered under creditable coverage at any time during the 30-day period beginning with their date of birth. However, the waiting period for transplants will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 63 days.
- Adoptive children who are adopted or placed for adoption after the subscriber's effective date of coverage under this plan, provided they're covered from the date of their adoption or placement for adoption as explained under the "When Does Coverage Begin?" section.

- Adoptive children, who before the age of 18, were covered under creditable coverage at any time during the 30-day period beginning with their date of adoption or placement for adoption. However, the waiting period for transplants will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 63 days.

Please see the Transplants benefit for more information on the transplant benefit.

### **EXCLUSIONS**

This section of the contract lists those services, supplies or drugs are not covered under this plan.

#### **Allergy Testing and Injections**

Benefits are not provided for allergy testing, evaluations or allergy injections.

#### **Amounts That Exceed The Allowable Charge**

All benefits of this plan are based on the allowable charge (see Definitions). Benefits are not provided for amounts in excess of the allowable charge.

#### **Benefits From Other Sources**

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage

#### **Benefits That Have Been Exhausted**

Services, supplies, drugs, and medications furnished in connection with or directly related to a benefit that has been exhausted, or in excess of stated benefit maximums.

#### **Biofeedback**

Benefits are not provided for biofeedback regardless of diagnosis, except as stated in the Mental Health Care benefit.

#### **Chemical Dependency**

Services and supplies for the treatment of chemical

appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.

This exclusion does not apply to certain services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the Definitions section in this contract.

#### **Routine Hearing Examinations and Hearing Aids**

Routine hearing examinations; hearing aids and their fitting and maintenance.

#### **Hospital Admission Limitations**

Hospital admissions solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

#### **Human Growth Hormone**

Benefits for human growth hormone are not covered.

#### **Infertility or Fertility Enhancement**

Services, supplies, and drugs furnished in connection with infertility or fertility enhancement, and any direct or indirect complications of such procedures. This exclusion applies whether or not the condition is a consequence of illness, disease, or injury. This plan does not cover services for diagnosis of fertility problems, fertility-related drugs, donor sperm, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT).

Also not covered is reversal of prior sterilization, and the direct or indirect complications of such services.

#### **Learning Disorders and Neurodevelopmental Therapy**

Services, therapy and supplies related to the treatment of learning disorders, cognitive handicaps, dyslexia, developmental delay or neurodevelopmental disabilities.

#### **Medical Equipment and Supplies**

Medical equipment, prosthetics, orthotics (including foot orthotics) orthopedic shoes or appliances, and medical supplies. The exception is equipment furnished and billed as part of covered inpatient hospital, home health or hospice care, and post-mastectomy breast prostheses.

#### **Military-Related Disabilities**

Services to which you are legally entitled for a military service-connected disability and for which Facilities are reasonably available.

#### **Military Service And War-Related Conditions**

Conditions caused by or arising from military, war-related conditions and illegal acts, including :

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

#### **Non-Covered Services**

- Broken or missed appointments
- Services, supplies, drugs, and medications furnished in connection with or directly related to any condition, service, or supply that is not covered under this contract

#### **Obesity Services (Surgical and Pharmaceutical)**

Surgical or pharmaceutical treatments for obesity or morbid obesity, and any direct or indirect complications, follow-up services, and aftereffects thereof. (An example of an after effect that would not be covered is removal of excess skin and or fat that developed as a result of weight loss surgery or the use of obesity drugs). This exclusion applies to all surgical obesity procedures (inpatient and

# EXHIBIT E

P.A. 000060

## Policy Specifications

Policyholder: University of Washington  
Policy Number: GAIP UW (06-2012)  
Policy Coverage Dates: October 1, 2012 – September 30, 2013  
Governing Jurisdiction: This policy is issued and delivered in Washington and is subject to the laws of that jurisdiction.  
Premium Due Dates: The first of each month

## Introduction

This Contract is valid on the effective date indicated above only when signed by an officer of ours. Payment of the premium indicates that the Policyholder accepts this Contract.

The Policyholder delegates its authority to LifeWise Assurance Company to use its expertise and judgment to reasonably construe the terms of this coverage as applied to specific eligibility and claims determinations. LifeWise Assurance Company reserves the right to delegate these duties.

Any existing contract or agreement between the policyholder and us that is being replaced by this Contract is terminated when this one becomes effective.

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LifeWise Assurance Company  
Home Office: 7001-220th Street SW  
Mountlake Terrace, WA 98043-2124



LIFEWISE ASSURANCE COMPANY  
("LifeWise")



**"GAIP" GRADUATE APPOINTEE INSURANCE PROGRAM 2012-2013**

Coverage for academic student employees participating in the University of Washington's graduate appointee medical, dental and vision benefits. The "GAIP" Graduate Appointee Insurance Program is available to graduate student service appointees, Teachers Assistants, Research Assistants or Student Assistants, fellow/trainees and their eligible dependents. Benefits are underwritten and administered by LifeWise Assurance Company.

**Note:** This coverage is blanket disability insurance. Coverage provided is "excess" only and does not contain a "coordination of benefits" provision.

**Your student health insurance coverage, offered by LifeWise Assurance Company may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012, and \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014.**

**Your 2012-2013 student health insurance coverage has a limit of \$500,000 per condition per plan year. If you have any questions or concerns about this notice, contact LifeWise Assurance Company at (800) 971-1491. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.**

CUSTOMER SERVICE

UW Benefits Office  
Campus Mail Box 359556  
4333 Brooklyn Ave NE

UW Tower, Suite 01  
Seattle, WA 98195-9556  
[benefits@uw.edu](mailto:benefits@uw.edu)  
(206) 543-2800

LifeWise Assurance Company  
Toll Free (800) 971-1491  
TDD for Hearing-Impaired (800) 842-5357  
Web site [student.lifewiseac.com/uw/gaip](http://student.lifewiseac.com/uw/gaip)

CLAIMS SUBMISSION

LifeWise Assurance Company  
PO Box 91059  
Seattle, WA 98111

GAIP UW C (06-2012)

P.A. 000062

## Exceptions

The pre-existing condition limitation does not apply to:

- Abortion
- Pregnancy, including complications
- Covered newborn dependents who, on the last day of the 60-day period beginning with the date of birth, are covered under another health plan
- Covered adopted dependents under age 18 who, on the last day of the 30-day period beginning with the date of adoption or placement, are covered under another health plan (this does not apply to coverage the adopted child may have had before the adoption or placement).

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

If the plan pays a claim related to a pre-existing condition, payment doesn't constitute a waiver of this exclusion for that claim or for any subsequent claim if the plan later determines the condition was pre-existing.

## WHAT'S NOT COVERED

In addition to the limits and exclusions described elsewhere in this plan, no benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

- Addiction services and supplies related to: nicotine addiction, caffeine addiction and nonchemical addictions such as gambling, sexual, spending, shopping, work and religious, except as specifically described under the Mental Health Rider
- Bungee Jumping or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline
- Cosmetic procedures, except cosmetic surgery required to correct an injury for which benefits are otherwise payable under this plan or for newborn or adopted children
- Counseling, educational or training services
  - Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills, except for services that meet the standards for preventive medical services in the Preventive Care benefit.
  - Counseling, education or training services, except as stated under the Alcoholism/Chemical Dependency Treatment rider, Diabetes Treatment benefit, Mental Health rider, or for services that meet the standards for preventive medical services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; and caffeine dependency. Also not covered is family and marital psychotherapy, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a member.
  - Rehabilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children age 6 and under as stated under the Neurodevelopmental Therapy rider.
- Custodial care; care provided in rest homes, health resorts, homes for the aged, halfway houses or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care
- Dental treatment, except as specifically in the Dental Rider
- Elective surgery or elective treatment
- Experimental Or Investigational Services. Any service or supply that LifeWise Assurance Company determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of Experimental Services Or Supplies (please see the "Definitions" section in this booklet). This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the definitions section in this booklet.

**MENTAL HEALTH RIDER**

Benefits shall be subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan.

**PLAN SUMMARY - FOR ACADEMIC STUDENT EMPLOYEES**

<b>STUDENT BENEFITS</b>	<b>HALL HEALTH / RUBENSTEIN PHARMACY</b>	<b>NETWORK<sup>1</sup></b>	<b>NON-NETWORK<sup>2</sup></b>
<b>Inpatient</b> No maximum but subject to plan maximum benefit and must be medically necessary.	N/A	90% of allowable charge after deductible	60% of allowable charge after deductible
<b>Outpatient</b> No maximum but subject to plan maximum benefit and must be medically necessary.	100% of allowable charge (no deductible); Includes services at the Student Counseling Center at Schmitz Hall.	90% of allowable charge after deductible	60% of allowable charge after deductible

**PLAN SUMMARY - FOR DEPENDENTS**

<b>DEPENDENT BENEFITS</b>	<b>NETWORK<sup>1</sup></b>	<b>NON-NETWORK<sup>2</sup></b>
<b>Inpatient</b> No maximum but subject to plan maximum benefit and must be medically necessary.	90% of allowable charge after deductible	60% of allowable charge after deductible
<b>Outpatient</b> No maximum but subject to plan maximum benefit and must be medically necessary.	90% of allowable charge after deductible; includes services at the Student Counseling Center at Schmitz Hall.	60% of allowable charge after deductible

1. Network providers are healthcare providers that have a contractual arrangement with LifeWise Assurance Company.
2. Non-network providers include all other doctors and hospitals. These providers may bill you for charges over the allowable charge.

**Mental Health Treatment**

**Inpatient**

If you use a network provider for inpatient mental health services, the plan pays a percentage of covered charges. If you use a non-network provider, the plan pays a percentage of the allowable charge. The student and dependent Medical Plan Summaries show benefit levels.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.

## Outpatient

If you go to Hall Health for outpatient mental health services, the plan pays a percentage of covered charges. The deductible is waived for registered students who go to Hall Health. The deductible does apply for dependents who go to Hall Health. See the student and dependent Medical Plan Summaries for benefit levels.

The plan pays a percentage of covered charges when you see a network provider and a percentage of the allowable charge when you see a non-network provider, as listed in the Medical Plan Summaries.

Covered academic student employees also have access to the Student Counseling Center at Schmitz Hall. Academic student employees are covered at a percentage of the allowable charge, listed in the student and dependent Medical Plan Summaries, to a recognized provider at this facility.

Mental health services means medically necessary inpatient and outpatient services provided to treat Mental Disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, with the exception of the following categories, codes and services: (a) Substance-related disorders; (b) life transition problems, currently referred to as "v" codes, and diagnostic codes 302 through 302.9 as found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 4<sup>th</sup> edition, published by the American Psychiatric Association; and (c) skilled nursing facility services, home health care, residential treatment, and custodial care.

If the plan provides benefits for prescription drugs, benefits will be paid for prescription drugs to treat mental disorders the same as and under the same terms and conditions as other prescription drugs under the plan.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.

LifeWise Assurance Company  
 Home Office: 7001-220th Street SW  
 Mountlake Terrace, WA 98043-2124



**NEURODEVELOPMENTAL THERAPY RIDER**

Benefits shall be subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the policy.

**PLAN SUMMARY - FOR ACADEMIC STUDENT EMPLOYEES**

<b>STUDENT BENEFITS</b>	<b>HALL HEALTH / RUBENSTEIN PHARMACY</b>	<b>NETWORK<sup>1</sup></b>	<b>NON-NETWORK<sup>2</sup></b>
Neurodevelopmental Therapy Children age 6 and under	90% of allowable charge after deductible		60% of allowable charge after deductible

**PLAN SUMMARY - FOR DEPENDENTS**

<b>DEPENDENT BENEFITS</b>	<b>NETWORK<sup>1</sup></b>	<b>NON-NETWORK<sup>2</sup></b>
Neurodevelopmental Therapy Children age 6 and under	90% of allowable charge after deductible	60% of allowable charge after deductible

1. Network providers are healthcare providers that have a contractual arrangement with LifeWise Assurance Company.
2. Non-network providers include all other doctors and hospitals. These providers may bill you for charges over the allowable charge.

**Neurodevelopmental Therapy**

This benefit includes covered charges for neurodevelopmental therapy to restore and improve function for children age 6 and younger. Maintenance services are included if significant deterioration of the condition would result without the service.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with the terms of the rider.

# EXHIBIT F

P.A. 000067

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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of THE TECHNOLOGY ACCESS FOUNDATION HEALTH BENEFIT PLAN, and on behalf of similarly situated individuals,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, *et al.*,

Defendants.

No. C11-1119RSL

ORDER GRANTING  
PLAINTIFFS' MOTIONS FOR  
SUMMARY JUDGMENT

This matter comes before the Court on Plaintiffs' "Motion for Summary Judgment re: Exhaustion of Administrative Remedies" (Dkt. # 43) and "Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and Injunctive Relief under ERISA" (Dkt. # 44). Plaintiffs ask the Court to find as a matter of law that they exhausted their administrative remedies or that those remedies would be futile and to enter a permanent injunction requiring Defendants to comply with the requirements of Washington's Mental Health Parity Act, RCW 48.46.291, which the Court previously found to apply. The Court finds that Plaintiffs have exhausted their administrative remedies. It further finds that Plaintiffs are entitled to a permanent injunction requiring Defendants to adhere to the plain requirements of Washington's Mental Health Parity Act. Accordingly, the Court GRANTS both motions.

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## I. BACKGROUND

This case concerns a dispute over healthcare benefits. Plaintiff Z.D. is the twelve-year-old daughter and dependant of Plaintiffs J.D. (her mother) and T.D. (her father). See Dkt. # 45 at ¶ 2. She is a beneficiary of “The Technology Access Foundation Health Benefit Plan” (the “Plan”), an ERISA “employee welfare benefit plan,” 29 U.S.C. § 1002(1), underwritten and administered by Defendant Group Health Options, Inc.—a wholly owned subsidiary of Defendant Group Health Cooperative. Amended Complaint (Dkt. # 3) at ¶¶ 1–5.

In 2006, Defendant Group Health diagnosed Z.D. with two DSM-IV-TR mental health conditions: a “moderate-severe receptive language disorder” and “other specific developmental learning disabilities.” Dkt. # 45 at ¶ 4; see also Dkt. # 49-1 (Exhibit B).<sup>1</sup> At the time of her diagnoses, Z.D. was already a beneficiary of the Plan and began receiving covered non-“restorative”<sup>2</sup> speech therapy treatment for her conditions. Circumstances changed, however, shortly before Z.D.’s seventh birthday. Plaintiff was told that, per the Plan, non-restorative speech therapy treatments were not covered for individuals over the age of six and thus her treatments would no longer be covered once she turned seven. Dkt. # 45 at ¶ 5. As a result, Z.D. stopped going to outpatient therapy, though she did receive some limited treatment services through her public elementary school. Id. at ¶ 6; Dkt. # 49-1 at 21.

Unfortunately, this limited therapy did not seem to be enough. Six months after Z.D.’s seventh birthday, her mother complained to Z.D.’s doctor that Z.D. was

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<sup>1</sup> The Court notes that this exhibit is sealed and, because it prefers that the present Order be accessible by the public, has not disclosed any information not otherwise available from the parties’ public filings. Nevertheless, throughout this Order the Court will cite to sealed documents that it considered but is not publicly disclosing in order to build a more thorough record in the event of an appeal.

<sup>2</sup> The Plan distinguishes between “restorative” treatment, which is intended to restore function and is covered regardless of age, and “non-restorative” treatment, which is intended to improve function and is not covered for individuals older than seven. E.g., Dkt. # 56-1 at 28.

1 continuing to experience problems at school. In October 2007, Z.D. was evaluated  
2 extensively at the University of Washington's LEARN Clinic, which confirmed Group  
3 Health's earlier diagnosis. Dkt. # 45 at ¶ 6; see Dkt. # 49-1 at 19-37. Group Health  
4 covered this evaluation. Dkt. # 57 at ¶ 4; Dkt. # 57-1 at 2.

5 On November 28, 2007, J.D. phoned Group Health to ask if Group Health would  
6 cover speech therapy for Z.D. Dkt. # 50-1 at 83; Opp. (Dkt. # 54) at 8. According to  
7 Group Health's records, it told her that Z.D.'s therapy would not be covered because she  
8 was over the age of six. Dkt. # 50-1 at 83.

9 In 2008, Z.D.'s parents began paying for her to receive treatment at Bellevue  
10 Mosaic in 2008. Dkt. # 45 at ¶ 7. In late 2008, Bellevue Mosaic recommended that  
11 Z.D. seek a higher level of treatment than it could provide. Id. at ¶ 8. Her parents took  
12 her to Northwest Language and Learning Center in September 2008. Id. Shortly after,  
13 J.D. emailed Group Health about coverage. Dkt. # 45-1 at 6-7. After she provided  
14 some extra information requested by Group Health, id. at 8, she received a formal denial  
15 of coverage on December 18, 2008. Group Health explained that "neurodevelopmental  
16 speech therapy is not covered beyond the age of 6" and that Northwest Learning and  
17 Language was not a provider within the Group Health system."<sup>3</sup> Id. at 11. Z.D.'s  
18 parents sent her to the center anyway, paying for her treatment out of pocket beginning  
19 in January 2009. Dkt. # 45 at ¶ 11.

20 On September 15, 2010, Z.D. received an evaluation from Dr. Deborah Hill. Id.  
21 at ¶ 12. On October 15, J.D. sent Group Health another letter informing them of its  
22 prior age-based denials of her requests for treatment for Z.D. and asking it to reconsider  
23 its position. Dkt. # 45-1 at 18. She explained that she intended to enroll Z.D. at the  
24 Northwest Language and Learning Center and added: "Please consider this letter to be  
25 an appeal of Group Health's denial of my requests for speech therapy and

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26 <sup>3</sup> This rationale is somewhat curious given that Group Health covered Z.D.'s  
September and October sessions at Northwest. Dkt. # 57-1 at 4.

1 neurodevelopmental evaluation for my daughter.” Id. She also included a claim for  
2 reimbursement for the September 15 evaluation. Id. at 19–21.

3 Group Health responded in a letter dated November 1, 2010. Id. at 23. It stated  
4 that it did not have any record of having denied coverage for the September evaluation  
5 and would forward her claim to the claims department. Id.

6 J.D. responded via a certified letter dated December 9, 2010. Id. at 25. She  
7 wrote that she had not heard anything further from Group Health in regard to either her  
8 general request for coverage or her specific claim for the September evaluation. Id. She  
9 explained that because she had not received any explanation of benefits in regard to her  
10 request for coverage, she considered Group Health’s inaction to be a denial and wished  
11 to appeal that denial. Id. Group Health states that it never received that letter. Opp.  
12 (Dkt. # 54) at 11. It did eventually “cover” the September 15 claim, though. Compare  
13 Dkt. # 45 at ¶ 17 (stating that Group Health paid the claim), with Dkt. # 57 at ¶ 6  
14 (stating that Group Health denied coverage because Plaintiffs had used the maximum  
15 number of mental health evaluations to which they were entitled, but that Plaintiffs still  
16 received the benefit of Group Health’s lower rate).

17 In any case, Plaintiffs continued to send Z.D. to Northwest, paying for her  
18 therapy themselves. Dkt. # 45 at ¶ 17. On July 6, 2011, they filed the instant suit  
19 against Defendants, alleging that Washington’s Mental Health Parity Act, RCW  
20 48.46.291, requires Defendants to cover Z.D.’s mental health therapy sessions.  
21 Complaint (Dkt. # 1). They seek to recover the “benefits due them due to the improper  
22 exclusion and/or limitations of behavioral and neurodevelopmental therapy.” Amended  
23 Complaint (Dkt. # 3) at ¶¶ 36–38 (relying on 29 U.S.C. § 1132(a)(1)(B)). And they seek  
24 the recovery of all losses to the Plan for Defendants’ alleged failure “to act in  
25 accordance with the documents and instruments governing the Plan.” Id. at ¶¶ 28–35  
26 (relying on 29 U.S.C. § 1132(a)(2) (“breach of fiduciary duty”)). Finally, they ask the

1 Court to enjoin Defendants from continuing to process and pay claims in a manner  
2 inconsistent with RCW 48.46.291. *Id.* at ¶¶ 39–41 (relying on 29 U.S.C. § 1132(a)(3)).

3 After filing suit, Plaintiffs filed a claim for each of Z.D.’s 2011 sessions at  
4 Northwest. Dkt. # 45 at ¶ 17. Group Health tendered a check in payment of these  
5 claims on November 17, 2011. *Id.* In a subsequent deposition, however, Group Health  
6 stated that it had erroneously tendered that payment. Dkt. # 48-1 at 60–61 (“[I]t should  
7 not have been paid.”).

## 8 II. DISCUSSION

9 In the present motions, Plaintiffs argue first that they are entitled to a legal  
10 finding that they exhausted their administrative remedies or that those remedies would  
11 have been futile. Dkt. # 43. Moreover, they ask the Court to enter a permanent  
12 injunction against Defendants, enjoining “Group Health from denying coverage for  
13 medically necessary neurodevelopmental therapy to treat insureds with DSM-IV-TR  
14 mental health conditions simply because the insured is over six years old.” Dkt. # 44.

15 Notably, the Court may grant Plaintiffs’ motions only if it is satisfied that there is  
16 no genuine issue of material fact and that judgment is appropriate as a matter of law.  
17 Fed. R. Civ. P. 56(c). As the moving party, Plaintiffs bear the initial burden of  
18 informing the Court of the basis for summary judgment. *Celotex Corp. v. Catrett*, 477  
19 U.S. 317, 323 (1986). They must prove each and every element of their claims or  
20 defenses such that no reasonable jury could find otherwise. *Anderson v. Liberty Lobby,*  
21 *Inc.*, 477 U.S. 242, 248 (1986). In doing so, they are entitled to rely on nothing more  
22 than the pleading themselves. *Celotex*, 477 U.S. at 322–24. Only once they make their  
23 initial showing does the burden shift to the Defendants to show by affidavits,  
24 depositions, answers to interrogatories, admissions, or other evidence that summary  
25 judgment is not warranted because a genuine issue of material fact exists. *Id.* at 324.

26 To be material, the fact must be one that bears on the outcome of the case. A  
genuine issue exists only if the evidence is such that a reasonable trier of fact could

1 resolve the dispute in favor of the nonmoving party. Anderson, 477 U.S. at 249. “If the  
2 evidence is merely colorable . . . or is not significantly probative . . . summary judgment  
3 may be granted.” Id. at 249–50. In reviewing the evidence “the court must draw all  
4 reasonable inferences in favor of the nonmoving party, and it may not make credibility  
5 determinations or weigh the evidence.” Reeves v. Sanderson Plumbing Prods. Inc., 530  
6 U.S. 133, 150 (2000).

7 **A. Exhaustion**

8 “Section 502 of ERISA entitles a participant or beneficiary of an  
9 ERISA-regulated plan to bring a civil action ‘to recover benefits due to him under the  
10 terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights  
11 to future benefits under the terms of the plan.’” Chappel v. Lab. Corp. of Am., 232 F.3d  
12 719, 724 (9th Cir. 2000) (quoting 29 U.S.C. § 1132(a)(1)(B)). Before a beneficiary may  
13 bring such a claim, though, “exhaustion, at least to the level of the trustees, is ordinarily  
14 required where an action seeks a declaration of the parties’ rights and duties under the  
15 [ERISA] plan.” Graphic Commc’ns Union, Dist. Council No. 2, AFL-CIO v.  
16 GCIU-Emp’r Ret. Benefit Plan, 917 F.2d 1184, 1187 (9th Cir. 1990) (emphasis in  
17 original) (citations and internal quotation marks omitted). Suits raising unexhausted  
18 claims are barred absent a showing that the relevant unexhausted plan provision is either  
19 unenforceable or invalid. Chappel, 232 F.3d at 724.

20 Plaintiffs’ argument in favor of exhaustion in this case is confined to three  
21 occasions: specifically, that “Group Health failed to (1) timely process and respond to  
22 Z.D.’s October 25, 2010 pre[-]service request for coverage of speech therapy; (2)  
23 institute any appeal or consideration of a pre-service speech therapy claim in response to  
24 Z.D.’s December 9, 2010 request to do so; and (3) timely respond to Z.D.’s September  
25 12, 2011 post-service claim for speech therapy benefits.”<sup>4</sup>

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26 <sup>4</sup> Accordingly, the Court does not address Defendants’ arguments as to other dates.

1 In response, Defendants raise three arguments. First, they contend that Plaintiff's  
2 "pre-service" requests were not true "pre-service" requests at all and that Group Health  
3 therefore had no obligation to respond. Second, they contend that Group Health did  
4 timely respond to the 2011 claim and that, even if it did not, it has since tendered  
5 payment, mooting any claim. Finally, it argues that Plaintiffs' administrative remedies  
6 would not have been be futile. The Court disagrees with each of Defendants' positions  
7 and finds that Plaintiffs are entitled to judgment as a matter of law. It thus GRANTS the  
8 motion (Dkt. # 43).

9 **1. Exhaustion of 2010 "Pre-Service" Claims**

10 The facts relevant to Plaintiffs' 2010 "pre-service" requests are straightforward  
11 and undisputed: On October 15, 2010, J.D. sent Group Health a letter that recounted its  
12 prior age-based denials of her requests for treatment for Z.D. and immediately added,  
13 "Please consider this letter to be an appeal of Group Health's denial of my requests for  
14 speech therapy and neurodevelopmental evaluation for my daughter." Dkt. # 45-1 at 18  
(emphasis in original).

15 She further noted that she had recently had her daughter evaluated again and had  
16 been told that she needed to "receive additional medically necessary speech therapy."  
17 Id. (emphasis omitted). She explained that she intended "to enroll Z.D. at Northwest  
18 Language and Learning for the recommended speech therapy" and stated: "I request  
19 that Group Health reconsider its exclusion of neurodevelopmental therapy coverage for  
20 my daughter and provide her with coverage for neuropsychological evaluation and  
21 speech therapy services. Both neurodevelopmental evaluation and speech therapy are  
22 medically necessary services to treat my daughter's developmental disabilities and  
23 communication disorder." Id. (emphasis in original).

24 In its response, Group Health did not address J.D.'s request for speech therapy,  
25 stating only that it had no record of having denied any claims arising from a distinct  
26 evaluation not at issue here. Id. at 23. J.D. was not dissuaded. She wrote back in a

1 certified letter dated December 9, 2010, stating bluntly that she considered Group  
2 Health's non-response to her request for coverage to be a de facto denial of coverage.  
3 Id. at 25. She then immediately stated again: "Please consider this letter to be an appeal  
4 of Group Health's denial of my requests for speech therapy and neurodevelopmental  
5 evaluation for my daughter." Id. (emphasis in original).

6 Moreover, eliminating any reasonable objective potential for ambiguity,<sup>5</sup> she  
7 went on to explain that she had "enrolled Z.D. at Northwest Language and Learning for  
8 the recommended speech therapy" and then immediately stated again: "I request that  
9 Group Health reconsider its exclusion of neurodevelopmental therapy coverage for my  
10 daughter and provide her with coverage for neuropsychological evaluation and speech  
11 therapy services. Both neurodevelopmental evaluation and speech therapy are  
12 medically necessary services to treat my daughter's developmental disabilities and  
13 communication disorder." Id. (emphasis in original).

14 In the face of these plain requests for coverage and notices of appeal, Defendants  
15 argue simply that no response was required because Plaintiffs' requests were not valid  
16 "pre-service" claims, as defined under ERISA. See Opp. (Dkt. # 54) at 15-18. They  
17 contend that ERISA places procedural requirements only on a "claim for a benefit under  
18 a group health plan with respect to which the terms of the plan condition receipt of the  
19 benefit, in whole or in part, on approval of the benefit in advance of obtaining medical  
20 care," 29 C.F.R. § 2560.503-1(m)(2), and that, because the Plan does not require pre-  
21 approval of outpatient speech therapy like Z.D. was requesting, her requests did not  
22 constitute pre-service requests. Opp. (Dkt. # 54) at 15-18. Technically speaking, the  
23 Court agrees. J.D.'s letters would not appear to fall within the technical definition of  
24 "Pre-service claims" set forth in the regulation.

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25 <sup>5</sup> To be clear, the Court sees absolutely no factual basis from which to conclude that  
26 reasonable minds could disagree as to the import of J.D.'s correspondences. Her letters make it  
clear beyond any possibility for fairminded disagreement that she was requesting both coverage  
for future expected treatment at Northwest and reconsideration of prior denials.

1 Notably, however, that does not mean that the regulation contemplates that  
2 Defendants could merely sit on their hands in the face of her requests. Apart from the  
3 specific obligations attached to “pre-service claims,” the regulation precludes claim  
4 procedures from being “administered in a way, that unduly inhibits or hampers the  
5 initiation or processing of claims for benefits.” § 2560.503-1(b)(3). It goes on to  
6 specifically provide “that, in the case of a failure by a claimant or an authorized  
7 representative of a claimant to follow the plan’s procedures for filing a pre-service  
8 claim, within the meaning of paragraph (m)(2) of this section, the claimant or  
9 representative shall be notified of the failure and the proper procedures to be followed in  
10 filing a claim for benefits.” § 2560.503-1(c)(1)(i) (emphasis added). Compare  
11 § 2560.503-1(c)(1)(ii) (noting requirements), with Dkt. # 45-1 at 18 (naming “a specific  
12 claimant; a specific medical condition or symptom; and a specific treatment . . . for  
13 which approval is requested”).

14 As explained by the Department of Labor, which promulgated the regulation, “a  
15 group health plan that requires the submission of pre-service claims, such as requests for  
16 preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis  
17 for concluding that the inquirer is attempting to file or further a claim for benefits,  
18 although not acting in compliance with the plan’s claim filing procedures.” U.S.  
19 Department of Labor FAQs About the Benefits Claim Procedure Regulations (“DOL  
20 FAQs”), available at [http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html), at A-5  
21 (emphasis added). Rather, “the regulation requires the plan to inform the individual of  
22 his or her failure to file a claim and the proper procedures to be followed.” Id.; see  
23 Barboza v. Cal. Ass’n of Prof’l Firefighters, 651 F.3d 1073, 1079 (9th Cir. 2011)  
24 (deferring to the Secretary of Labor’s interpretation of § 2650.503-1 because “[w]hen  
25 evaluating conflicting interpretations of an administrative regulation, we are required to  
26 give ‘substantial deference’ to the agency’s interpretation of its own regulations”).

1           Thus, even assuming that J.D.’s letter was an inappropriate pre-service claim, the  
2 Court finds it beyond any possibility for fairminded disagreement that Group Health had  
3 “a basis” for concluding that J.D. was “attempting to file or further a claim for benefits.”  
4 Compare Dkt. # 45-1 at 18, with DOL FAQs, at A-5. Group Health therefore had an  
5 obligation to inform her of the shortcoming of her request—that, as Defendants now  
6 contend, it was not an appropriate pre-service claim—and of the proper procedure for  
7 filing a claim, i.e., either concurrently or post-service.<sup>6</sup> Compare § 2560.503-1(c)(1)(i),  
8 with Dkt. # 48-1 at 80 (noting that Group Health recognizes pre-service, concurrent, and  
9 post-service claims). Because it failed to do either, Plaintiffs’ claims are deemed  
10 exhausted. § 2560.503-1(l) (“In the case of the failure of a plan to establish or follow  
11 claims procedures consistent with the requirements of this section, a claimant shall be  
12 deemed to have exhausted the administrative remedies available under the plan and shall  
13 be entitled to pursue any available remedies under section 502(a) of the Act on the basis  
14 that the plan has failed to provide a reasonable claims procedure that would yield a  
15 decision on the merits of the claim.”).

16           Moreover, the fact that the Plaintiffs may not have filed a claim contemplated by  
17 § 2560.503-1(m)(2) does not mean that it was not a valid claim under the terms of the  
18 Plan itself. As § 2560.503-1(a) states, it “sets forth minimum requirements for employee  
19 benefit plan procedures pertaining to claims for benefits by participants and  
20 beneficiaries.” Id. (emphasis added). It does not preclude a Plan from providing greater  
21 protections. See Chappel, 232 F.3d at 724 (noting the distinction between rights and  
22 benefits accorded “by the statutory provisions of ERISA itself” and rights and benefits  
23 provided “by the contractual terms of the benefits plan”). And in this case, the Plan does

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24           <sup>6</sup> As Plaintiffs point out, Group Health is a fiduciary. The law does not permit it to  
25 simply sit on its hands while a beneficiary unsuccessfully attempts to “navigate the byzantine  
26 bureaucracy of a health carrier.” Mot. (Dkt. # 43) at 15. It had a duty to aid J.D. in her  
attempts to present a claim. See § 2560.503-1(c)(1)(i).

1 not expressly incorporate § 2560.503-1(m)(2)'s definition of or otherwise define "pre-  
2 service claim." It simply states:

3 D. Claims

4 Claims for benefits may be made before or after services are  
5 obtained. To make a claim for benefits under the Agreement, a  
6 Member (or the Member's authorized representative) must contact  
7 GHO Customer Service, or submit a claim for reimbursement as  
8 described below. Other inquiries, such as asking a health care  
9 provider about care or coverage, or submitting a prescription to a  
10 pharmacy, will not be considered a claim for benefits.

11 \* \* \*

12 GHO will generally process claims for benefits within the  
13 following timeframes after GHO receives the claims:

14 § Pre-service claims – within fifteen (15) days.

15 § Claims involving urgently needed care – within seventy-two  
16 (72) hours.

17 § Concurrent care claims – within twenty-four (24) hours.

18 § Post-service claims – within thirty (30) days.

19 Timeframes for pre-service and post-service claims can be  
20 extended by GHO for up to an additional fifteen (15) days.

21 Members will be notified in writing of such extension prior to the  
22 expiration of the initial timeframe.

23 Dkt. # 56-2 at 6 (2010 Plan Benefit Booklet)<sup>7</sup>; accord Dkt. # 56-2 at 59 (2011 Plan  
24 Benefit Booklet); see also Dkt. # 56 at ¶ 4 (stating that the 2010 Contract was effective  
25 March 1, 2010, and the 2011 Contract was effective March 1, 2011).

26 Undoubtedly recognizing the lack of textual support for its litigation position,  
Defendants argue that Group Health nonetheless applies the ERISA definition of "pre-

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<sup>7</sup> The Court recognizes that the Supreme Court has distinguished between summary documents and Plan terms. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) ("[S]ummary documents, important as they are, provide communication with beneficiaries about the plan, . . . their statements do not themselves constitute the terms of the plan for purposes of § 502(a)(1)(B)." (emphasis omitted)). Noting that the "GHO Booklets" relied upon by the parties themselves state they are "not the contract itself," e.g., Dkt. # 56-2 at 2, 51, the Court directed the parties to file the actual contracts. Dkt. # 69. The parties subsequently filed those documents, pointing out, however, that the contracts themselves do not provide specific terms. Instead, they incorporate as Plan terms the provisions set forth in the GHO Booklets. E.g., Dkt. # 70 at 34 ¶ 1. The Court therefore treats the Booklet terms as the Plan terms.

1 service” claim. In support, they offer only the deposition testimony of Carroll Candace,  
2 one of their Rule 30(b)(6) deponents, arguing that she testified that “such claims need to  
3 be ‘contractually contingent’ on Group Health’s advance approval.” Opp. (Dkt. # 54) at  
4 18 (citing Dkt. # 48-1 at 80). The Court finds no support for that assertion.

5 The entirety of the relevant exchange between Ms. Carroll and Plaintiffs’ counsel  
6 was as follows:

7 Q: Do you also deal with situations where there is a pre-  
service request for authorization?

8 A: Yes.

9 Q: And that’s a situation where somebody is asking Group  
Health under the contract to approve benefits before the service has  
been provided, right?

10 A: Exactly.

11 Q: And that would then be sort of contractually contingent  
upon Group Health saying, yes, we bless this for payment in  
advance?”

12 A: Yes

13 Q: I tend to call those pre-service claims. Is that what Group  
Health calls them as well?

14 A: We call them – yes, I technically call them that, but Group  
Health doesn’t necessarily do that. That’s a health care reform term.  
So yes, I do use the word claim because ERISA uses the word claim.

15 \* \* \*

16 A: It’s a claim against benefit pre-service versus a claim to  
pay.

17 \* \* \*

18 Q: How does Group Health determine whether an individual  
is making a request for a pre-service claim?

19 A: The request comes in prior to the delivery of care.

20 Dkt. # 48-1 at 80 (emphasis added). As the whole conversation makes clear, Ms. Carroll  
21 not only fails to ever condition her understanding of the Plan term on the need for pre-  
22 approval, she expressly distinguishes Group Health’s understanding of its terms from the  
23 statutory definitions. Id. Furthermore, when asked point blank to identify how Group  
24 Health determines if “an individual is making a request for a pre-service claim,” she  
25 relies on only one condition: the timing of the claim. Id. Accordingly, the Court finds  
that Defendants have failed to offer any evidence sufficient to give rise to a genuine issue

1 as to the import of Group Health’s terms. Anderson, 477 U.S. at 249–50 (“If the  
2 evidence is merely colorable . . . or is not significantly probative . . . summary judgment  
3 may be granted.”). The October 25 letter served as “a claim for benefits under the  
4 Agreement” to which Group Health was obligated to respond.

5 And, of course, Group Health did respond. Moreover, it did so within the 15-day  
6 period set forth by the Plan for “processing” pre-service claims rather than the 30-day  
7 post-service review period, further reinforcing its understanding of its own terms’  
8 requirements. Dkt. # 45-1 at 23. It informed J.D. that it had no record of a denial and  
9 advised her that it had “forwarded her information to the claims department for  
10 processing.” Id. Dissatisfied with Group Health’s response, J.D. again wrote to appeal  
11 Group Health’s apparent de facto denial, wisely mailing her letter via certified mail.  
12 Group Health concedes it never responded to that letter, claiming that it never even  
13 received it. Opp. (Dkt. # 54) at 11. That claim is ultimately insufficient to overcome  
14 Plaintiffs’ exhaustion contention, however. Plaintiffs have presented evidence of both  
15 their mailing and Group Health’s receipt of their December 9, 2010 letter. Dkt. # 45-1 at  
16 25, 27–28. In response, Defendants merely assert non-receipt. And it is settled law that  
17 “[m]erely stating that the document isn’t in the addressee’s files or records . . . is  
18 insufficient to defeat the presumption of receipt.” Huizar v. Carey, 273 F.3d 1220, 1223  
19 n.3 (9th Cir. 2001).

20 Thus, in sum, the Court finds that, in addition to being able to claim the benefit of  
21 the automatic exhaustion provision of § 2560.503-1(i), Plaintiffs fulfilled their  
22 exhaustion obligations under the Plan itself. They both presented their 2010 claims to  
23 Group Health as the Plan terms required and subsequently appealed Group Health’s de  
24 facto denial. Accordingly, under either theory, the Court finds that Plaintiffs 2010 claims  
25 are exhausted. See Barboza, 651 F.3d at 1076 (“[T]he ‘applicability *vel non* of  
26 exhaustion principles is a question of law’ that ‘we consider . . . de novo.’”).

1                   **2. Exhaustion of the 2011 Claim**

2           Next, the Court whether Plaintiffs exhausted their 2011 post-service claim.

3           Notably, Group Health tendered a check in partial payment of these claims on  
4 November 12, 2011—60 days after the claim was filed. See Dkt. # 57-2 at 4 (noting that  
5 Group Health paid \$609.00 of the \$810.00 claimed). The only amount it declined to pay  
6 was Plaintiffs’ Plan-designated co-pay amount. Accordingly, Defendants assert that  
7 there is no adverse benefit determination to appeal. Plaintiffs disagree. They assert that  
8 Group Health’s decision not to pay the entirety of the claim constituted an “adverse  
9 benefit determination.” Dkt. # 62 at 10–11. And, because Group Health did not provide  
10 them with notice of that adverse decision within 30 days of its receipt of their claim as  
11 required by § 560.503-1(f)(2)(iii)(B), the automatic exhaustion provisions of  
12 § 2560.503-1(l) were triggered.<sup>8</sup> The Court agrees.

13           While Defendants are correct in their assertion that “the regulation does not  
14 address the periods within which payments that have been granted must be actually paid  
15 or services that have been approved must be actually rendered,” DOL FAQs, at A-10,  
16 that is not the crux of Plaintiffs’ claim. To the contrary, Plaintiffs note that the regulation  
17 defines “adverse benefit determination” as any “failure to provide or make payment (in  
18 whole or in part).” § 2560.503-1(m)(4) (emphasis added). They argue that this includes  
19 even denials based on the imposition of co-pays, pointing out that this is the official  
20 position of the Department of Labor. DOL FAQs, at C-12 (answering the question, “If a  
21 claimant submits medical bills to a plan for reimbursement or payment, and the plan,  
22 applying the plan’s limits on co-payment, deductibles, etc., pays less than 100% of the  
23 medical bills, must the plan treat its decision as an adverse benefit determination?” in the

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24           <sup>8</sup> Plaintiffs also complain that Group Health has since indicated that it should not have  
25 paid any of the claim. See Dkt. # 48-1 at 50–61 (statement by one of Defendants’ Rule  
26 30(b)(6) deponents, Dean Solis, the acting associate of “Western Washington Health Plan  
Operations,” that Group Health should not have paid the claim). As a result, Plaintiffs rightly  
fear that Group Health could seek to clawback those funds at any time.

1 affirmative because “[i]n any instance where the plan pays less than the total amount of  
2 expenses submitted with regard to a claim, while the plan is paying out the benefits to  
3 which the claimant is entitled under its terms, the claimant is nonetheless receiving less  
4 than full reimbursement of the submitted expenses.”). The Court sees no reason not to  
5 defer to this interpretation. See Barboza, 651 F.3d at 1079.

6 Thus, the undisputed fact that Group Health did not pay the entirety of the claim  
7 constituted a partial denial of benefits and thus an adverse benefits determination.  
8 § 2560.503-1(m)(4). Accordingly, Group Health was required to inform Plaintiffs of this  
9 partial denial within 30 days of receiving the claim. § 560.503-1(f)(2)(iii)(B). Plaintiffs  
10 assert that it failed to do so, and, in response, Defendants essentially concede the point.  
11 Accordingly, the Court finds that Plaintiffs’ 2011-based claim is exhausted.

### 12 3. Futility

13 Because the Court finds that Plaintiffs exhausted both of the claims that are the  
14 subject of this motion, it does not reach the issue of futility.

15 Notably, though, the Court wishes to point out that Defendants’ position on  
16 futility—that administrative remedies may not have been futile because, despite the fact  
17 that the Plan does not permit coverage of non-restorative mental health therapies for  
18 individuals over the age of six,<sup>9</sup> Group Health sometimes paid them anyway—is  
19 troubling. As Plaintiffs point out, ERISA fiduciaries are not permitted to process claims  
20 on a whim. Rather, they are required to do precisely the opposite: “a fiduciary shall  
21 discharge his duties with respect to a plan solely in the interest of the participants and  
22 beneficiaries and . . . in accordance with the documents and instruments governing the

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23 <sup>9</sup> To be clear, the Court agrees with Plaintiffs that Defendants’ official position  
24 throughout this litigation has been that the Plan “required Group Health to deny  
25 neurodevelopmental therapy benefits for claimants over six years old,” Dkt. # 19 at 7, and that  
26 the record is replete with examples of Defendants asserting Group Health’s official position.  
See, e.g., Mot. (Dkt. # 43) at 21–27 (summarizing the many instances in which Group Health  
asserted its official position); Reply (Dkt. # 62) at 5–8 (same). Certainly, Defendants filed two  
motions premised on that position. Dkt. ## 7, 31. It is the entire reason this case exists.

1 plan insofar as such documents and instruments are consistent with the provisions of  
2 [ERISA].” 29 U.S.C. § 1104(a)(1)(D). Moreover,

3           The claims procedures for a plan will be deemed to be reasonable  
4           only if . . . [t]he claims procedures contain administrative processes  
5           and safeguards designed to ensure and to verify that benefit claim  
6           determinations are made in accordance with governing plan  
7           documents and that, where appropriate, the plan provisions have  
8           been applied consistently with respect to similarly situated claimants.

9 29 C.F.R. § 2560.503-1(b)(5).

10           Thus, in attempting to win the exhaustion battle, Defendants essentially concede  
11           the war by representing to this Court that Group Health deviates from the Plan’s terms to  
12           pay claims not permitted under the Plan contract. *E.g.*, Opp. (Dkt. # 54) at 23  
13           (“Notwithstanding Group Health’s policy limiting speech benefits to children under 7,  
14           the record shows that in Z.D.’s case Group Health paid speech therapy claims when she  
15           submitted them. . . . But even though those payments may have been ‘error’ in the sense  
16           that they were inconsistent with the TAF Contract, that ‘error’ has benefitted Plaintiffs  
17           every time . . .”). The Court has no choice but to treat this representation as a  
18           concession that Group Health is administering the Plan in an arbitrary and capricious  
19           fashion, i.e., that it is wholly failing to act as a fiduciary.

20 **B. Injunctive Relief**

21           The Court next considers Plaintiffs’ motion for “an order and judgment under  
22           ERISA clarifying that neurodevelopmental therapy to treat insureds with DSM-IV-TR  
23           mental health conditions may not be denied simply because the insured is over the age of  
24           six” and “enjoin[ing] Group Health from denying coverage for medically necessary  
25           neurodevelopmental therapy to treat insureds with DSM-IV-TR mental health conditions  
26           simply because the insured is over six years old.” Mot. (Dkt. # 44) at 7.

          In opposition, Defendants raise three arguments: First, that “Group Health treats  
all neurodevelopmental disorders the same”; second, that “Plaintiffs’ own experience  
demonstrates the lack of an actual or imminent injury”; and third, that “the

1 Neurodevelopmental Therapies Mandate specifically permits terminating speech therapy  
2 at age 7.” Opp. (Dkt. # 53) at 15. The Court finds none persuasive. Rather, it finds that  
3 no genuine issue of material fact exists and that Plaintiffs are entitled to judgment as a  
4 matter of law under 29 U.S.C. § 1132(a)(1)(B) and (a)(3). It thus GRANTS Plaintiffs’  
5 motion (Dkt. # 44).

6 **1. Revisiting the Neurodevelopmental Therapies Mandate Issue**

7 The Court thinks it prudent to start with Defendant’s third argument: their third  
8 attempt to convince this Court that “the Neurodevelopmental Therapies Mandate  
9 specifically permits terminating speech therapy at age 7” and that the Mental Health  
10 Parity Act must therefore be interpreted in such a fashion that it does not require  
11 neurodevelopmental therapy coverage. Opp. (Dkt. # 53) at 15. As the Court stated in its  
12 prior resolution of this same argument,<sup>10</sup> the issue is not whether the Mandate requires  
13 coverage. Plainly it does not. Neither is there any dispute as to whether the Mental  
14 Health Parity Act repealed the Mandate. Again, plainly it did not. The only issue is  
15 whether the two statutes conflict, and as the Court has found on two separate occasions,  
16 they do not. Order (Dkt. # 30) at 8; Order (Dkt. # 36) at 2–3.

17 The previously enacted Mandate required “coverage for neurodevelopmental  
18 therapies for covered individuals age six and under.” RCW 48.44.450(1). It established  
19 a coverage floor, not a ceiling. Thus, the subsequently enacted Mental Health Parity Act  
20 merely imposed an additional, distinct requirement that mental health coverage “be  
21 delivered under the same terms and conditions as medical and surgical services.” H.B.  
22 1154, 59th Leg., Reg. Sess., ¶ 1 (Wash. 2005); see, e.g., Order (Dkt. # 30); Order (Dkt. #  
23 36). There does not exist even a close question as to whether there is a conflict between

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24 <sup>10</sup> The Court disagrees with Defendants’ representations regarding the “newness” of  
25 their argument. As before, Defendants contend that the Neurodevelopmental Therapies  
26 Mandate does not require coverage after an individual turns seven. As before, they argue that  
the Mental Health Parity Act did not repeal the Neurodevelopmental Therapies Mandate. And,  
as before, they contend that the two statutes conflict and that the Mandate trumps the Parity  
Act. There is nothing materially new about Defendants’ argument.

1 the statutes under established Washington law.<sup>11</sup>

2 In any case, as it appears that the message has yet to be received, the Court wishes  
3 to be clear: The coverage at issue in this case is the product of RCW 48.46.291, not the  
4 Neurodevelopmental Therapies Mandate. The Mandate continues to apply, requiring  
5 “coverage for neurodevelopmental therapies for covered individuals age six and under.”  
6 RCW 48.44.450(1). And while the Mandate no longer applies after a child turns seven,  
7 RCW 48.46.291 does. By its plain terms, it requires health maintenance organizations  
8 like Group Health to provide coverage for “mental health services” at increasing levels  
9 of parity with the coverage such entities provide for medical and surgical services. See  
10 RCW 48.46.291(2)(a)–(c).

## 11 2. Statutory Treatment Requirements

12 The Court next considers Defendants’ contention that, since January 2011, they  
13 have brought their policies in conformity with the Mental Health Parity Act and that an  
14 injunction is therefore unnecessary.<sup>12</sup> Opp. (Dkt. # 53) at 17. The Court disagrees.

15 The Court notes at the outset that Defendants paint a much rosier picture of their  
16 policies in their briefs than they apply in practice. For example, Defendants argue that  
17 they are in compliance with RCW 48.46.291(2)(c) because Group Health applies the  
18 same treatment limitations to mental health therapy services that it applies to all therapies  
19 services. Opp. (Dkt. # 53) at 16 (“Group Health imposes a treatment limit (age seven) on  
20 a limited set of therapies (speech therapy, physical therapy and occupational therapy)  
21 that treat medical and mental conditions alike.”). In actuality, however, Group Health  
does not apply an age-based treatment limitation across the board to all therapies related

22 <sup>11</sup> A litany of Washington state courts have held the same. See, e.g., D.F. v. Wash.  
23 State Health Care Auth., No. 10-2-294007 SEA; Dkt. ## 74, 74-1 (listing decisions).

24 <sup>12</sup> The Court notes that Defendants mischaracterize Plaintiffs’ request. To be clear,  
25 Plaintiffs do not request that the Court find that an age limit is never appropriate under any  
26 circumstance. Opp. (Dkt. # 53) at 15–16. They assert only that Group Health cannot impose  
an age-based treatment limitation on neurodevelopmental therapies unless it generally imposes  
that same limit on “medical and surgical services.”

1 to medical and surgical services. See Dkt. # 56-2 at 82 (2011 terms).<sup>13</sup> It applies an age-

2  
3 <sup>13</sup> The Plan states:

4 **G. Rehabilitation Services.**

5 1. Rehabilitation services are covered as set forth in this section, limited  
6 to the following: physical therapy; occupational therapy; massage  
7 therapy; and speech therapy to restore function following illness, injury  
8 or surgery. Services are subject to all terms, conditions and limitations of  
9 the Agreement including the following:

10 a. All services require a prescription from either a MHCN or  
11 community physician and must be provided by a MHCN-approved or  
12 Community Provider rehabilitation team that may include medical,  
13 nursing, physical therapy, occupational therapy, massage therapy and  
14 speech therapy providers.

15 b. Under the Community Provider option, inpatient rehabilitation  
16 services must be authorized in advance by GHO.

17 c. Services are limited to those necessary to restore or improve  
18 functional abilities when physical, sensori-perceptual and/or  
19 communication impairment exists due to injury, illness or surgery.  
20 Such services are provided only when significant, measurable  
21 improvement to the Member's condition can be expected within a sixty  
22 (60) day period as a consequence of intervention by covered therapy  
23 services described in paragraph a., above.

24 d. Coverage for inpatient and outpatient services is limited to the  
25 Allowance set forth in the Allowances Schedule.

26 Excluded: inpatient Residential Treatment services; specialty  
rehabilitation programs; long-term rehabilitation programs; physical  
therapy, occupational therapy and speech therapy services when such  
services are available (whether application is made or not) through  
programs offered by public school districts; therapy for degenerative or  
static conditions when the expected outcome is primarily to maintain  
the Member's level of functioning (except as set forth in subsection 2.  
below); recreational, life-enhancing, relaxation or palliative therapy;  
implementation of home maintenance programs; programs for treatment  
of learning problems; any services not specifically included as covered  
in this section; and any services that are excluded under Section V.

**2. Neurodevelopmental Therapies for Children Age Six (6) and**

1 based limitation only to a narrow subcategory of medical and surgical services, namely,  
2 non-rehabilitative therapies—“therapy for degenerative or static conditions when the  
3 expected outcome is primarily to maintain the Member’s level of functioning.” as  
4 opposed to “restore function following illness, injury or surgery.” *Id.* (emphasis added).  
5 Thus, in reality, Group Health applies its age-based limitation to only a sub-category of a  
6 sub-category of its covered services: non-rehabilitative, therapy services.

7 In any case, the end result of Group Health’s actions is simple. As Defendants  
8 concede, “Group Health’s ‘official policy’” remains to terminate “neurodevelopmental  
9 therapies at age seven.” *Opp.* (Dkt. # 53) at 16 (“The plain language of the TAF  
10 Contract makes this equal treatment clear: the Neurodevelopmental Therapies benefit  
11 does not distinguish between types of conditions, but simply grants coverage for  
12 neurodevelopmentally disabled children (regardless of whether the neurodevelopmental  
13 disability is “mental” or “physical”), subject to common treatment limitations (e.g., no  
14 coverage after age six).”). They defend this practice by pointing to a single line of RCW  
15 48.46.291(2)(c): “Treatment limitations or any other financial requirements on coverage

16 **Under.** Physical therapy, occupational therapy and speech therapy  
17 services for the restoration and improvement of function for  
18 neurodevelopmentally disabled children age six (6) and under shall be  
19 covered. Coverage includes maintenance of a covered Member in cases  
20 where significant deterioration in the Member’s condition would result  
21 without the services. Coverage for inpatient and outpatient services is  
22 limited to the Allowances set forth in the Allowances Schedule.

23 Excluded: inpatient Residential Treatment services; specialty  
24 rehabilitation programs; long-term rehabilitation programs; physical  
25 therapy, occupational therapy and speech therapy services when such  
26 services are available (whether application is made or not) through  
programs offered by public school districts; recreational, life-enhancing,  
relaxation or palliative therapy, implementation of home maintenance  
programs; programs for treatment of learning problems; any services not  
specifically included as covered in this section; and any services that are  
excluded under Section V.

Dkt. # 56-2 at 82 (some emphasis omitted).

1 for mental health services are only allowed if the same limitations or requirements are  
2 imposed on coverage for medical and surgical services . . . .” They contend that because  
3 Group Health essentially excludes all non-restorative “rehabilitative therapies related to  
4 medical and surgical services,” it may similarly exclude all coverage for similar non-  
5 restorative mental health or neurodevelopmental disorders. See Opp. (Dkt. # 53) at 17.

6 The Court finds two problems with this interpretation. First, Defendant’s  
7 interpretation ignores the full text of RCW 48.46.291. Even the subsection containing  
8 the clause relied upon by Defendants states plainly:

9 (2) All health benefit plans offered by health maintenance  
10 organizations that provide coverage for medical and surgical services  
11 shall provide:

12 (c) For all health benefit plans delivered, issued for delivery, or  
13 renewed on or after July 1, 2010, coverage for:

14 (i) Mental health services. The copayment or coinsurance for  
15 mental health services may be no more than the copayment or  
16 coinsurance for medical and surgical services otherwise  
17 provided under the health benefit plan. Wellness and  
18 preventive services that are provided or reimbursed at a lesser  
19 copayment, coinsurance, or other cost sharing than other  
20 medical and surgical services are excluded from this  
21 comparison. If the health benefit plan imposes a maximum  
out-of-pocket limit or stop loss, it shall be a single limit or  
stop loss for medical, surgical, and mental health services. If  
the health benefit plan imposes any deductible, mental health  
services shall be included with medical and surgical services  
for the purpose of meeting the deductible requirement.  
Treatment limitations or any other financial requirements on  
coverage for mental health services are only allowed if the  
same limitations or requirements are imposed on coverage for  
medical and surgical services . . . .

22 RCW 48.46.291(2)(c)(i) (emphasis added). And the statute defines “mental health  
23 services” as “medically necessary outpatient and inpatient services provided to treat  
24 mental disorders covered by the diagnostic categories listed in the most current version  
25 of the diagnostic and statistical manual of mental disorders, published by the American

1 psychiatric association,” with exceptions not at issue here. RCW 48.46.291(1). Thus,  
2 the Act plainly imposes a baseline coverage requirement requiring Group Health  
3 “provide . . . coverage for” Z.D.’s “medically necessary” treatment for her DSM-IV-TR  
4 mental health conditions without any regard for whether that treatment is restorative or  
5 non-restorative. RCW 48.46.291(2)(c)(i); see RCW 48.46.291(2)(a)(i), (b)(i).<sup>14</sup>

6 Second, Defendants’ focus on the final clause of subsection (c)(i) ignores the  
7 history and structure of the statute. As enacted, the statute is meant to impose  
8 increasingly stringent requirements on entities like Group Health every two years. RCW  
9 48.46.291(2)(a)–(c). Thus, the addition of the treatment limitation is not meant to  
10 weaken or supplant the baseline coverage requirement; it is meant to bolster it by further  
11 limiting the conditions an entity like Group Health can impose on its coverage of mental  
12 health conditions like Z.D.’s. *Id.* In short, the clause precludes Group Health from  
13 imposing precisely the sort of tailored limitations at issue here—limitations that would  
14 defeat the very purpose of the statute: providing coverage.

15 In sum then, the Court finds that RCW 48.46.291(2)(c)(i) requires Group Health  
16 to provide coverage for “medically necessary outpatient and inpatient services provided  
17 to treat mental disorders covered by the diagnostic categories listed in the most current  
18 version of the diagnostic and statistical manual of mental disorders, published by the  
19 American psychiatric association,” with those limited exceptions set forth in the statute,  
20 RCW 48.46.291(1). And it finds that the final clause of subsection (c)(i) only further  
21 precludes Group Health from imposing treatment limitations it does not generally  
22 “impose[] on coverage for medical and surgical services.” RCW 48.46.291(2)(c)(i).  
23 Accordingly, because Group Health does not exclude individuals over the age of six

24 <sup>14</sup> This interpretation is also supported by the Washington Senate Bill Report for the  
25 Parity Act, which states: “**Background:** Current Washington law does not require health  
26 carriers to include mental health coverage in any benefit plan. . . . **Summary of Bill:**  
Beginning January 1, 2006[,] a health benefit plan that provides coverage for medical and  
surgical services must provide coverage for mental health services and prescription drugs to  
treat mental disorders.” Dkt. # 9 at 40–41.

1 from coverage for medical and surgical services or even impose an age-based limitation  
2 on its therapy coverage in general, it may not impose that limitation on non-restorative  
3 mental health therapy coverage.<sup>15</sup>

### 4 3. Actual or Imminent Injury

5 Finally, the Court turns to Defendants' contention that Plaintiffs cannot show a  
6 likelihood of irreparable injury.

7 The crux of Defendants' position is, again, that regardless of Group Health's  
8 actual policies, they may in fact pay future claims.<sup>16</sup> As Defendants state: "Apart from  
9 Group Health's policies, Plaintiffs' actual experience with Group Health's claims  
10 practice belies their claim that Group Health 'systematic[ally] violates . . . plan terms' or  
11 will do so in the future." *See* Opp. (Dkt. # 53) at 17.

12 First and foremost, this contention is patently deficient as a matter of law. As  
13 stated, ERISA requires "a fiduciary [to] discharge his duties with respect to a plan solely  
14 . . . in accordance with the documents and instruments governing the plan." 29 U.S.C.  
15 § 1104(a)(1)(D). Accordingly, it is no excuse for Defendants to represent that the Plan  
16 precludes the coverage sought, and yet simultaneously argue that, "[w]hile there may be  
17 some discrepancy between Group Health's practice and its official policy toward  
18 neurodevelopmental therapies, . . . its practice has changed in Plaintiffs' favor,  
19 suggesting a strong likelihood of future coverage." Opp. (Dkt. # 53) at 20. The Court  
20 will not leave Plaintiffs at the mercy of Group Health's plainly arbitrary application of its  
21 own Plan terms or its ever-evolving understanding of Plaintiffs' entitlement to coverage.

22 <sup>15</sup> Accordingly, it would also seem that Group Health cannot condition coverage on the  
23 availability of treatment through "programs offered by public school districts." *Cf.* Dkt. # 56-2  
24 at 82 (2011 terms).

25 <sup>16</sup> Defendants also contend that Plaintiffs conceded that they have no plans to start  
26 speech therapy again. Opp. (Dkt. # 53) at 19. As they concede, though, that is no longer the  
case. *Id.* Moreover, as the entirety of the record in this case makes clear, every doctor who has  
evaluated Z.D. has recommended that she get treatment. And her parents' desire to follow  
doctor's recommendations is the impetus for this case.

1           Moreover, Group Health's boots on the ground clearly do not share the same  
2 impression as its lawyers as to Plaintiffs' likelihood of future coverage. As one of its  
3 regional managers, Tomi McVay, testified in her role as Rule 30(b)(6) deponent:

4           Q: So if a person comes to you who is age seven, has a  
5 neurodevelopmental problem, disorder—let's go even further and  
6 say that they have diagnosed DSM-IV-TR diagnoses as well.

\* \* \*

6           The person then comes to you and says, "I understand that I'm not  
7 covered under the neurodevelopmental benefit because I'm age  
8 seven, am I covered under the rehab benefit?"

8           And the first thing you do [is] determine whether they are  
9 trying to improve their function or restore function? Is that what  
10 goes on clinically?

9           A: I do an evaluation and I send it to clinical review.

10          Q: And if the evaluation concludes that they're seeking  
11 speech therapy to not just restore previous function but to improve  
12 function, your expectation is that Group Health would determine that  
13 to be not medically necessary?

\* \* \*

13          A: Typically, yes.

14          Q: And that's your current understanding up to today, is that  
15 correct?

16          A: Yes. . . .

15 Dkt. # 64 at 27. Furthermore, she goes on to note that there have been "[l]ess than  
16 seven" cases in which treatment has continued to be covered after the individual turned  
17 seven. *Id.* It thus appears that both Defendants' policies and its practices do not favor  
18 Plaintiffs' chances of obtaining the coverage to which she is entitled absent an injunctive  
19 order—acutely demonstrating the need for the Court "to clarify [Plaintiffs'] rights to  
20 future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

\* \* \*

21           In sum, the Court finds (1) that RCW 48.46.291 is effective against Group Health,  
22 (2) that neither Group Health's policies nor its practices adhere to the statute's mandates,  
23 and (3) that Plaintiffs have more than demonstrated a substantial likelihood of harm  
24 absent injunctive relief. Accordingly, the Court GRANTS Plaintiffs' motion for  
25 declaratory and injunctive relief under § 1132(a)(1)(B) and (a)(3). The Court ORDERS

26 ORDER GRANTING PLAINTIFFS' MOTIONS FOR SUMMARY JUDGMENT - 24

1 Defendants to cease denying coverage for medically necessary neurodevelopmental  
2 therapy to treat insureds with DSM-IV-TR mental health conditions simply because the  
3 insured is over six years old. Moreover, the Court ORDERS Defendants to cease their  
4 application of any treatment limitations that are not generally “imposed on coverage for  
5 medical and surgical services.” RCW 48.46.291(2)(c)(i). The Court will not look kindly  
6 on failures to immediately implement its directive.

### 7 III. CONCLUSION

8 For all of the foregoing reasons, the Court GRANTS Plaintiffs’ “Motion for  
9 Summary Judgment re: Exhaustion of Administrative Remedies” (Dkt. # 43) and  
10 “Motion for Partial Summary Judgment re: Clarification of Rights to Benefits and  
11 Injunctive Relief under ERISA” (Dkt. # 44).

12 Plaintiffs exhausted their 2010 and 2011 claims and have demonstrated as a  
13 matter of law that Group Health’s policies and its actions fail to comport with the plain  
14 requirements of Washington’s Mental Health Parity Act. Accordingly, they are entitled  
15 to declaratory relief. Moreover, because they have demonstrated a strong likelihood of  
16 future irreparable injury absent injunctive relief, the Court ORDERS Defendants to  
17 immediately cease denying coverage for medically necessary neurodevelopmental  
18 therapy to treat insureds with DSM-IV-TR mental health conditions simply because an  
19 insured is over six years old. Defendants must immediately cease their application of  
20 any treatment limitations that are not generally “imposed on coverage for medical and  
21 surgical services.” RCW 48.46.291(2)(c)(i).

22 DATED this 1st day of June, 2012.

23   
24 Robert S. Lasnik  
25 United States District Judge

26 ORDER GRANTING PLAINTIFFS’ MOTIONS FOR SUMMARY JUDGMENT - 25

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HON. MICHAEL J. TRICKEY  
Noted for Hearing: November 9, 2012 at 9:30 a.m.  
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and  
K.G., and K.N. and T.N., by and through  
their parents P.N. and L.N., each on his or  
her own behalf and on behalf of all similarly  
situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE OF  
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

PLAINTIFFS' MOTION FOR PARTIAL  
SUMMARY JUDGMENT REGARDING  
VISIT LIMITS

AND

MOTION FOR PERMANENT  
INJUNCTIVE RELIEF PURSUANT TO  
CR 65 (a)(2)

I. INTRODUCTION

Since April 26, 2012, Premera has ignored the Court's declaratory judgment that under the Mental Health Parity Act, neurodevelopmental therapies to treat DSM-IV conditions must be covered as "mental health services." The insurer continues to violate the law in two ways: (1) Premera continues to exclude coverage of neurodevelopmental therapies entirely in its contracts and coverage policies; and (2) for some limited diagnoses (including autism), the insurer covers the therapies as "rehabilitation services," not mental health services, and *lumps speech, occupational physical and massage therapies together to apply an aggregate annual visit limit cap.*

Plaintiffs ask the Court to take the following action to protect the rights of Plaintiffs K.N. and T.N. and proposed class members: *First*, the Court should enjoin

1 Premera to cease its application of its neurodevelopmental therapy exclusion to class  
2 members and to cover neurodevelopmental therapies to treat DSM-IV conditions as  
3 "mental health services."

4           *Second*, the Court should further rule that Premera's "lump and cap"  
5 visit limits also violate the Mental Health Parity Act. This arbitrary cap is not applied  
6 generally to medical and surgical services. It has nothing to do with the medical  
7 necessity of the therapy - it is automatically imposed on medically necessary care once  
8 the arbitrary cap is reached. The "lump and cap" provision violates the plain language  
9 of the Mental Health Parity Statute. Of course, it also violates the plain language of this  
10 Court's April 26 Order:

11           Under the Mental Health Parity Act, *Defendants must*  
12 *provide coverage for all medically necessary "mental health*  
13 *services" to the same extent as they provide coverage for*  
14 *other medical and surgical services.* Neurodevelopmental  
15 therapies are "mental health services" designed to treat  
16 autism, a mental disorder listed in the DSM-IV. Since  
17 neurodevelopmental therapies may be medically necessary to  
18 treat autism, Defendants cannot use a blanket exclusion to  
19 deny coverage for those therapies.

20 Order Granting Plaintiff's Motion for Partial Summary Judgment and Injunctive Relief  
21 and Denying Defendants' Motion to Dismiss, April 26, 2012, p. 3 (emphasis added).

22           Premera knows full well that its "lump and cap" limitation is illegal. It  
23 has repeatedly and publicly represented that *all* visit limits on mental health services  
24 must be abolished due to the requirements of the Parity Act. As Premera informed  
25 A.G. in June 2010:

26           Mental Health Care benefits of your plan will be revised to  
27 comply with the new state requirements for equivalent  
28 benefits for mental health care treatment. Under this law,  
29 member cost-sharing requirements (deductibles, copays and  
30 coinsurance), benefit limits, including network restrictions,  
31 may not be more restrictive than the common or most

1 frequent cost-sharing requirements, benefit limits or network  
2 restrictions that apply to medical or surgical benefits.

3 ...  
4 Effective July 1, 2010, your contract is amended to reflect  
5 coverage for Mental Health Care services as stated above.  
6 Benefits for Mental Health Care will be subject to the same  
7 calendar year deductible, coinsurance or copays as you  
8 would pay for inpatient services and outpatient visits for  
9 other covered medical conditions and *do not have an annual  
10 or separate benefit limit.*

11 Hamburger Decl. (10/12/12) Exh. A. At that time, Premera eliminated all visit limits  
12 for "mental health services" in A.G.'s policy and that of other class members. *Id.*  
13 Lifewise and Premera also informed its brokers that visit limits would be eliminated  
14 for mental health services in all plans:

15 Starting July 1, 2010, all Lifewise Health Plan of  
16 Washington Individual and Family Plans are changing to  
17 comply with Washington state mental health parity laws.  
18 All current and closed plans, as well as group conversion  
19 plans will have *unlimited mental health limits.*

20 *Id.*, Exh. B; LifeWise Connections, April 2010, pp. 8-9; *See also Exh. C*, Premera Pulse,  
21 April 2010, p. 10 (starting July 1, 2010, both small group and individual Premera plans  
22 had "*unlimited mental health benefits*" due to final implementation of the Parity Act).

23 Premera should be ordered to immediately cease its lump and cap visit  
24 limit on medically necessary neurodevelopmental therapies to treat DSM-IV  
25 conditions. Those services must be covered as "mental health services" without any  
26 visit limits, just as Premera does for other mental health, medical and surgical services.

## 27 II. RELIEF REQUESTED

28 Plaintiffs and the class, if certified, respectfully request that the Court:

- 29 (1) Order Premera to immediately cease applying all visit limits to  
30 neurodevelopmental therapies to treat DSM-IV conditions, since there

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are no corresponding visit limitations imposed on medical and surgical services generally;

(2) Order Premera to immediately alter its Certificates of Coverage to (a) explicitly cover medically necessary neurodevelopmental therapies to treat DSM-IV conditions as "mental health services" and (b) eliminate all exclusions and treatment limitations imposed on services to treat developmental DSM-IV conditions, where such exclusions and limitations are not generally imposed on medical and surgical services.

(3) Order Premera to immediately provide corrective Notice to all class members regarding Premera's obligation to cover neurodevelopmental therapies to treat DSM-IV conditions as "mental health services;" and

(4) Order Premera to issue corrected Certificates of Coverage that reflect the Court's injunctive order.

**III. FACTS**

The facts of this case have been described in detail in the Court's April 26, 2012 Order and are incorporated herein by reference. The following additional facts relate to Premera's continued use of exclusions and treatment limitations on neurodevelopmental therapies to treat autism and other DSM-IV conditions after the Court's April 26, 2012 ruling:<sup>1</sup>

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<sup>1</sup> After the Court's ruling, Premera moved for interlocutory appeal of the Court's Order. Hamburger Decl., ¶2. Shortly thereafter, the parties engaged in protracted settlement negotiations, meeting together with Ret. Judge George Finkle on three occasions, as well as in many more informal conversations between negotiations. *Id.* On September 27, 2012, however, the settlement negotiations broke down and the parties returned to actively litigating this case. *Id.*

1                    Since the Court's order, Premera has apparently processed A.G.'s  
2 neurodevelopmental therapies under the mental health benefit of his policy, without  
3 the application of any combined visit limits. Hamburger Decl. ¶3. Premera has not,  
4 however, changed its policies or practices for other affected non-ERISA insureds. See  
5 P.N. Decl. ¶13. For example, new Plaintiffs K.N. and T.N. were never informed by  
6 Premera that neurodevelopmental therapies would not be covered as "mental health  
7 services." *Id.* Although Premera has covered some of K.N. and T.N.'s  
8 neurodevelopmental therapy services under the rehabilitation benefit (see P.N. Decl.  
9 ¶8), they are at risk for a "clawback" just like A.G. experienced. Moreover, Premera's  
10 denials of K.N. and T.N.'s ongoing therapies, and their administrative appeals, shows  
11 that Premera persists in treating neurodevelopmental therapies to treat DSM-IV  
12 conditions as something other than "mental health services. *Id.*

13                    Premera's Certificates of Coverage in its non-ERISA plans still contain the  
14 very language that the Court ruled was void and against public policy. In an  
15 individual policy filed with the Washington Office of the Insurance Commissioner,  
16 effective in May 2012 (and not modified since), Premera's illegal exclusions persist:

17                    **EXCLUSIONS**

18                    This section of the contract lists those services, supplies  
19 or drugs that are not covered under this plan.

20                    ...

- 21                    • Habilitation, education, or training services or  
22                    supplies for dyslexia, for attention deficit  
23                    disorders, and for disorders or delays in the  
24                    development of a child's language, cognitive,  
25                    motor or social skills including evaluations thereof

26                    ...

**Learning Disorders and Neurodevelopmental Therapy**

1 Services, therapy and supplies related to the treatment of  
2 learning disorders, cognitive handicaps, dyslexia,  
3 developmental delay or neurodevelopmental disabilities.

4 Hamburger Decl., *Exh. D*, p. 29.

5 Again, in a contract Premera filed with the Office of the Insurance  
6 Commissioner in June 2012 for coverage of graduate students at the University of  
7 Washington (a non-ERISA plan), Premera retained all of the exclusions that this Court  
8 had declared illegal:

9 **WHAT'S NOT COVERED**

10 ...

- 11 • Habilitation, education, or training services or  
12 supplies for dyslexia, for attention deficit disorders,  
13 and for *disorders or delays in the development of a  
14 child's language, cognitive, motor or social skills  
15 including evaluations thereof.* However, this  
16 exclusion doesn't apply to treatment of  
17 neurodevelopmental disabilities in children age 6 and  
18 under as state under the Neurodevelopmental  
19 Therapy rider.

20 Hamburger Decl., *Exh. E*, p. 26 (emphasis added).

21 Premera's actual practices haven't changed either. Just as with A.G.,  
22 Premera apparently covers some neurodevelopmental therapies to treat DSM-IV  
23 conditions (including autism) as rehabilitation services, not mental health services.  
24 When it does, it lumps the therapies together with other rehabilitative services to  
25 impose a combined cap on coverage. New Plaintiffs K.N. and T.N. are sisters, both of  
26 whom are diagnosed with autism and other developmental DSM-IV conditions. P.N.  
Decl. ¶¶3-4. In 2012, both submitted claims for speech and occupational therapies to  
Lifewise/Premera. *Id.* ¶8. Both had their therapies covered, up to 20 combined visits,  
under their rehabilitation therapy benefit. *Id.*

1                   But K.N. and T.N. need more therapy than just 20 visits, which ran out in  
2 April and June 2012 respectively. *Id.* Their mother appealed Premera's denial of  
3 coverage once the 20-visit limit was reached. *Id.* ¶11, *Exhs. A, B, C, and D.* At both  
4 levels of internal administrative review, Premera denied coverage simply because the  
5 plan's visit limit had been reached. *Id.* ¶12, *Exhs. E, F, G, and H.* Premera refused to  
6 consider the therapies to be "mental health services" - even though P.N.'s appeal was  
7 filed after this Court's Order declaring that such therapies should be covered under  
8 Premera's mental health benefit. *See id.* Premera never denied the claims based upon  
9 medical necessity. The only reason provided for Premera's denial was that the plan's  
10 annual visit limit for the therapies had been reached.

11                   K.N. and T.N. and the proposed class need ongoing therapy in order to  
12 improve their condition and development. *See* P.N. Decl. ¶ 10; Glass Decl. ¶¶5-9. These  
13 therapies are the essential health benefit for children with developmental disabilities  
14 and are instrumental in reducing the impact of their disabilities on their health and  
15 safety:

16                   Children who need these therapies, but do not receive  
17 them (or do not receive them in a timely manner and at the  
18 required intensity) are likely to lose the opportunity to have  
19 the impact of their developmental deficits reduced to the  
20 maximum degree or, to enjoy the prospects of their  
21 development being restored to normal functioning, or at the  
22 very least, as near to normal functioning as possible. The  
23 harm attendant in the delay to provide EI [Early  
24 Intervention] services is real and substantial. Especially for  
25 the very young child, losing access to needed therapies in a  
26 timely manner can make reversible or treatable  
developmental conditions more severe, of greater long-term  
functional impact and at times, devastating, and unneeded,  
consequences may be seen.

1 Glass Decl. ¶8. Without the neurodevelopmental therapies provided by Cascade  
2 Children's Clinic, K.N. and T.N. continue to experience severe communication deficits  
3 and behavioral problems. P.N. Decl. ¶10.

4  
5 **IV. LAW AND ARGUMENT**

6 **A. Premera May Not Lump and Cap Outpatient Neurodevelopmental**  
7 **Mental Health Services Because the Insurer Does Not Similarly**  
8 **Lump and Cap Outpatient Medical and Surgical Services.**

9 The Parity Act makes that clear that visit limits are illegal if they are not  
10 also imposed on general medical and surgical services:

11 *Treatment limitations* or any *other* financial requirements on  
12 coverage for mental health services are only allowed if *the*  
13 *same limitations or requirements* are imposed on coverage  
14 for *medical and surgical services*.

15 RCW 48.46.291(2)(c)(i) (emphasis added). The word "other" directly modifies  
16 "treatment limitations" and reveals that the legislature intended that any such  
17 limitations be considered a form of financial requirement, such as a visit limit, age  
18 limit, or annual or lifetime financial cap.

19 Ending discriminatory visit limits was at the heart of the Parity Act.  
20 Historically, as the legislative Sunrise Review noted, "most health plans ... do cover  
21 mental health services but nearly all do so with limits on *visits*, days, cumulative cost,  
22 or other parameters." Hamburger Decl., (1/14/12), *Exh. H*, p. 1 (emphasis added). The  
23 Act was therefore specifically designed to require that those treatment limitations and  
24 financial limits on mental health services be the same as those generally applied to all  
25 medical and surgical services. As the Sunrise Review explained:

26 The requirement for parity is also broadly worded, so  
that it applies to both treatment limitations and various  
other forms of financial participation. ... For example, if  
there is a \$10 co-pay for office visits, the co-pay for mental  
health visit must not be more than \$10. In addition, *there*  
*could be no maximum number of visits on either an*

1                    *inpatient or outpatient basis, unless similar requirements*  
2                    *were imposed on coverage for medical and surgical services.*

3                    *Id.* (emphasis added). This Court agreed:

4                    Under the Mental Health Parity Act, Defendants must  
5                    provide coverage for all medically necessary "mental health  
6                    services" to the same extent as they provide coverage for  
7                    other medical and surgical services. Neurodevelopmental  
8                    therapies are "mental health services" designed to treat  
9                    autism, a mental disorder listed in the DSM-IV. Since  
10                    neurodevelopmental therapies may be medically necessary to  
11                    treat autism, Defendants cannot use a blanket exclusion to  
12                    deny coverage for those therapies.

13                    ...

14                    *Defendants shall review any new claims* submitted by  
15                    Plaintiff A.G. and/or his providers *for neurodevelopmental*  
16                    *therapy as a mental health benefit* and consistent with all  
17                    other provisions in Plaintiff A.G.'s contract, including  
18                    medical necessity

19                    April 26, 2012 Order pp. 3, 8 (emphasis added). Thus, no treatment limitations,  
20                    including visit limits, can be imposed on neurodevelopmental therapies to treat DSM-  
21                    IV conditions, if such limits are not imposed on medical and surgical services  
22                    generally.

23                    This is not news to Premera. Premera understood that full  
24                    implementation of the Parity Act would eliminate all visit limits imposed on mental  
25                    health services. Premera removed visit limits from its large group plans in November  
26                    2009. *See* Hamburger Decl., *Exh. C*, p. 10. It removed all visit limits from its mental  
                    health benefits in small group and individual plans in July 1, 2010. *Id.*; *see also id.*, *Exh.*  
                    *C*, pp. 8-9. The sole reason given for these changes was "to comply with Washington  
                    state mental health parity laws." *Id.* Even in this litigation, Premera conceded that the  
                    state Parity Act requires the elimination of treatment limitations where such services  
                    are not imposed on medical and surgical services generally:

1 The Parity Act was first enacted in 2005, but did not include  
2 individual health plans until 2007. 2007 Laws, ch. 8. The Act  
3 requires plans that cover medical and surgical services to also  
4 provide coverage for "mental health services" to individuals  
5 diagnosed with a condition listed in DSM-IV (*sic*). The Parity  
6 Act mandates this coverage in phases. For plans issued or  
7 renewed after January 1, 2008, the Act generally requires only  
8 that the co-pay for mental health services be no more than the  
9 co-pay for medical and surgical services. RCW 48.44.341  
(2)(b)(ii). *For plans issued or renewed after July 1, 2010, the  
Act also requires that treatment limitations on coverage for  
mental health services be the same as those imposed on  
coverage for medical and surgical services.* RCW 48.44.341  
(2)(c)(i).

10 Premera's Mot. to Dismiss, (10/5/11), pp. 6-7 (emphasis added).

11 This exact issue was addressed by Judge Lasnik in *Z.D. v. Group Health  
12 Cooperative* when he rejected Group Health's age-limit for coverage of  
13 neurodevelopmental therapies to treat DSM-IV conditions. In that case, Group Health  
14 provided coverage of neurodevelopmental therapies, but only up to age 6. All  
15 coverage after age 6 was excluded. Judge Lasnik determined that the age-limitation  
16 was an impermissible treatment limit because it was not imposed on medical and  
17 surgical services generally:

18 In short, the clause precludes Group Health from imposing  
19 precisely the sort of *tailored limitations at issue here*—  
20 limitations that would defeat the very purpose of the statute:  
providing coverage.

21 In sum then, the Court finds that RCW 48.46.291(2)(c)(i)  
22 requires Group Health to provide coverage for "medically  
23 necessary outpatient and inpatient services provided to treat  
24 mental disorders covered by the diagnostic categories listed  
25 in the most current version of the diagnostic and statistical  
26 manual of mental disorders, published by the American  
psychiatric association," with those limited exceptions set  
forth in the statute, RCW 48.46.291(1). And it finds that the  
*final clause of subsection (c)(i) only further precludes Group  
Health from imposing treatment limitations it does not*

1 generally "impose[] on coverage for medical and surgical  
2 services." RCW 48.46.291(2)(c)(i).

3 Hamburger Decl., *Exh. F*, Z.D. v. Group Health Cooperative, No. 2:11-cv-01119-RSL,  
4 Dkt. No. 77, pp. 22-23 (emphasis added).

5 This is not a close question. The Parity Act prevents Premera from  
6 imposing visit limits on mental health services, including neurodevelopmental  
7 therapies to treat DSM-IV conditions, since it does not impose visit limits on medical  
8 and surgical services generally. Despite the clear prohibition, Premera now singles out  
9 just one type of mental health therapy for visit limits - neurodevelopmental therapy -  
10 which is the predominant therapy to treat developmentally disabled enrollees. It is the  
11 essence of discrimination. It is precisely what the Parity Act prohibits.

12 **B. Premera May Not Impose Visit Limits Simply Because It Also  
13 Imposes Visit Limits on Rehabilitation Services.**

14 Premera may claim that it can impose a visit limit on a subset of mental  
15 health services -- neurodevelopmental therapies to treat DSM-IV conditions -- because  
16 it imposes a similar visit limit on rehabilitation therapies. Of course, Group Health  
17 made - and lost -- this argument when it asked Judge Lasnik to approve its age limit  
18 for neurodevelopmental therapies. In *Z.D.*, Group Health claimed that it could impose  
19 an age limit on all neurodevelopmental therapies, whether provided to treat DSM-IV  
20 conditions or medical conditions, because the age limit applied the same to both  
21 medical or mental health conditions. *Id.*, *Exh. F*, p. 21 ("They contend that because  
22 Group Health essentially excludes all non-restorative "rehabilitative therapies related  
23 to medical and surgical services," it may similarly exclude all coverage for similar non-  
24 restorative mental health or neurodevelopmental disorders.").

25 The *Z.D.* court rejected Group Health's attempt to use a special parity  
26 "comparator" just for neurodevelopmental therapy services to treat DSM-IV  
conditions. Judge Lasnik concluded that the Parity Act's regulation of treatment limits

1 was designed to "preclude[ ] Group Health from imposing precisely the sort of  
2 *tailored limitations at issue here.*" *Id.*, p. 22 (emphasis added). The Court continued  
3 that such limitation "would defeat the very purpose of the statute: providing  
4 coverage." *Id.*

5 [B]ecause Group Health does not exclude individuals over  
6 the age of six from coverage for medical and surgical services  
7 or even impose an age-based limitation on its therapy  
8 coverage in general, it may not impose that limitation on  
non-restorative mental health therapy coverage.

9 *Id.*, pp. 22-23. Premera's visit limits for neurodevelopmental mental health services  
10 violate the Parity Act in the exact same manner.

11 The Parity Act unambiguously prohibits treatment limitations for all  
12 "mental health services" if a health benefit plan does not similarly limit "coverage for  
13 medical and surgical services." RCW 48.46.291(2)(c)(i) (emphasis added). As the  
14 Senate Bill Report explained, "Beginning January 1, 2010:...treatment limitations or any  
15 other financial requirements on coverage for mental health services are only allowed if  
16 the *same limitations* or requirements are imposed on coverage for medical and  
17 surgical services." Hamburger Decl., *Exh. G*, p. 41 (emphasis added). The mandate is  
18 not linked to any specific medical or surgical benefit, but to the existence of those  
19 services generally. If Premera does not impose a visit limit on coverage for outpatient  
20 medical services and surgical services generally -- which it does not--then it is  
21 prohibited from imposing such a visit limit on any outpatient mental health service,  
22 even neurodevelopmental mental health services.

23 Washington's Parity Act is consistent with the federal Mental Health  
24 Parity Act, which likewise requires that any exclusions imposed on a mental health  
25 service be applied to "substantially all" medical and surgical benefits. *See* 29 U.S.C. §  
26 1185a (a)(3); *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health*

1 Parity and Addiction Equity Act of 2008, 75 FR 5410-01, p. 5413 (“[A]ny treatment  
2 limitations applied to mental health or substance use disorder benefits may be no more  
3 restrictive than the *predominant treatment limitations applied to substantially all*  
4 *medical/surgical benefits.*”) (emphasis added); 26 C.F.R. § 54.9812-1T(b)(plans may not  
5 impose limits on mental health services if those limits do not also apply to at least two-  
6 thirds of all medical and surgical benefits).<sup>2</sup> The Washington Parity Act is also  
7 consistent with that of other states. *See e.g., Harlick v. Blue Shield of California*, 686 F.3d  
8 699, 711-12 (9th Cir. 2012) (California’s Parity Act requires health insurers to apply the  
9 same financial conditions that are applied to coverage for physical illnesses generally  
10 to covered mental conditions).

11 Using general medical and surgical services as the comparator for parity  
12 prevents disparate impacts, such as where (as here) a specific benefit is primarily—but  
13 not exclusively—utilized to treat persons with mental health conditions. The  
14 requirement prevents insurers from gaming true parity by selecting the “skinniest”  
15 medical/surgical benefit as the comparator. *See* 75 FR 5410-01, 5412 (February 2, 2010)  
16 (“This requirement is included to ensure that a plan does not misclassify a benefit in  
17 order to avoid complying with the parity requirements.”). That is why the federal Act,  
18 like Washington’s Parity Act, forbids limiting parity to a comparison between one  
19 single type of mental health service and another type of medical service.

20 The result, an effective prohibition on visit limits in mental health, is the  
21 “largest benefit” associated with the federal Parity Act. *Id.*, p. 5422. The regulators  
22

23  
24 <sup>2</sup> Premera admits that it must comply with the federal Mental Health Parity and Addiction Equity  
25 Act Parity Act’s requirements for its ERISA group plans covering 51 or more enrollees, including many  
26 of the class members in this case. 26 C.F.R. § 54.9812-1T (e). As a matter of both state and *federal law*,  
Group Health cannot impose visit limits on neurodevelopmental mental health services in its large  
group ERISA plans. *See e.g., Hamburger Decl., Exh. C*, p. 10 (“Since November 2009, Premera group  
plans for 51 or more...have unlimited mental health...benefits...to comply with this legislation.”).

1 explained that the federal Act's use of broad categories of medical and surgical services  
2 for the parity comparison was designed to add substantial "teeth" to the 1996 Parity  
3 Act:

4 [A] major shortcoming of [the prior federal Mental Health  
5 Parity Act of 1996] was its failure to apply parity to visit  
6 limitations. *Applying parity to visit limitations will help  
7 ensure that vulnerable populations -- those accessing  
8 substantial amounts of mental health and substance use  
9 disorder services -- have better access to appropriate care. ...*

10 The most common visit limits under current insurance  
11 arrangements are those for 20 visits per year. That means  
12 assuming a minimal approach to treatment of one visit per  
13 week, people with severe and persistent mental disorders  
14 will exhaust their coverage in about five months. This often  
15 results in people foregoing outpatient treatment and a higher  
16 likelihood of non-adherence to treatment regimes that  
17 produce poor outcomes and the potential for increased  
18 hospitalization costs.<sup>3</sup>

19 *Id.* (emphasis added).

20 That is exactly what happened to K.N. and T.N. Both are diagnosed with  
21 autism, a severe, life-long disorder for which the only evidence-based, effective  
22 treatment is early, intensive intervention. Such intensive interventions are designed to  
23 quickly return children with autism to a normal or as near normal developmental  
24 trajectory as possible at the time in their lives when such recovery is possible. Glass  
25 Decl. ¶8. Timely and adequate speech and occupational therapy are a critical  
26 component of this early intervention approach. *Id.* ¶¶6-8.

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<sup>3</sup> The Department of Health and Human Services found that requiring parity of visit limits would likely reduce out-of-pocket expenses for services that were needed but not covered, thereby reducing bankruptcy, financial distress for families, cost-shifting of those services to the public sector, and increase productivity of persons with mental disorders at work, as well as the quality of mental health care provided. 75 FR 5410-01, pp. 5422-5423.

1 Both K.N. and T.N. received speech and occupational therapies 2012 that  
2 were covered by Premera. P.N. Decl. ¶8. Coverage for those therapies, however, was  
3 exhausted by April for K.N. and June for T.N. *Id.* Without continued therapy, all of  
4 the progress made in the first four months of treatment was lost. *Id.* ¶10. When  
5 Premera's plan covers only 20 combined visits, Premera effectively denies most  
6 coverage of the essential treatment for children with autism such as K.N. and T.N. This  
7 Court should not countenance a visit limit on neurodevelopmental mental health  
8 therapies when Premera does not generally limit visits for medical or surgical services  
9 or even for other mental health services.

10 **C. The Court Should Issue a Permanent Injunction Against Premera to**  
11 **Eliminate All Exclusions and Limitations Imposed on Coverage for**  
12 **Neurodevelopmental Mental Conditions.**

13 An injunction is appropriate where a plaintiff does not have a plain,  
14 complete, speedy and adequate remedy at law. *Kucera v. State, Dept. of Transp.*, 140 Wn.  
15 2d 200, 209, 995 P.2d 63 (2000). If that is the case, the plaintiff must "demonstrate that  
16 (1) he has a clear legal or equitable right, (2) he has a well-grounded fear of immediate  
17 invasion of that right, and (3) that the acts he is complaining of have or will result in  
18 actual and substantial injury." *DeLong v. Parmelee*, 157 Wn. App. 119, 150-51, 236 P.3d  
19 936, 951-52 (2010). Additionally, courts must consider a "balancing of the relative  
20 interests of the parties, and if appropriate, the interests of the public." *Kucera*, 140 Wn.  
21 2d at 209. A permanent injunction may be issued when all parties have notice that the  
22 trial on the merits related to the injunctive relief sought will be advanced and  
23 consolidated with the hearing. CR 65 (a)(2); *Nw. Gas Ass'n v. Washington Utilities &*  
24 *Transp. Comm'n*, 141 Wn. App. 98, 113, 168 P.3d 443 (2007). Here, all of the factors are  
25 met.  
26

1                   1.     Plaintiffs K.N. and T.N. and the Proposed Class Have No  
2                                   Speedy, Adequate Remedy at Law.

3                   Plaintiffs K.N. and T.N. claims for legal relief arising out of Premera's  
4 wrongful denial of coverage for their neurodevelopmental mental health services.  
5 Those claims include reimbursement for treatment that Plaintiff and proposed class  
6 members have paid out-of-pocket. Legal relief, however, is far from adequate.  
7 Plaintiffs K.N. and T.N. have been without speech and occupational therapy treatment  
8 since May and July 2012, respectively. Their parents cannot afford to pay for these  
9 services and wait for monetary relief. P.N. Decl., ¶9. This precise problem was  
10 identified by the Department of Health:

11                               Many children with ASD go without necessary treatments  
12                               and services because the costs are so high and insurance  
13                               coverage is not generally available. Many families simply  
                                  cannot afford to pay for the necessary early, intensive  
                                  treatments.

14                   Hamburger Decl., (1/14/12), *Exh. C*, p. 10. Premera could have implemented the  
15 Court's declaratory order without further judicial action, but it has not done so.  
16 Permanent injunctive relief is required to ensure that all non-ERISA enrollees receive  
17 access to neurodevelopmental therapies, just like as A.G. has.

18                   2.     Clear Legal Right.

19                   As demonstrated above and as determined by this Court in its April 26,  
20 2012 Order, Plaintiffs and the proposed class have a clear legal right to medically  
21 necessary neurodevelopmental therapies to treat their DSM-IV conditions. Those  
22 therapies must be covered as "mental health services" under their Premera contracts,  
23 and covered, when medically necessary, without visit limits, so long as Premera does  
24 not impose visit limits on medical and surgical services generally.  
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3. **Premera's Actions Invade The Legal Rights of Plaintiffs and the Proposed Class.**

Premera's ongoing refusal to cover neurodevelopmental therapies to treat DSM-IV conditions as "mental health services" and its application of illegal contract exclusions and limitations is an invasion of their legal rights.

4. **Actual and Substantial Injury/Irreparable Harm.**

As this Court found on April 26:

The loss of speech and occupational therapy services will harm Plaintiff A.G.'s health and continued development. *See, e.g., LaForest v. Former Clean Air Holding Co., Inc.*, 376 F.3d 48, 55 (2d Cir. 2004). Money damages are insufficient to compensate A.G. for the resulting developmental loss. *See Washington Fed'n of State Employees (WSFE), Council 28, AFL-CIO v. State*, 99 Wn. 2d 878, 891, 665 P.2d 1337 (1983) (It is "well nigh irrefutable" that a cancellation of health insurance is an injury that has no remedy at law).

Order, p. 7. The harm suffered by A.G. when his speech and occupational therapy services were threatened, is the same harm currently suffered by Plaintiffs K.N., T.N. and the proposed class. All either face or already suffer irreparable harm from the loss of medically necessary neurodevelopmental therapies to treat their DSM-IV conditions.

Dr. Glass confirms that actual and substantial harm is inflicted on the class the longer they wait for coverage of medically necessary neurodevelopmental mental health services. With timely services, children are less disabled, have fewer long-term care needs, and may avoid costly, complex and risk-laden treatment or procedures. Glass Decl. ¶9. Without the services, children with conditions *that could have been reversed or treated*, end up more impaired, with greater long-term functional disabilities, and, at times, experiencing devastating and avoidable consequences. *Id.* ¶8.

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**5. Balance of the Hardships.**

Balancing of the hardships tips decidedly in favor of the Plaintiffs and the proposed Class. As the Court previously concluded: "The loss of medically necessary therapies needed to maintain and improve a disabled child's functioning at a critical time in his development causes a tremendous hardship." April 26, 2012 Order p. 7. And, as the Court further concluded, Premera suffers no hardship when it is enjoined from enforcing illegal provisions of its contracts. *Id.*

**6. Bond**

Any bond requirement should be waived under RCW 7.40.080 because "a person's health ...would be jeopardized" without this permanent injunction.

**V. CONCLUSION**

Despite the Court's April 26, 2012 Order, Premera continues to systematically impose exclusions and limitations that deny coverage of medically necessary neurodevelopmental therapies to treat DSM-IV conditions. Premera's visit limits are as illegal as its developmental disability exclusion. The Court should permanently enjoin Premera from applying exclusions and visit limitations to neurodevelopmental mental health services because it does not apply the same exclusions and limitations to medical and surgical services.

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DATED: October 11, 2012.

SIRIANNI YOUTZ SPOONEMORE

          /s/ Eleanor Hamburger            
Eleanor Hamburger (WSBA #26478)  
Richard E. Spoonemore (WSBA #21833)  
Attorneys for Plaintiffs

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on October 11, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

Barbara J. Duffy	<input checked="" type="checkbox"/>	By United States Mail
Gwendolyn C. Payton	<input type="checkbox"/>	By Legal Messenger
Ryan P. McBride	<input checked="" type="checkbox"/>	By Email
LANE POWELL PC		Tel. 206.223.7000
1420 Fifth Avenue, Suite 4100		<a href="mailto:duffy@lanepowell.com">duffy@lanepowell.com</a>
Seattle, WA 98101		<a href="mailto:payton@lanepowell.com">payton@lanepowell.com</a>
<i>Attorneys for Defendants</i>		<a href="mailto:mcbri@lanepowell.com">mcbri@lanepowell.com</a>

DATED: October 11, 2012, at Seattle, Washington.

/s/ Richard E. Spoonemore  
Richard E. Spoonemore (WSBA #21833)

# EXHIBIT G

P.A. 000113

## SENATE BILL REPORT SHB 1154

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As Passed Senate, March 3, 2005

**Title:** An act relating to mental health parity.

**Brief Description:** Requiring that insurance coverage for mental health services be at parity with medical and surgical services.

**Sponsors:** House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Schual-Berke, Campbell, Kirby, Jarrett, Green, Kessler, Simpson, Clibborn, Hasegawa, Appleton, Moeller, Kagi, Ormsby, Chase, McCoy, Kilmer, Williams, O'Brien, P. Sullivan, Tom, Morrell, Fromhold, Dunshee, Lantz, McIntire, Sells, Murray, Kenney, Haigh, Darneille, McDermott, Dickerson, Santos and Linville).

**Brief History:** Passed House: 1/28/05, 67-25.

**Committee Activity:** Health & Long-Term Care: 2/21/05, 2/24/05 [DP, w/oRec, DNP].

Passed Senate: 3/3/05, 40-9.

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### SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

**Majority Report:** Do pass.

Signed by Senators Keiser, Chair; Thibaudcau, Vice Chair; Deccio, Ranking Minority Member; Brandland, Franklin, Kastama, Kline and Poulsen.

**Minority Report:** That it be referred without recommendation.

Signed by Senators Johnson and Parlette.

**Minority Report:** Do not pass. Signed by Senator Benson.

**Staff:** Jonathan Seib (786-7427)

**Background:** Current Washington law does not require health carriers to include mental health coverage in any benefit plan. If a carrier nonetheless chooses to include such coverage, the law does not mandate a specific benefit level. The law does require that carriers providing group coverage to employers offer coverage for mental health, but the coverage can be waived by the employer. Where provided, most plans generally limit inpatient mental health coverage to a specified number of days, and outpatient coverage to a specified number of visits. These limitations are not imposed on most other treatment.

The federal Mental Health Parity Act (MHPA) took effect on January 1, 1998, and will sunset on December 31, 2005. Under the MHPA, businesses with more than 50 employees that choose to offer mental health benefits may not impose annual or lifetime dollar limits on those benefits that are lower than the limits set for the medical and surgical benefits that they provide. Cost sharing requirements, and limits on the number of visits or days of coverage, may still vary from other coverage. The requirements of the MHPA do not apply where they would increase costs to a business by more than one percent.

The Basic Health Plan (BHP) is authorized to offer mental health services under as long as those services, along with chemical dependency and organ transplant services, do not increase the actuarial value of BHP benefits by more than 5 percent. Currently, inpatient care requires a 20 percent co-pay (up to \$300 per admittance) for coverage up to 10 days per calendar year, and outpatient care requires a \$15 co-pay for up to 12 visits per year.

The Public Employee Benefits Board (PEBB) provides health coverage to state employees through both fully-insured managed care plans and the self-insured Uniform Medical Plan (UMP). For all (PEBB) plans, inpatient mental health care requires a \$200 per day co-pay (up to \$600) for coverage up to 10 days per year. Outpatient services require either a 10 percent (UMP) or 10 dollar (managed care) per visit co-pay for up to 20 visits per year.

Reflecting concerns that health insurance generally fails to cover mental health services to the same extent as other health care services, state legislation was introduced in 1998 calling for coverage parity. The legislation was referred to the Department of Health for review under the mandated health benefits sunrise review process set forth in statute. The Department of Health issued its final report in November 1998. The report analyzed the efficacy of the mandate, and its social and financial impact, and recommended that the legislation be enacted.

**Summary of Bill:** Beginning January 1, 2006 a health benefit plan that provides coverage for medical and surgical services must provide coverage for mental health services and prescription drugs to treat mental disorders. The co-pay or coinsurance for mental health services may be no more than the co-pay or coinsurance for medical and surgical services otherwise provided under the plan. Mental health drugs must be covered to the same extent, and under the same terms and conditions, as other prescription drugs covered by the plan.

Beginning January 1, 2008, if the plan imposes a maximum out-of-pocket limit or stop loss, it must be a single limit or stop loss for medical, surgical and mental health services.

Beginning July 1, 2010: (1) if the plan imposes any deductible, mental health services must be included with medical and surgical services for purposes of meeting the deductible requirement; and (2) treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services.

"Mental health services" is defined to include medically necessary services to treat any disorders listed in the current version of the diagnostic and statistical manual of mental disorders, except: (1) substance related disorders; (2) life transition problems; (3) nursing home, home health, residential treatment, and custodial care services; and (4) court ordered care that is not medically necessary.

The act applies to the Basic Health Plan, public employee plans issued by the Health Care Authority, and state regulated commercial plans for groups greater than 50.

Current laws mandating the offering of supplemental mental health coverage by carriers are amended to reflect the new requirements of the act.

The Insurance Commissioner and the administrator of the Health Care Authority are authorized to adopt rules implementing the act.

**Appropriation:** None.

**Fiscal Note:** Available.

**Committee/Commission/Task Force Created:** No.

**Effective Date:** Ninety days after adjournment of session in which bill is passed.

**Testimony For:** It is time for the distinction to end between mental and physical health. Better mental health coverage will reduce the need for other costly medical treatment. Any cost of the bill will also be more than offset by reduced employee absenteeism and increased productivity. At least 34 other states have enacted mental health parity laws, and none have been repealed. Many of those states have studied the impact of the law and determined that it resulted in only a minor impact on overall health care premiums. Mental illness has a devastating impact on individuals and families that is only made worse when treatment costs are not covered. Untreated mental illness also significantly impacts the criminal justice system. It is important that mental health be covered at similar levels by all carriers to avoid the risk of adverse selection.

**Testimony Against:** Mandating benefits does not help those who lose their coverage because of the increased cost of coverage. Mandates cannot be viewed in a vacuum, because their cumulative impact is what matters. Washington has one of the highest levels of mandates and regulations placed on health insurance in the country. Mandates are supposed to improve health coverage, but the actual effect is that they reduce the ability to provide coverage by increasing its costs. Others estimate the cost of this legislation to be much higher than the proponents, and comparisons to costs in other states are not accurate. Even a small percentage increase in cost means a lot in actual dollars. Mental illnesses are not like other illnesses. More mental health treatment does not lead to better mental health.

**Who Testified:** PRO: Representative Schual-Berke, prime sponsor; Randy Revelle, Washington Coalition for Insurance Parity; Ronald Bachman, Price Waterhouse Coopers; Greg Simon, M.D., Pam McEwan, Group Health; Chelene Alkire; Beth Berner; John Rothwell; Joanne Wilson; Colleen McManus; Terri Webster, Ben Bridge Jewelers; Peter Lukevich, Washington Partners in Crisis.

CON: Carolyn Logue, National Federation of Independent Business; Gary Smith, Independent Business Association; Sydney Smith Zvara, Association of Washington Healthcare Plans; Mellani Hughes McAleenan, Association of Washington Business; Richard Warner, Citizens Commission on Human Rights; Mel Sorenson, America's Health Insurance Plans, Washington Association of Health Underwriters.

# Exhibit H

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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of THE TECHNOLOGY ACCESS FOUNDATION HEALTH BENEFIT PLAN, and on behalf of similarly situated individuals,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, *et al.*,

Defendants.

No. C11-1119RSL

ORDER APPROVING  
SUBSTANCE OF PROPOSED  
CLASS NOTICE, REQUIRING  
DIRECT MAIL DELIVERY

This matter comes before the Court *sua sponte*. On June 1, 2012, the Court found that “Defendants’ official policy of denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM-IV-TR mental health conditions simply because an insured is over the age of six violates the plain requirements of RCW 48.46.291.” Dkt. # 78 at 13. It ordered Defendants to “immediately cease denying coverage” on the basis of age and to “notify each of their beneficiaries of this Court’s Order.” *Id.* It gave Defendants 21 days to submit their proposed notice to the Court. *Id.*

On June 22, 2012, Defendants submitted their initial proposed notice. Dkt. # 82. Seven days later, they submitted a revised notice approved by class counsel. Dkt. # 85. Defendants also notified the Court of their intent to provide the required notice in two

ORDER APPROVING SUBSTANCE OF PROPOSED  
CLASS NOTICE, REQUIRING DIRECT MAIL DELIVERY - 1

1 tiers: general notice to all beneficiaries via Group Health's web site and direct mail  
2 notice to a more limited group of beneficiaries—those who “(1) have diagnostic codes  
3 (ICD-9 codes) for DSM-IV mental health conditions for which treatment with  
4 neurodevelopmental therapies may be or may have been medically necessary, and (2)  
5 requested a referral or submitted a claim to Group Health for neurodevelopmental  
6 therapies.” Dkt. # 82. They indicated that the process of identifying the “direct mail”  
7 group may take up to four weeks. Dkt. # 83. Class counsel has indicated that it does not  
8 oppose Defendants' proposed two-tier system in the abstract, but makes clear that it will  
9 oppose Defendants' proposal if the resulting direct mail count is too low.

10 Having reviewed the substance of the revised proposed notice, the Court  
11 approves it. Like class counsel, however, the Court has serious concerns about the  
12 proposed two-tier system. The Court's notice requirement was intended to be remedial  
13 in nature—to provide notice of the Court's rulings and their entitlement to coverage to  
14 all beneficiaries who “require, or are expected to require, neurodevelopmental therapy  
15 for the treatment of a qualified mental health condition,” Dkt. # 78 at 3. And the Court  
16 is not confident that the proposed two-tier system would reasonably guarantee that  
17 result. In the Court's experience, most people open and review their mail; few peruse  
18 their insurer's web site absent some external stimuli.

19 In sum, the Court approves of the substance of the revised notice (Dkt. # 85). It  
20 does not, however, approve of the proposed two-tier notice scheme. The Court  
21 ORDERS Defendants to provide the now-approved notice to each of its beneficiaries via  
22 direct mail within two weeks of the date of this Order.

23 DATED this 6th day of July, 2012.

24 

25 Robert S. Lasnik  
United States District Judge

26 ORDER APPROVING SUBSTANCE OF PROPOSED  
CLASS NOTICE, REQUIRING DIRECT MAIL DELIVERY - 2

# Exhibit D

P.A. 000120

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HON. MICHAEL J. TRICKEY  
Noted for Hearing: March 2, 2012 @ 10:00 a.m.  
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and  
K.G., on his own behalf and on behalf of all  
similarly situated individuals,  
Plaintiff,

NO. 11-2-30233-4 SEA

v.

DECLARATION OF  
ELEANOR HAMBURGER

PREMERA BLUE CROSS and LIFEWISE OF  
WASHINGTON, Washington corporations,  
Defendants.

I, Eleanor Hamburger, declare under penalty of perjury and in  
accordance with the laws of the State of Washington that:

1. I am a partner at Sirianni Youtz Spoonemore and am one of the  
attorneys for Plaintiffs in this action.

2. Attached are true and correct copies of the following documents,  
with underlining where appropriate for the Court's convenience:

Exhibit	Description
A	Excerpts from Premera Blue Cross WEA Select Plan 1 effective October 1, 2011, from <a href="https://www.premera.com/stellent/groups/public/documents/xcpproject/wea-medical.asp">https://www.premera.com/stellent/groups/public/documents/xcpproject/wea-medical.asp</a> (as of 01/13/2012).

Exhibit	Description
B	Washington Office of the Insurance Commissioner Summary of Premera Blue Cross and Lifewise Health Plan of Washington, from <a href="http://www.insurance.wa.gov/consumertoolkit/start.aspx">http://www.insurance.wa.gov/consumertoolkit/start.aspx</a> (as of 01/10/12).
C	Excerpts from the Washington State Department of Health's <i>Information Summary and Recommendations concerning Treatment of Autism Spectrum Disorders Mandated Benefits Sunrise Review</i> dated January 2009.
D	Pages 163 and 164 from <i>Mental Health: A Report of the Surgeon General</i> (1999). See <a href="http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf">www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf</a> (as of 12/02/10).
E	Excerpts from Washington Department of Health, "Caring for Washington Individuals with Autism Task Force," December 2007. See <a href="http://www.doh.wa.gov/cfh/autism/ATF/default.htm">http://www.doh.wa.gov/cfh/autism/ATF/default.htm</a> (as of 01/13/12).
F	Mental Health: A Report of the Surgeon General, Children and Mental Health (selected pages)
G	Substitute House Bill 1154, as passed, effective 7/24/05.
H	The Washington State Department of Health's <i>Information Summary and Recommendations concerning Mental Health Party Mandated Benefits Sunrise Review</i> dated November 1998.
I	A web page from the United States Centers for Disease Control and Prevention (CDC) concerning the DSM-IV-TR code for autism disorders.

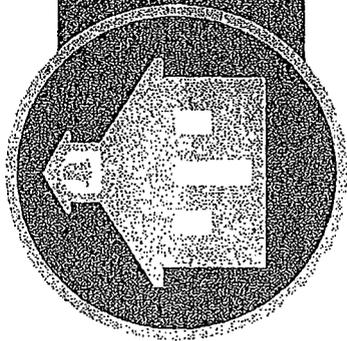
I declare under penalty of perjury of the laws of the State of Washington and the United States of America that the foregoing is true and correct.

DATED: January 13, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger  
Eleanor Hamburger



# Exhibit A



# WEA Select Plan 1

Plan effective October 1, 2011

## INTRODUCTION

Your WEA Select Medical Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Hewitt (Employee Benefits Consultant), Premera Blue Cross (Medical Plan Underwriter) and UnumProvident Life and Accident Insurance Company (Life Insurance Underwriter).

The WEA is the policyholder for this medical benefits plan. The WEA retains full and exclusive authority, at its discretion, to determine its availability. The plan is not guaranteed to continue indefinitely, and it may be altered or terminated at any time.

The WEA Benefits Services Advisory Board (BSAB) reviews all plan benefits and limitations, and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Hewitt.

### WEA CLAIM REVIEW

The WEA Board of Directors or its appointed Benefit Services Advisory Board (BSAB) has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed BSAB may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a request for review. BSAB shall conduct a hearing at which the participant shall be entitled to present his or her opinion and any evidence in support thereof. Thereafter, BSAB shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Hewitt at 206-467-4646.

Costs incurred by a claimant in preparing or presenting an appeal to the BSAB, such as attorney's fees, copying or postage charges or travel expenses, must be born by the claimant, and the claimant will be asked to sign a written consent to have the pertinent medical information provided to the BSAB.

**To understand how your benefits are paid, please review this booklet when you enroll.** As you incur medical expenses, you may wish to review the section which applies to them.

Premera Blue Cross has a WEA Select Customer Service Team which serves WEA Medical Plan enrollees. Please call one of the following numbers if you have questions on coverage or claims:

Toll-Free: 1-800-932-9221

Hearing-impaired TDD: 1-800-842-5357

The WEA Select Medical Plans are administered to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA), also known as federal health care reform. Federal and state authorities continue to issue new and revised guidance, including laws regulations, regarding administration of health plans. If additional laws or regulations are issued, this plan will be administered in accordance with the applicable requirements.

Group Name:..... Washington Education Association  
Plan Year:..... October 1, 2011 – September 30, 2012  
Group Number: ..... WEA Select Medical Plan 1 (Heritage)  
Contract Form Number: ..... 1223W1

The benefit does not include:

- Weight loss drugs
- Food supplements or replacements
- Weight loss programs not supervised by a physician, even when the enrollee's participation is prescribed or recommended by a physician

Please call the WEA Select Customer Service Team at 1-800-932-9221 for details.

#### **Naturopathic Services (See Office Visits)**

#### **Neurodevelopmental Therapy, Outpatient**

Benefits are provided when the enrollee is not confined in a hospital.

Benefits are provided up to 45 visits per calendar year for enrollees age 6 and under for all forms of therapy combined. A "visit" is a session of treatment for each type of therapy. Each type of therapy accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different providers. Benefits are provided as follows:

- **Heritage Providers:** .....\$20 copay
- **Non-Heritage Providers:** .....\$25 copay

Outpatient neurodevelopmental therapy services are not subject to your calendar year deductible.

Benefits may include speech and hearing therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy when it meets all of the following criteria:

- The care restores or improves lost body functions, or maintains function, related to neurodevelopmental delay or deficiencies (neurological and body functions that fail to develop normally after birth) where significant deterioration would occur without the services.
- Treatment is appropriate to the condition being treated.
- Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a massage practitioner, physical, occupational or speech therapist.

When the covered child reaches age seven, outpatient neurodevelopmental therapy services may be continued as outpatient rehabilitative care if discontinuation of therapy would result in a loss or deterioration in function.

#### Benefits are not provided for:

- Neurodevelopmental therapy and related evaluations for enrollees age seven and older
- Social, cultural, and vocational therapy
- Acupressure
- Services provided by employees of a home health agency or hospice

Please see "What's Not Covered?" for additional limitations and exclusions.

#### **Nicotine Dependency/Tobacco Cessation**

Benefits are provided for classes, programs and other services customarily used in a formal treatment program to help the enrollee quit using tobacco. Treatment must be performed by a recognized organization, group or individual known to normally and routinely provide treatment as follows:

- **Heritage Providers:** The plan pays 100% of allowable charges; deductible waived.
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 30% of allowable charges; plan pays 70% of allowable charges.

Excluded are expenses for over-the-counter drugs and supplies, travel, meals, lodging, books, tapes and other personal expenses or charges considered to be incidental, unreasonable or inconsistent with the intent of this benefit.

# Exhibit B

Search > PREMIERA BLUE CROSS

## PREMERA BLUE CROSS

[General](#) | [Contact](#) | [Licensing](#) | [Appointments](#) | [Complaints](#) | [Orders](#) | [National Info](#) | [Ratings](#)

[Back to Search](#)

### General information

**Name:** PREMIERA BLUE CROSS  
**Corporate family group:** PREMIERA BLUE CROSS GRP [What is this?](#)  
**Organization type:** HEALTH CARE SERVICE CONTRACTOR

**WAOIC:** 204  
**NAIC:** 47570

**Status:** ACTIVE  
**Admitted date:** 07/08/1948  
**Ownership type:** NON-PROFIT

[↑ back to top](#)

### Contact information

**Registered address**  
7001 - 220TH ST SW  
MTLAKE TERRACE, WA  
98043

**Mailing address**  
P O BOX 327  
SEATTLE, WA 98111

**Telephone**  
425-670-4000

**Telephone**  
425-670-4000

### Types of coverage authorized to sell [What is this?](#)

#### Insurance types

Health Care

[↑ back to top](#)

### Agents and agencies that represent this company (Appointments) [What is this?](#)

[View agents](#)

[View agencies](#)

[↑ back to top](#)

### Company complaint history [What is this?](#)

[View complaints](#)

[↑ back to top](#)

### Disciplinary orders 2008-2012 [What is this?](#)

Year	Order Number
2009	09-0015

Looking for other orders? Our online orders search allows you to search a ten year history of all orders, including enforcement orders, administrative orders, and general orders.

[↑ back to top](#)

### National information on insurance companies

Want more information about this company? The NAIC's Consumer Information (CIS) page allows you to retrieve national financial and complaint information on insurance companies, plus has information and tips to help you understand current insurance issues.

[↑ back to top](#)

### Ratings by financial organizations

The following organizations rate insurance companies on their financial strength and stability. Some of these companies charge for their services.

A.M. Best
Weiss Group Ratings

DECLARATION OF ELEANOR HAMBURGER - 9

Search > LIFEWISE HEALTH PLAN OF WASHINGTON

## LIFEWISE HEALTH PLAN OF WASHINGTON

[General](#) | [Contact](#) | [Licensing](#) | [Appointments](#) | [Complaints](#) | [Orders](#) | [National Info](#) | [Ratings](#)

[Back to Search](#)

### General information

**Name:** LIFEWISE HEALTH PLAN OF WASHINGTON  
**Corporate family group:** PREMIER BLUE CROSS GRP [What is this?](#)  
**Organization type:** HEALTH CARE SERVICE CONTRACTOR

**WAOIC:** 170257  
**NAIC:** 52633

**Status:** ACTIVE  
**Admitted date:** 08/31/2000  
**Ownership type:** NON-PROFIT

[↑ back to top](#)

### Contact information

**Registered address**  
 7001 - 220TH SW  
 MNTLAKE TERRACE, WA  
 98043

**Mailing address**  
 PO BOX 91120  
 SEATTLE, WA 98111-9220

**Telephone**  
 425-670-4000

**Telephone**  
 425-670-4000

### Types of coverage authorized to sell [What is this?](#)

#### Insurance types

Health Care

[↑ back to top](#)

### Agents and agencies that represent this company (Appointments) [What is this?](#)

[View agents](#)

[View agencies](#)

[↑ back to top](#)

### Company complaint history [What is this?](#)

[View complaints](#)

[↑ back to top](#)

### Disciplinary orders 2008-2012 [What is this?](#)

Year	Order Number
2009	09-0128
2011	11-0149

Looking for other orders? Our online orders search allows you to search a ten year history of all orders, including enforcement orders, administrative orders, and general orders.

[↑ back to top](#)

### National information on insurance companies

Want more information about this company? The NAIC's Consumer Information (CIS) page allows you to retrieve national financial and complaint information on insurance companies, plus has information and tips to help you understand current insurance issues.

[↑ back to top](#)

### Ratings by financial organizations

The following organizations rate insurance companies on their financial strength and stability. Some of these companies charge for their services.

A.M. Best

DECLARATION OF ELEANOR HAMBURGER - 10

Weiss Group Ratings
Standard and Poor's Corp
Moody's Investors Service
Fitch IBCA, Duff and Phelps Ratings

[↑ back to top](#)

# Exhibit C

*Information Summary and Recommendations*

# Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



## SUMMARY OF INFORMATION

### Overview of Proceedings

Department of Health informed interested parties of the mandated benefit review. Interested parties included parents of children with autism spectrum disorders, insurance carriers, and health care providers. The proponent, Arzu Forough, submitted a proposal to assess the bill based on the statutory criteria (See Appendix A). The department shared the proposal with interested parties and invited them to comment. Agency staff did research when needed and reviewed all information submitted.

We conducted a public hearing on Sept. 5, 2008. Interested parties, including parents of children with autism spectrum disorders, health care providers, a representative from the insurance industry, and a representative from the state Health Care Authority (HCA), presented testimony. A review panel assisted with the hearing by asking clarifying questions of the hearing participants. We sought further comments from interested parties after the hearing.

We sent a draft report to participants and interested parties for review. There was a 10-day rebuttal period to comment on the draft report. Once the final comment period ended, staff finalized the recommendations. The final draft was reviewed and approved by the Assistant Secretary for Health Systems Quality Assurance and the Secretary of the Department of Health. The final report was sent to the legislature via the Office of Financial Management.

### Background

In 2007 the Caring for Washington Individuals with Autism Task Force issued a report on autism spectrum disorders. Their report listed an insurance mandate for evidence-based autism spectrum disorders services as its highest and most urgent priority. The proposal under review was not submitted by the task force. However, the task force's 2007 report included a recommendation for an analysis to assess the sunrise criteria.

Autism spectrum disorders (ASD) are pervasive developmental disorders characterized by impairments or delays in social interaction, communication and language, as well as by repetitive routines and behaviors. They are called spectrum disorders because of the wide range and severity of symptoms. Children diagnosed with ASD suffer from problems with sensory integration, speech, and basic functions like toilet training, getting dressed, eating meals, brushing teeth, or sitting still during classes. Many medical conditions can accompany autism spectrum disorders. These include digestive problems, severe allergies, inability to detoxify, very high rate of infection, and vision problems. Some children with ASD display violent or self-harmful behaviors. IQs in children with this disorder range from superior to severely mentally retarded.<sup>1,2</sup>

<sup>1</sup> "Caring for Washington Individuals with Autism Task Force: Report to the Governor and Legislature," Caring for Washington Individuals with Autism Task Force, 2006, Executive Summary.

<sup>2</sup> *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> ed., American Psychiatric Association, Washington DC, 1994, pp. 65-66.

- Some insurance carriers only cover a small portion of the therapies necessary to treat ASD. They often limit treatment to \$1,000 to \$2,000 per year and/or limit the number of visits. Effective treatment for children with autism spectrum disorder can far surpass these limits.
- Low income children in Washington eligible for Medicaid have no age limits or therapy limits for neurodevelopmental therapy services.

*Mental health parity*

There is also a mental health parity mandate. It is unclear at this time how much (if any) ASD treatment should be covered under this mandate. The statute defines mental health services as, "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)..." Autism spectrum disorder is a disorder included in the DSM.

*State and federal programs*

There are some programs that provide limited treatment for autism spectrum disorder. These include the Infant and Toddler Early Intervention Program's (ITEIP) Birth to Three Program, some programs through the Department of Social and Health Services, Department of Health's Children with Special Health Care Needs Program, neurodevelopmental therapy services under Medicaid, and some other ASD coverage under Medicaid.

A number of states have insurance mandates for autism. The Council for Affordable Health Insurance reports 11 states as having mandates. However, the proponent counts eight states as having autism parity mandates. The proponent reports as many as 21 states that have either introduced legislation or are working on legislation for autism parity mandates.

*Private insurance*

Many parents described the Premera Blue Cross Health Insurance plan offered by Microsoft as being a model for other plans to follow. This plan covers applied behavior analysis (ABA) therapy for children with ASD. Providers must meet strict qualifications including a master's or doctoral degree in education, psychology, speech/language pathology, behavior analysis or occupational therapy (or have national ABA certification), and 1,500 supervised hours working with children with autism spectrum disorder.

**Education or health care?**

Anecdotal evidence given during the review indicates that autism spectrum disorder (ASD) treatment is sometimes considered the responsibility of schools. Representatives from the insurance industry and the Health Care Authority questioned whether this is an educational issue, rather than a health care issue.

Limited treatment may be available in schools. However, it is designed, as required by law, to be educationally-relevant. It is designed to allow the child to participate in the educational program. The therapy does not include skills the child may need in other environments such as home, work place, and the community.

## ASSESSMENT OF THE SUNRISE CRITERIA

### Social impact

To what extent is the benefit generally utilized by a significant portion of the population?

It is estimated that one in 150 children has autism spectrum disorder. All of these children have need of some level of autism treatment.<sup>10,11</sup>

To what extent is the benefit already generally available?

Intensive early intervention for autism, such as applied behavior analysis (ABA), is not generally available, nor is it covered through most health insurance plans.

There are a few programs that provide limited treatment to a small number of children with autism. These programs include:

- Infant and Toddler Early Intervention Program's (ITEIP) Birth to Three Program
- Programs through the Department of Social and Health Services
- Department of Health's Children with Special Health Care Needs Program
- Microsoft's private health plan
- Neurodevelopmental therapy services under Medicaid
- Other coverage under Medicaid

These programs are not generally available to a large portion of the population of children with ASD.

According to the 2007 "Washington State Autism Task Force Report", medically necessary treatment for people with autism spectrum disorder (ASD) is not widely available. It is routinely denied by insurance plans based on certain misconceptions. These include:

- ASD is widely seen as a mental illness, leading to referrals to ineffective treatments such as counseling or psychotherapy
- Treatment is considered habilitative, rather than rehabilitative
- Treatments are incorrectly thought of as being available in schools

If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

Many children with ASD go without necessary treatments and services because the costs are so high and insurance coverage is not generally available. Many families simply cannot afford to pay for the necessary early, intensive treatments.

<sup>10</sup> "Surveillance Summaries. Prevalence of Autism Spectrum Disorders--Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2002," *MMWR Morbidity Mortality Weekly Report*, Centers for Disease Control and Prevention, February 9, 2007, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5601a1.htm>, accessed on October 1, 2008, cited by proponent's proposal, Appendix A.

<sup>11</sup> Eric Fombonne, "Epidemiology of Autistic Disorder and Other Pervasive Developmental Disorders," *Journal of Clinical Psychiatry*, 66 (suppl 10), 2005, pp. 3-8, cited by proponent's proposal, Appendix A.

Several parents stated that they chose less expensive, less effective therapies or unqualified providers because that is all they could afford. Many families said they were forced to end effective treatments because they could no longer afford to pay for them.

**If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?**

"In the absence of coverage, out-of-pocket expenses for services can cost upwards of \$50,000 per year. In the process of trying to attain medical treatments and therapies, many risk their homes and the educations of their unaffected children — essentially mortgaging their entire futures."<sup>12</sup>

Many families wrote letters and testified at the hearing about the severe financial hardships caused by the high cost of treatment for autism spectrum disorder. The costs of treatments for children more severely impacted ranged from \$40,000 to \$100,000 per year. However, the proponent also notes that the cost for older children and those less severely impacted are often much lower, with average costs of \$9,000 to \$15,000 per year. Without adequate insurance coverage, parents were forced to cash in retirement accounts and college funds, charge up the maximum on multiple credit cards, borrow from extended families, take out second mortgages or sell their homes, or hold fundraisers in their communities.

We received testimony about families being in dire financial positions in order to pay for necessary treatments for their children with ASD. Many were forced to file bankruptcy or lost their homes to foreclosure. Many have spent their life savings on treatments. Some have been forced to quit their jobs because their children with ASD need full-time care. Parents also shared stories about siblings of children with this disorder being forced to sacrifice dental or vision care, sports, and other opportunities so their family could pay for treatment.

In addition, parents of children with autism spectrum disorder reported a higher than average divorce rate, which often results in increased financial hardship for the family. They believe effective ASD treatment provides a benefit to the entire family, not just the child.

**What is the level of public demand for the benefit?**

The demand for autism treatments is high. During the review, over 80 families stated there is a great need for an autism benefits mandate. No member of the public testified that ASD treatment is unnecessary. However, several parties commented that singling out ASD for a mandate unfairly excludes children with other developmental disabilities, such as Down syndrome.

**What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?**

The proponent did not have sufficient information to address this question.

<sup>12</sup> See proponent's response included in proposal.

# Exhibit D

Recent research suggests that some children with OCD develop the condition after experiencing one type of streptococcal infection (Swedo et al., 1995). This condition is referred to by the acronym PANDAS, which stands for Pediatric Autoimmune Neuro-psychiatric Disorders Associated with Streptococcal infections. Its hallmark is a sudden and abrupt exacerbation of OCD symptoms after a strep infection. This form of OCD occurs when the immune system generates antibodies to the streptococcal bacteria, and the antibodies cross-react with the basal ganglia<sup>13</sup> of a susceptible child, provoking OCD (Garvey et al., 1998). In other words, the cause of this form of OCD appears to be antibodies directed against the infection mistakenly attacking a region of the brain and setting off an inflammatory reaction.

The selective serotonin reuptake inhibitors appear effective in ameliorating the symptoms of OCD in children, although more clinical trials have been done with adults than with children. Several randomized, controlled trials revealed SSRIs to be effective in treating children and adolescents with OCD (Flament et al., 1985; DeVeaugh-Geiss et al., 1992; Riddle et al., 1992, 1998). The appropriate duration of treatment is still being studied. Side effects are not inconsequential: dry mouth, somnolence, dizziness, fatigue, tremors, and constipation occur at fairly high rates. Cognitive-behavioral treatments also have been used to treat OCD (March et al., 1997), but the evidence is not yet conclusive.

### Autism

Autism, the most common of the pervasive developmental disorders (with a prevalence of 10 to 12 children per 10,000 [Bryson & Smith, 1998]), is characterized by severely compromised ability to engage in, and by a lack of interest in, social interactions. It has roots in both structural brain abnormalities and genetic predispositions, according to family studies and studies of brain anatomy. The search for genes that predispose to autism is considered an

extremely high research priority for the National Institute of Mental Health (NIMH, 1998). Although the reported association between autism and obstetrical hazard may be due to genetic factors (Bailey et al., 1995), there is evidence that several different causes of toxic or infectious damage to the central nervous system during early development also may contribute to autism. Autism has been reported in children with fetal alcohol syndrome (Aronson et al., 1997), in children who were infected with rubella during pregnancy (Chess et al., 1978), and in children whose mothers took a variety of medications that are known to damage the fetus (Williams & Hersh, 1997).

Cognitive deficits in social perception likely result from abnormalities in neural circuitry. Children with autism have been studied with several imaging techniques, but no strongly consistent findings have emerged, although abnormalities in the cerebellum and limbic system (Rapin & Katzman, 1998) and larger brains (Fiven, 1997) have been reported. In one small study (Zilbovicius et al., 1995), evidence of delayed maturation of the frontal cortex was found. The evidence for genetic influences include a much greater concordance in identical than in fraternal twins (Cook, 1998).

### Treatment

Because autism is a severe, chronic developmental disorder, which results in significant lifelong disability, the goal of treatment is to promote the child's social and language development and minimize behaviors that interfere with the child's functioning and learning. Intensive, sustained special education programs and behavior therapy early in life can increase the ability of the child with autism to acquire language and ability to learn. Special education programs in highly structured environments appear to help the child acquire self-care, social, and job skills. Only in the past decade have studies shown positive outcomes for very young children with autism. Given the severity of the impairment, high intensity of service needs, and costs (both human and financial), there has been an ongoing search for effective treatment.

<sup>13</sup> Basal ganglia are groups of neurons responsible for motor and impulse control, attention, and regulation of mood and behavior.

## Mental Health: A Report of the Surgeon General

Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior. A well-designed study of a psychosocial intervention was carried out by Lovaas and colleagues (Lovaas, 1987; McEachin et al., 1993). Nineteen children with autism were treated intensively with behavior therapy for 2 years and compared with two control groups. Followup of the experimental group in first grade, in late childhood, and in adolescence found that nearly half the experimental group but almost none of the children in the matched control group were able to participate in regular schooling. Up to this point, a number of other research groups have provided at least a partial replication of the Lovaas model (see Rogers, 1998).

Several uncontrolled studies of comprehensive center-based programs have been conducted, focusing on language development and other developmental skills. A comprehensive model, Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH), demonstrated short-term gains for preschoolers with autism who received daily TEACCH home-teaching sessions, compared with a matched control group (Ozonoff & Cathcart, 1998). A review of other comprehensive, center-based programs has been conducted, focusing on elements considered critical to school-based programs, including minimum hours of service and necessary curricular components (Dawson & Osterling, 1997).

The antipsychotic drug, haloperidol, has been shown to be superior to placebo in the treatment of autism (Perry et al., 1989; Locascio et al., 1991), although a significant number of children develop dyskinesias<sup>14</sup> as a side effect (Campbell et al., 1997). Two of the SSRIs, clomipramine (Gordon et al., 1993) and fluoxetine (McDougle et al., 1996), have been tested, with positive results, except in young autistic children, in whom clomipramine was not found to be therapeutic, and who experienced untoward side effects (Sanchez et al., 1996). Of note, preliminary studies of

some of the newer antipsychotic drugs suggest that they may have fewer side effects than conventional antipsychotics such as haloperidol, but controlled studies are needed before firm conclusions can be drawn about any possible advantages in safety and efficacy over traditional agents.

### Disruptive Disorders

Disruptive disorders, such as oppositional defiant disorder and conduct disorder, are characterized by antisocial behavior and, as such, seem to be a collection of behaviors rather than a coherent pattern of mental dysfunction. These behaviors are also frequently found in children who suffer from attention-deficit/hyperactivity disorder, another disruptive disorder, which is discussed separately in this chapter. Children who develop the more serious conduct disorders often show signs of these disorders at an earlier age. Although it is common for a very young children to snatch something they want from another child, this kind of behavior may herald a more generally aggressive behavior and be the first sign of an emerging oppositional defiant or conduct disorder if it occurs by the ages of 4 or 5 and later. However, not every oppositional defiant child develops conduct disorder, and the difficult behaviors associated with these conditions often remit.

*Oppositional defiant disorder* (ODD) is diagnosed when a child displays a persistent or consistent pattern of defiance, disobedience, and hostility toward various authority figures including parents, teachers, and other adults. ODD is characterized by such problem behaviors as persistent fighting and arguing, being touchy or easily annoyed, and deliberately annoying or being spiteful or vindictive to other people. Children with ODD may repeatedly lose their temper, argue with adults, deliberately refuse to comply with requests or rules of adults, blame others for their own mistakes, and be repeatedly angry and resentful. Stubbornness and testing of limits are common. These behaviors cause significant difficulties with family and friends and at school or work (DSM-IV; Weiner, 1997). Oppositional defiant disorder is sometimes a precursor of conduct disorder (DSM-IV).

<sup>14</sup> Dyskinesia is an impairment of voluntary movement, such that it becomes fragmentary or incomplete.

# Exhibit E

# Caring for Washington Individuals with Autism Task Force

Report to Governor and Legislature  
Priority Recommendations and Implementation Plans

December 2007

## Chapter 4

# Priority Recommendation 1

***Ensure all individuals with ASD receive comprehensive health services and coverage within a Medical Home.***

### Cost Estimates

Estimating costs for mandated insurance benefits would require a Sunrise Review by the Department of Health (48.47.030 RCW).<sup>17</sup> The Caring for Washington Individuals with Autism Task Force will continue to explore the activities described in Objective 2 to increase access to medical homes for individuals with ASD and identify any related costs in the future.

### Justification

The ATF chose to make mandating insurance benefits its first priority recommendation. Transforming the way insurance carriers include autism and related conditions within health insurance policy will significantly affect access for the majority of individuals with an autism spectrum or related disorder in our state.

Children with autism commonly have a range of medical conditions for which they need treatment.<sup>18</sup> Nationally, 22 states have successfully mandated insurance coverage for evidence based intervention services that benefit children with autism.<sup>19</sup> There is no mandate for insurance coverage within Washington State. Only four major private insurers in Washington offer any coverage for comprehensive services for children with autism. Only Microsoft, one of the four, is broad in benefit coverage. This could be a model for the state and industry. Many families have no coverage for needed services. This places families under tremendous financial burdens and strain to provide adequate care for their children. The Council for Affordable Health Insurance, in a 2007 report reviewing 10 states mandating insurance coverage, find the incremental cost of mandated benefits for autism at less than one percent.<sup>20</sup>

<sup>17</sup> Sunrise Review Process. Mandated Health Insurance Benefits. Washington State Department of Health. Accessed November 9, 2007 <http://www.doh.wa.gov/hsqa/sunrise/mandated.htm>

<sup>18</sup> Gurney, J. G., McPheeters, M. L., Davis, M. M. *Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism*. National Survey of Children's Health. *Archives of Pediatrics & Adolescent Medicine*. 2006; Vol. 160: pp. 825-830. Accessed November 21, 2007 from <http://archpedi.ama-assn.org/cgi/content/full/160/8/825>

<sup>19</sup> Steering Committee Legislative Information, Appendix 4f)

<sup>20</sup> Bunce, V. C., Wieske, J. P., Prikazsky, V. *Health Insurance Mandates in the States, 2007*. Council for Affordable Health Insurance. Accessed November 21, 2007 from [www.cahi.org](http://www.cahi.org)

Appropriate, financially feasible services are not accessible for many individuals and families within their communities. Barriers to health care access include specific exclusions for autism diagnosis by many private health insurance plans,<sup>21</sup> no coverage for Applied Behavioral Analysis (ABA) and other autism—related services,<sup>22</sup> or denial of coverage for behavioral interventions by licensed PhD clinical psychologists or Board Certified Behavior Analysts (BCBA). All of these barriers contribute to access of care.

Wait-lists in the greater Seattle area typically exceed 6 months. Many families in our state have no access to services. To ensure that all individuals with autism and related conditions receive appropriate, accessible, and affordable services within their communities, insurance coverage for evidenced-based practices, including but not limited to, early intensive behavioral intervention is critical.

The task force believes that everyone deserves to have access to health care that follows sound evidence-based practices, and that the struggle for equality and recognition of autism and appropriate treatment will take both time and effort. Establishing good health policy takes thoughtful and considerate action to accomplish. As such, the task force recognizes that other priority recommendations such as training providers on new screening tools regarding autism may be more immediately attainable. These other steps are important for raising awareness and will help in the developing comprehensive health policy.

## Implementation Plan

### Objective 1: Improve Insurance Coverage for Individuals with ASD

1. Extend insurance benefits to cover interventions for individuals with ASD.
  - a. Consult with individuals from states such as South Carolina and Pennsylvania where successful legislation mandating state insurance coverage for ASD intervention was passed.
  - b. Mandate coverage of behavioral interventions provided by licensed PhD level clinical psychologists and Board Certified Behavior Analysts (BCBA).
2. Expand Medicaid benefits to promote equity in health care access and encourage providers to serve clients who are enrolled in Medicaid.

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<sup>21</sup> Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

<sup>22</sup> Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

- a. Increase the number of psychological assessments allowed (currently one per lifetime).
  - b. Increase rate of reimbursement and streamline paperwork and service approval process to encourage more providers to accept Medicaid patients.
  - c. Provide benefits comparable to private insurance, including reimbursement for costs of behavioral intervention.
  - d. Allow coverage of behavioral interventions provided by licensed PhD level clinical psychologists and board certified behavior analysts for individuals with an autism spectrum disorder.
3. Support policies that ensure neurodevelopmental therapy insurance benefits.
- a. Extend neurodevelopmental therapy benefit including speech-language services, occupational and physical therapy to individuals aged 18 years.
  - b. Include certified behavioral analysts (BCBA) in neurodevelopmental therapy benefits.

*Objective 2: Train and provide support to health care providers caring for individuals with ASD and increase access to medical homes.*

The ATF recognizes that a medical home supports knowledge of and access to comprehensive services within the community. Providing increased support to health care providers is essential so that they have easily accessible, scientifically sound, reliable information about autism and related disorders. Health care providers need to be able to easily direct patients to the services they need. See Chapter 6 for additional activities to promote medical homes and increase provider knowledge of ASD and related disorders.

1. Improve advanced registered nurse practitioners, physician assistants, and medical school residency training on ASD and related conditions.
  - a. Assess and provide training standards for Washington State programs.
  - b. Collaborate with training programs to increase awareness and surveillance of autism and related conditions.
2. Identify an on-line medical consultation service to provide a quality consultation resource for primary care providers. Service could expand consultative service to primary care providers who serve individuals with autism. Promote use of the service across the state.<sup>23</sup>
3. Improve access to high-quality medical homes for individuals with ASD and related disorders.
  - a. Explore successful programs nationally:
    - i. Obtain consultation from the Waisman Center or similar organization.<sup>24</sup>

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<sup>23</sup> Appendix 4c), Identification/Tracking Mid-Term Report

<sup>24</sup> Waisman Center. National Medical Home Autism Initiative. Framework, Partnerships, Resources, Publications, What's New. 2007. Accessed October 30, 2007 website <http://www.waisman.wisc.edu/nmhai/index.html>

- ii. Obtain assistance from the National Center on Medical Home Initiatives for Children with Special Needs at the American Academy of Pediatrics.<sup>25</sup>
- b. Explore regional successful medical home programs such as those available to the armed forces.
- c. Make use of the Medical Home Leadership Network in Washington to pilot successful strategies to increase high quality medical homes throughout the state.<sup>26</sup>
- d. Use Child Health Notes<sup>27</sup> as another possible model to provide more information about autism to primary care providers in Washington.

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<sup>25</sup> National Center of Medical Home Initiatives for Children with Special Needs. What is a Medical Home. May 24, 2006. American Academy of Pediatrics. Accessed November 1, 2007 from website <http://www.medicalhomeinfo.org/llion.html>

<sup>26</sup> Washington State Medical Home. The Medical Home Leadership Network. Washington State Department of Health. 2007. Accessed October 30, 2007 from website [http://www.medicalhome.org/leadership/the\\_mhln.cfm](http://www.medicalhome.org/leadership/the_mhln.cfm)

<sup>27</sup> Washington State Medical Home. Child Health Notes. University of Washington & DOH. 2007. Accessed November 9, 2007 from <http://www.medicalhome.org/leadership/chn.cfm>

# Exhibit F

# Mental Health

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A Report of the Surgeon General  
Executive Summary

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. Public Health Service



The Center for Mental Health Services  
*Substance Abuse and Mental Health  
Services Administration*

**NIMH**

National Institute  
of Mental Health  
National Institutes of Health

**Suggested Citation**

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**Message from Donna E. Shalala**  
*Secretary of Health and Human Services*

The United States leads the world in understanding the importance of overall health and well-being to the strength of a Nation and its people. What we are coming to realize is that mental health is absolutely essential to achieving prosperity. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, 4 of the 10 leading causes of disability for persons age 5 and older are mental disorders. Among developed nations, including the United States, major depression is the leading cause of disability. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. Mental disorders also are tragic contributors to mortality, with suicide perennially representing one of the leading preventable causes of death in the United States and worldwide.

The U.S. Congress declared the 1990s the Decade of the Brain. In this decade we have learned much through research—in basic neuroscience, behavioral science, and genetics—about the complex workings of the brain. Research can help us gain a further understanding of the fundamental mechanisms underlying thought, emotion, and behavior—and an understanding of what goes wrong in the brain in mental illness. It can also lead to better treatments and improved services for our diverse population.

Now, with the publication of this first Surgeon General's Report on Mental Health, we are poised to take what we know and to advance the state of mental health in the Nation. We can with great confidence encourage individuals to seek treatment when they find themselves experiencing the signs and symptoms of mental distress. Research has given us effective treatments and service delivery strategies for many mental disorders. An array of safe and potent medications and psychosocial interventions, typically used in combination, allow us to effectively treat most mental disorders.

This seminal report provides us with an opportunity to dispel the myths and stigma surrounding mental illness. For too long the fear of mental illness has been profoundly destructive to people's lives. In fact mental illnesses are just as real as other illnesses, and they are like other illnesses in most ways. Yet fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover.

In this Administration, a persistent, courageous advocate of affordable, quality mental health services for all Americans is Mrs. Tipper Gore, wife of the Vice President. We salute her for her historic leadership and for her enthusiastic support of the initiative by the Surgeon General, Dr. David Satcher, to issue this groundbreaking Report on Mental Health.

The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a Call to Action on Suicide Prevention in 1999 as well. This Surgeon General's Report on Mental Health takes the next step in advancing the important notion that mental health is fundamental health.

## Foreword

Since the turn of this century, thanks in large measure to research-based public health innovations, the lifespan of the average American has nearly doubled. Today, our Nation's physical health—as a whole—has never been better. Moreover, illnesses of the body, once shrouded in fear—such as cancer, epilepsy, and HIV/AIDS to name just a few—increasingly are seen as treatable, survivable, even curable ailments. Yet, despite unprecedented knowledge gained in just the past three decades about the brain and human behavior, mental health is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding.

This Report of the Surgeon General on Mental Health is the product of an invigorating collaboration between two Federal agencies. The Substance Abuse and Mental Health Services Administration (SAMHSA), which provides national leadership and funding to the states and many professional and citizen organizations that are striving to improve the availability, accessibility, and quality of mental health services, was assigned lead responsibility for coordinating the development of the report. The National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through its National Institute of Mental Health (NIMH), was pleased to be a partner in this effort. The agencies we respectively head were able to rely on the enthusiastic participation of hundreds of people who played a role in researching, writing, reviewing, and disseminating this report. We wish to express our appreciation and that of a mental health constituency, millions of Americans strong, to Surgeon General David Satcher, M.D., Ph.D., for inviting us to participate in this landmark report.

The year 1999 witnessed the first White House Conference on Mental Health and the first Secretarial Initiative on Mental Health prepared under the aegis of the Department of Health and Human Services. These activities set an optimistic tone for progress that will be realized in the years ahead. Looking ahead, we take special pride in the remarkable record of accomplishment, in the spheres of both science and services, to which our agencies have contributed over past decades. With the impetus that the Surgeon General's report provides, we intend to expand that record of accomplishment. This report recognizes the inextricably intertwined relationship between our mental health and our physical health and well-being. The report emphasizes that mental health and mental illnesses are important concerns at all ages. Accordingly, we will continue to attend to needs that occur across the lifespan, from the youngest child to the oldest among us.

The report lays down a challenge to the Nation—to our communities, our health and social service agencies, our policymakers, employers, and citizens—to take action. SAMHSA and NIH look forward to continuing our collaboration to generate needed knowledge about the brain and behavior and to translate that knowledge to the service systems, providers, and citizens.

Nelba Chavez, Ph.D.  
Administrator  
Substance Abuse and Mental Health  
Services Administration

Steven E. Hyman, M.D.  
Director  
National Institute of Mental Health  
for The National Institutes of Health

Bernard S. Arons, M.D.  
Director  
Center for Mental Health Services

**Preface**  
*from the Surgeon General*  
*U.S. Public Health Service*

The past century has witnessed extraordinary progress in our improvement of the public health through medical science and ambitious, often innovative, approaches to health care services. Previous Surgeons General reports have saluted our gains while continuing to set ever higher benchmarks for the public health. Through much of this era of great challenge and greater achievement, however, concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness. Tragic and devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame. Fortunately, leaders in the mental health field—fiercely dedicated advocates, scientists, government officials, and consumers—have been insistent that mental health flow in the mainstream of health. I agree and issue this report in that spirit.

This report makes evident that the neuroscience of mental health—a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena—has emerged as one of the most exciting arenas of scientific activity and human inquiry. We recognize that the brain is the integrator of thought, emotion, behavior, and health. Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between “mental” and “physical” health.

We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health. Common sense and respect for our fellow humans tells us that a focus on the positive aspects of mental health demands our immediate attention.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.

Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstanding that remain as barriers before us. It is my intent that this report will usher in a healthy era of mind and body for the Nation.

David Satcher, M.D., Ph.D.  
Surgeon General

# CHAPTER 1

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## INTRODUCTION AND THEMES

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# CHAPTER 1

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## INTRODUCTION AND THEMES

This first Surgeon General's Report on Mental Health is issued at the culmination of a half-century that has witnessed remarkable advances in the understanding of mental disorders and the brain and in our appreciation of the centrality of mental health to overall health and well-being. The report was prepared against a backdrop of growing awareness in the United States and throughout the world of the immense burden of disability associated with mental illnesses. In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer (Murray & Lopez, 1996). These data underscore the importance and urgency of treating and preventing mental disorders and of promoting mental health in our society.

The report in its entirety provides an up-to-date review of scientific advances in the study of mental health and of mental illnesses that affect at least one in five Americans. Several important conclusions may be drawn from the extensive scientific literature summarized in the report. One is that a variety of treatments of well-documented efficacy exist for the array of clearly defined mental and behavioral disorders that occur across the life span. Every person should be encouraged to seek help when questions arise about mental health, just as each person is encouraged to seek help when questions arise about health. Research highlighted in the report demonstrates that mental health is a facet of health that evolves throughout the lifetime. Just as each person can do much to promote and maintain overall health regardless of age, each also can do much to promote and strengthen mental health at every stage of life.

Much remains to be learned about the causes, treatment, and prevention of mental and behavioral

disorders. Obstacles that may limit the availability or accessibility of mental health services for some Americans are being dismantled, but disparities persist. Still, thanks to research and the experiences of millions of individuals who have a mental disorder, their family members, and other advocates, the Nation has the power today to tear down the most formidable obstacle to future progress in the arena of mental illness and health. That obstacle is stigma. Stigmatization of mental illness is an excuse for inaction and discrimination that is inexcusably outmoded in 1999. As evident in the chapters that follow, we have acquired an immense amount of knowledge that permits us, as a Nation, to respond to the needs of persons with mental illness in a manner that is both effective and respectful.

### Overarching Themes

#### Mental Health and Mental Illness: A Public Health Approach

The Nation's contemporary mental health enterprise, like the broader field of health, is rooted in a population-based public health model. The public health model is characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psychosocial environment. Public health focuses not only on traditional areas of diagnosis, treatment, and etiology, but also on epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services (Last & Wallace, 1992).

Just as the mainstream of public health takes a broad view of health and illness, this Surgeon General's Report on Mental Health takes a wide-angle lens to *both* mental health and mental illness. In years

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past, the mental health field often focused principally on mental illness in order to serve individuals who were most severely affected. Only as the field has matured has it begun to respond to intensifying interest and concerns about disease prevention and health promotion. Because of the more recent consideration of these topic areas, the body of accumulated knowledge regarding them is not as expansive as that for mental illness.

### Mental Disorders are Disabling

The burden of mental illness on health and productivity in the United States and throughout the world has long been profoundly underestimated. Data developed by the massive Global Burden of Disease study,<sup>1</sup> conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide,<sup>2</sup> ranks second in the burden of disease in established market economies, such as the United States (Table 1-1).

Mental illness emerged from the Global Burden of Disease study as a surprisingly significant contributor to the burden of disease. The measure of calculating disease burden in this study, called Disability Adjusted Life Years (DALYs), allows comparison of the burden

Table 1-1. Disease burden by selected illness categories in established market economies, 1990

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness**	15.4
All malignant diseases (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic diseases	2.8
All drug use	1.6

\*Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration (Murray & Lopez, 1996).

\*\*Disease burden associated with "mental illness" includes suicide.

<sup>1</sup> Murray & Lopez, 1996.

<sup>2</sup> The Surgeon General issued a Call to Action on Suicide in 1999, reflecting the public health magnitude of this consequence of mental illness. The Call to Action is summarized in Figure 4-1.

of disease across many different disease conditions. DALYs account for lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability. For example, major depression is equivalent in burden to blindness or paraplegia, whereas active psychosis seen in schizophrenia is equal in disability burden to quadriplegia.

By this measure, major depression alone ranked second only to ischemic heart disease in magnitude of disease burden (see Table 1-2). Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the burden represented by mental illness.

Table 1-2. Leading sources of disease burden in established market economies, 1990

	Total DALYs (millions)	Percent of Total
All causes	98.7	
1 Ischemic heart disease	8.9	9.0
2 Unipolar major depression	6.7	6.8
3 Cardiovascular disease	5.0	5.0
4 Alcohol use	4.7	4.7
5 Road traffic accidents	4.3	4.4

Source: Murray & Lopez, 1996.

### Mental Health and Mental Illness: Points on a Continuum

As will be evident in the pages that follow, "mental health" and "mental illness" are not polar opposites but may be thought of as points on a continuum. *Mental health* is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These

are the ingredients of each individual's successful contribution to community and society. Americans are inundated with messages about *success*—in school, in a profession, in parenting, in relationships—without appreciating that successful performance rests on a foundation of mental health.

Many ingredients of mental health may be identifiable, but mental health is not easy to define. In the words of a distinguished leader in the field of mental health prevention, “. . . built into any definition of wellness . . . are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the constructs is illusory” (Cowen, 1994). In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. The challenge of defining mental health has stalled the development of programs to foster mental health (Secker, 1998), although strides have been made with wellness programs for older people (Chapter 5).

*Mental illness* is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 1994).

This report uses the term “mental health problems” for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some

of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment. Bereavement symptoms in older adults offer a case in point. Bereavement symptoms of less than 2 months' duration do not qualify as a mental disorder, according to professional manuals for diagnosis (American Psychiatric Association, 1994). Nevertheless, bereavement symptoms can be debilitating if they are left unattended. They place older people at risk for depression, which, in turn, is linked to death from suicide, heart attack, or other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Much can be done—through formal treatment or through support group participation—to ameliorate the symptoms and to avert the consequences of bereavement. In this case, early intervention is needed to address a mental health problem before it becomes a potentially life-threatening disorder.

### Mind and Body are Inseparable

Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that “mental health” or “mental illness” is unrelated to “physical health” or “physical illness.” In fact, the two are inseparable.

Seventeenth-century philosopher Rene Descartes conceptualized the distinction between the mind and the body. He viewed the “mind” as completely separable from the “body” (or “matter” in general). The mind (and spirit) was seen as the concern of organized religion, whereas the body was seen as the concern of physicians (Eisendrath & Feder, in press). This partitioning ushered in a separation between so-called “mental” and “physical” health, despite advances in the 20th century that proved the interrelationships between mental and physical health (Cohen & Herbert, 1996; Baum & Posluszny, 1999).

Although “mind” is a broad term that has had many different meanings over the centuries, today it refers to the totality of mental functions related to thinking, mood, and purposive behavior. The mind is generally

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seen as deriving from activities within the brain but displaying emergent properties, such as consciousness (Fischbach, 1992; Gazzaniga et al., 1998).

One reason the public continues to this day to emphasize the difference between mental and physical health is embedded in language. Common parlance continues to use the term "physical" to distinguish some forms of health and illness from "mental" health and illness. People continue to see mental and physical as separate functions when, in fact, mental functions (e.g., memory) are physical as well (American Psychiatric Association, 1994). Mental functions are carried out by the brain. Likewise, mental disorders are reflected in physical changes in the brain (Kandel, 1998). Physical changes in the brain often trigger physical changes in other parts of the body too. The racing heart, dry mouth, and sweaty palms that accompany a terrifying nightmare are orchestrated by the brain. A nightmare is a mental state associated with alterations of brain chemistry that, in turn, provoke unmistakable changes elsewhere in the body.

Instead of dividing physical from mental health, the more appropriate and neutral distinction is between "mental" and "somatic" health. Somatic is a medical term that derives from the Greek word *soma* for the body. Mental health refers to the successful performance of mental functions in terms of thought, mood, and behavior. Mental disorders are those health conditions in which alterations in mental functions are paramount. Somatic conditions are those in which alterations in nonmental functions predominate. While the brain carries out all mental functions, it also carries out some somatic functions, such as movement, touch, and balance. That is why not all brain diseases are mental disorders. For example, a stroke causes a lesion in the brain that may produce disturbances of movement, such as paralysis of limbs. When such symptoms predominate in a patient, the stroke is considered a somatic condition. But when a stroke mainly produces alterations of thought, mood, or behavior, it is considered a mental condition (e.g., dementia). The point is that a brain disease can be seen as a mental disorder or a somatic disorder depending on the functions it perturbs.

## The Roots of Stigma

Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia (Penn & Martin, 1998; Corrigan & Penn, 1999). It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.

Explanations for stigma stem, in part, from the misguided split between mind and body first proposed by Descartes. Another source of stigma lies in the 19th-century separation of the mental health treatment system in the United States from the mainstream of health. These historical influences exert an often immediate influence on perceptions and behaviors in the modern world.

## Separation of Treatment Systems

In colonial times in the United States, people with mental illness were described as "lunaticks" and were largely cared for by families. There was no concerted effort to treat mental illness until urbanization in the early 19th century created a societal problem that previously had been relegated to families scattered among small rural communities. Social policy assumed the form of isolated asylums where persons with mental illness were administered the reigning treatments of the era. By the late 19th century, mental illness was thought to grow "out of a violation of those physical, mental and moral laws which, properly understood and obeyed, result not only in the highest development of the race, but the highest type of civilization" (cited in Grob, 1983). Throughout the history of institutionalization in asylums (later renamed mental hospitals), reformers strove to improve treatment and curtail abuse. Several waves of reform culminated in

the deinstitutionalization movement that began in the 1950s with the goal of shifting patients and care to the community.

*Public Attitudes About Mental Illness: 1950s to 1990s*

Nationally representative surveys have tracked public attitudes about mental illness since the 1950s (Star, 1952, 1955; Gurin et al., 1960; Veroff et al., 1981). To permit comparisons over time, several surveys of the 1970s and the 1990s phrased questions exactly as they had been asked in the 1950s (Swindle et al., 1997).

In the 1950s, the public viewed mental illness as a stigmatized condition and displayed an unscientific understanding of mental illness. Survey respondents typically were not able to identify individuals as "mentally ill" when presented with vignettes of individuals who would have been said to be mentally ill according to the professional standards of the day. The public was not particularly skilled at distinguishing mental illness from ordinary unhappiness and worry and tended to see only extreme forms of behavior—namely psychosis—as mental illness. Mental illness carried great social stigma, especially linked with fear of unpredictable and violent behavior (Star, 1952, 1955; Gurin et al., 1960; Veroff et al., 1981).

By 1996, a modern survey revealed that Americans had achieved greater scientific understanding of mental illness. But the increases in knowledge did not defuse social stigma (Phelan et al., 1997). The public learned to define mental illness and to distinguish it from ordinary worry and unhappiness. It expanded its definition of mental illness to encompass anxiety, depression, and other mental disorders. The public attributed mental illness to a mix of biological abnormalities and vulnerabilities to social and psychological stress (Link et al., in press). Yet, in comparison with the 1950s, the public's perception of mental illness more frequently incorporated violent behavior (Phelan et al., 1997). This was primarily true among those who defined mental illness to include psychosis (a view held by about one-third of the entire sample). Thirty-one percent of this group mentioned violence in its descriptions of mental illness, in

comparison with 13 percent in the 1950s. In other words, the perception of people with psychosis as being dangerous is stronger today than in the past (Phelan et al., 1997).

The 1996 survey also probed how perceptions of those with mental illness varied by diagnosis. The public was more likely to consider an individual with schizophrenia as having mental illness than an individual with depression. All of them were distinguished reasonably well from a worried and unhappy individual who did not meet professional criteria for a mental disorder. The desire for social distance was consistent with this hierarchy (Link et al., in press).

Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past (Phelan et al., 1997).

This finding begs yet another question: Are people with mental disorders truly more violent? Research supports some public concerns, but the overall likelihood of violence is low. The greatest risk of violence is from those who have dual diagnoses, i.e., individuals who have a mental disorder as well as a substance abuse disorder (Swanson, 1994; Eronen et al., 1998; Steadman et al., 1998). There is a small elevation in risk of violence from individuals with severe mental disorders (e.g., psychosis), especially if they are noncompliant with their medication (Eronen et al., 1998; Swartz et al., 1998). Yet the risk of violence is much less for a stranger than for a family member or person who is known to the person with mental illness (Eronen et al., 1998). *In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder.* Because the average person is ill-equipped to judge whether someone who is behaving erratically has any of these disorders, alone or in combination, the natural tendency is to be wary. Yet, to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small (Swanson, 1994).

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Because most people should have little reason to fear violence from those with mental illness, even in its most severe forms, *why* is fear of violence so entrenched? Most speculations focus on media coverage and deinstitutionalization (Phelan et al., 1997; Heginbotham, 1998). One series of surveys found that selective media reporting reinforced the public's stereotypes linking violence and mental illness and encouraged people to distance themselves from those with mental disorders (Angermeyer & Matschinger, 1996). And yet, deinstitutionalization made this distancing impossible over the 40 years as the population of state and county mental hospitals was reduced from a high of about 560,000 in 1955 to well below 100,000 by the 1990s (Bachrach, 1996). Some advocates of deinstitutionalization expected stigma to be reduced with community care and commonplace exposure. Stigma might have been greater today had not public education resulted in a more scientific understanding of mental illness.

### *Stigma and Seeking Help for Mental Disorders*

Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996). Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment (Sussman et al., 1987; Cooper-Patrick et al., 1997). Concern about stigma appears to be heightened in rural areas in relation to larger towns or cities (Hoyt et al., 1997). Stigma also disproportionately affects certain age groups, as explained in the chapters on children and older people.

The surveys cited above concerning evolving public attitudes about mental illness also monitored how people would cope with, and seek treatment for, mental illness if they became symptomatic. (The term "nervous breakdown" was used in lieu of the term "mental illness" in the 1996 survey to allow for comparisons with the surveys in the 1950s and 1970s.) The 1996 survey found that people were likelier than in the past to approach mental illness by coping with, rather than by avoiding, the problem. They also were more likely now to want *informal* social supports (e.g.,

self-help groups). Those who now sought *formal* support increasingly preferred counselors, psychologists, and social workers (Swindle et al., 1997).

### *Stigma and Paying for Mental Disorder Treatment* Another manifestation of stigma is reflected in the public's reluctance to pay for mental health services.

Public willingness to pay for mental health treatment, particularly through insurance premiums or taxes, has been assessed largely through public opinion polls. Members of the public report a greater willingness to pay for insurance coverage for individuals with severe mental disorders, such as schizophrenia and depression, rather than for less severe conditions such as worry and unhappiness (Hanson, 1998). While the public generally appears to support paying for treatment, its support diminishes upon the realization that higher taxes or premiums would be necessary (Hanson, 1998). In the lexicon of survey research, the willingness to pay for mental illness treatment services is considered to be "soft." The public generally ranks insurance coverage for mental disorders below that for somatic disorders (Hanson, 1998).

### *Reducing Stigma*

There is likely no simple or single panacea to eliminate the stigma associated with mental illness. Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved. Knowledge of mental illness appears by itself insufficient to dispel stigma (Phelan et al., 1997). Broader knowledge may be warranted, especially to redress public fears (Penn & Martin, 1998). Research is beginning to demonstrate that negative perceptions about severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness (Penn & Martin, 1998). Overall approaches to stigma reduction involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions (Corrigan & Penn, 1999).

Another way to eliminate stigma is to find causes and effective treatments for mental disorders (Jones, 1998). History suggests this to be true. Neurosyphilis and pellagra are illustrative of mental disorders for which stigma has receded. In the early part of this century, about 20 percent of those admitted to mental hospitals had "general paresis," later identified as tertiary syphilis (Grob, 1994). This advanced stage of syphilis occurs when the bacterium invades the brain and causes neurological deterioration (including psychosis), paralysis, and death. The discoveries of an infectious etiology and of penicillin led to the virtual elimination of neurosyphilis. Similarly, when pellagra was traced to a nutrient deficiency, and nutritional supplementation with niacin was introduced, the condition was eventually eradicated in the developed world. Pellagra's victims with delirium had been placed in mental hospitals early in the 20th century before its etiology was clarified. Although no one has documented directly the reduction of public stigma toward these conditions over the early and later parts of this century, disease eradication through widespread acceptance of treatment (and its cost) offers indirect proof.

Ironically, these examples also illustrate a more unsettling consequence: that the mental health field was adversely affected when causes and treatments were identified. As advances were achieved, each condition was transferred from the mental health field to another medical specialty (Grob, 1991). For instance, dominion over syphilis was moved to dermatology, internal medicine, and neurology upon advances in etiology and treatment. Dominion over hormone-related mental disorders was moved to endocrinology under similar circumstances. The consequence of this transformation, according to historian Gerald Grob, is that the mental health field became over the years the repository for mental disorders whose etiology was unknown. This left the mental health field "vulnerable to accusations by their medical brethren that psychiatry was not part of medicine, and that psychiatric practice rested on superstition and myth" (Grob, 1991).

These historical examples signify that stigma dissipates for individual disorders once advances

render them less disabling, infectious, or disfiguring. Yet the stigma surrounding *other* mental disorders not only persists but may be inadvertently reinforced by leaving to mental health care only those behavioral conditions without known causes or cures. To point this out is not intended to imply that advances in mental health should be halted; rather, advances should be nurtured and heralded. The purpose here is to explain some of the historical origins of the chasm between the health and mental health fields.

Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate. Still, fresh approaches to disseminate research information and, thus, to counter stigma need to be developed and evaluated. Social science research has much to contribute to the development and evaluation of anti-stigma programs (Corrigan & Penn, 1999). As stigma abates, a transformation in public attitudes should occur. People should become eager to seek care. They should become more willing to absorb its cost. And, most importantly, they should become far more receptive to the messages that are the subtext of this report: mental health and mental illness are part of the mainstream of health, and they are a concern for all people.

## The Science Base of the Report

### Reliance on Scientific Evidence

The statements and conclusions throughout this report are documented by reference to studies published in the scientific literature. For the most part, this report cites studies of empirical—rather than theoretical—research, peer-reviewed journal articles including reviews that integrate findings from numerous studies, and books by recognized experts. When a study has been accepted for publication but the publication has not yet appeared, owing to the delay between acceptance and final publication, the study is referred to as "in press." The

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report refers, on occasion, to unpublished research by means of reference to a presentation at a professional meeting or to a "personal communication" from the researcher, a practice that also is used sparingly in professional journals. These personal references are to acknowledged experts whose research is in progress.

### *Research Methods*

Quality research rests on accepted methods of testing hypotheses. Two of the more common research methods used in the mental health field are experimental research and correlational research. Experimental research is the preferred method for assessing causation but may be too difficult or too expensive to conduct. Experimental research strives to discover cause and effect relationships, such as whether a new drug is effective for treating a mental disorder. In an experimental study, the investigator deliberately introduces an intervention to determine its consequences (i.e., the drug's efficacy). The investigator sets up an experiment comparing the effects of giving the new drug to one group of people, the experimental group, while giving a placebo (an inert pill) to another group, the so-called control group. The incorporation of a control group rules out the possibility that something other than the experimental treatment (i.e., the new drug) produces the results. The difference in outcome between the experimental and control group—which, in this case, may be the reduction or elimination of the symptoms of the disorder—then can be causally attributed to the drug. Similarly, in an experimental study of a psychological treatment, the experimental group is given a new type of psychotherapy, while the control or comparison group receives either no psychotherapy or a different form of psychotherapy. With both pharmacological and psychological studies, the best way to assign study participants, called subjects, either to the treatment or the control (or comparison) group is by assigning them randomly to different treatment groups. Randomization reduces bias in the results. An experimental study in humans with randomization is called a randomized controlled trial.

Correlational research is employed when experimental research is logistically, ethically, or

financially impossible. Instead of deliberately introducing an intervention, researchers observe relationships to uncover whether two factors are associated, or correlated. Studying the relationship between stress and depression is illustrative. It would be unthinkable to introduce seriously stressful events to see if they cause depression. A correlational study in this case would compare a group of people already experiencing high levels of stress with another group experiencing low levels of stress to determine whether the high-stress group is more likely to develop depression. If this happens, then the results would indicate that high levels of stress are associated with depression. The limitation of this type of study is that it only can be used to establish associations, not cause and effect relationships. (The positive relationship between stress and depression is discussed most thoroughly in Chapter 4.)

Controlled studies—that is, studies with control or comparison groups—are considered superior to uncontrolled studies. But not every question in mental health can be studied with a control or comparison group. Findings from an uncontrolled study may be better than no information at all. An uncontrolled study also may be beneficial in generating hypotheses or in testing the feasibility of an intervention. The results presumably would lead to a controlled study. In short, uncontrolled studies offer a good starting point but are never conclusive by themselves.

### *Levels of Evidence*

In science, no single study by itself, however well designed, is generally considered sufficient to establish causation. The findings need to be replicated by other investigators to gain widespread acceptance by the scientific community.

The strength of the evidence amassed for any scientific fact or conclusion is referred to as "the level of evidence." The level of evidence, for example, to justify the entry of a new drug into the marketplace has to be substantial enough to meet with approval by the U.S. Food and Drug Administration (FDA). According to U.S. drug law, a new drug's safety and efficacy must be established through controlled clinical trials

conducted by the drug's manufacturer or sponsor (FDA, 1998). The FDA's decision to approve a drug represents the culmination of a lengthy, research-intensive process of drug development, which often consumes years of animal testing followed by human clinical trials (DiMasi & Lasagna, 1995). The FDA requires three phases of clinical trials<sup>3</sup> before a new drug can be approved for marketing (FDA, 1998).

With psychotherapy, the level of evidence similarly must be high. Although there are no formal Federal laws governing which psychotherapies can be introduced into practice, professional groups and experts in the field strive to assess the level of evidence in a given area through task forces, review articles, and other methods for evaluating the body of published studies on a topic. This Surgeon General's report is replete with references to such evaluations. One of the most prominent series of evaluations was set in motion by a group within the American Psychological Association (APA), one of the main professional organizations of psychologists. Beginning in the mid-1990s, the APA's Division of Clinical Psychology convened task forces with the objective of establishing which psychotherapies were of proven efficacy. To guide their evaluation, the first task force created a set of criteria that also was used or adapted by subsequent task forces. The first task force actually developed two sets of criteria: the first, and more rigorous, set of criteria was for *Well-Established Treatments*, while the other set was for *Probably Efficacious Treatments* (Chambless et al., 1996). For a psychotherapy to be well established, at least two experiments with group designs or similar types of studies must have been published to demonstrate efficacy. Chapters 3 through 5 of this report describe the findings of the task forces in relation to psychotherapies for children, adults, and older adults. Some types of psychotherapies that do not meet the criteria might be effective but may not have been studied sufficiently.

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<sup>3</sup> The first phase is to establish safety (Phase I), while the latter two phases establish efficacy through small and then large-scale randomized controlled clinical trials (Phases II and III) (FDA, 1998).

Another way of evaluating a collection of studies is through a formal statistical technique called a meta-analysis. A meta-analysis is a way of combining results from multiple studies. Its goal is to determine the size and consistency of the "effect" of a particular treatment or other intervention observed across the studies. The statistical technique makes the results of different studies comparable so that an overall "effect size" for the treatment can be identified. A meta-analysis determines if there is consistent evidence of a statistically significant effect of a specified treatment and estimates the size of the effect, according to widely accepted standards for a small, medium, or large effect.

### Overview of the Report's Chapters

The preceding sections have addressed overarching themes in the body of the report. This section provides a brief overview of the entire report, including a description of its general orientation and a summary of key conclusions drawn from each chapter.

Chapter 2 begins with an overview of research under way today that is focused on the brain and behavior in mental health and mental illness. It explains how newer approaches to neuroscience are mending the mind-body split, which for so long has been a stumbling block to understanding the relationship of the brain to behavior, thought, and emotion. Modern integrative neuroscience offers a means of linking research on broad "systems-level" aspects of brain function with the remarkably detailed tools and findings of molecular genetics. There follows an overview of mental illness that highlights topics including symptoms, diagnosis, epidemiology (i.e., research having to do with the distribution and determinants of mental disorders in population groups), and cost, all of which are discussed in the context of specific disorders throughout the report. The section on etiology reviews research that is seeking to define, with ever greater precision, the causes of mental illnesses. As will be seen, etiology research must examine fundamental biological and behavioral processes, as well as a necessarily broad array of life events. No less than research on normal healthy development, etiological research underscores the inextricability of

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nature and nurture, or biological and psychosocial influences, in mental illness. The section on development of temperament reveals how mental health research has attempted over much of the past century to understand how biological, psychological, and sociocultural factors meld in health as well as illness. The chapter then reviews research approaches to the prevention and treatment of mental disorders and provides an overview of mental health services and their delivery. Final sections cover the growing influence on the mental health field of cultural diversity, the importance of consumerism, and new optimism about recovery from mental illness.

Chapters 3, 4, and 5 capture the breadth, depth, and vibrancy of the mental health field. The chapters probe mental health and mental illness in children and adolescents, in adulthood (i.e., in persons up to ages 55 to 65), and in older adults, respectively. This life span approach reflects awareness that mental health, and the brain and behavioral disorders that impinge upon it, are dynamic, ever-changing phenomena that, at any given moment, reflect the sum total of every person's genetic inheritance and life experiences. The brain is extraordinarily "plastic," or malleable. It interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. Variability in expression of mental health and mental illness over the life span can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children yet not to extend that conceptual understanding to older people. In fact, older people continue to develop and change. Different stages of life are associated with distinct forms of mental and behavioral disorders and with distinctive capacities for mental health.

With rare exceptions, few persons are destined to a life marked by unremitting, acute mental illness. The most severe, persistent forms of mental illness tend to be amenable to treatment, even when recurrent and episodic. As conditions wax and wane, opportunities

exist for interventions. The goal of an intervention at any given time may vary. The focus may be on recovery, prevention of recurrence, or the acquisition of knowledge or skills that permit more effective management of an illness. Chapters 3 through 5 cover a uniform list of topics most relevant to each age cluster. Topics include mental health; prevention, diagnosis, and treatment of mental illness; service delivery; and other services and supports.

It would be impractical for a report of this type to attempt to address every domain of mental health and mental illness; therefore, this report casts a spotlight on selected topics in each of Chapters 3 through 5. The various disorders featured in depth in a given chapter were selected on the basis of their prevalence and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services) with which patients are so comfortable (Phelan et al., 1997) and upon which they depend for information. Patients and families welcome a proliferating array of support services—such as self-help programs, family self-help, crisis services, and advocacy—that help them cope with the isolation, family disruption, and possible loss of employment and housing that may accompany mental disorders. Support services can help dissipate stigma and guide patients into formal care as well.

Although the chapters that address stages of development afford a sense of the breadth of issues pertinent to mental health and illness, the report is not exhaustive. The neglect of any given disorder, population, or topic should not be construed as signifying a lack of importance.

Chapter 6 discusses the organization and financing of mental health services. The first section provides an overview of the current system of mental health services, describing where people get care and how they use services. The chapter then presents information on the costs of care and trends in spending. Only within recent decades have the dynamics of

insurance financing become a significant issue in the mental health field; these are discussed, as is the advent of managed care. The chapter addresses both positive and adverse effects of managed care on access and quality and describes efforts to guard against untoward consequences of aggressive cost-containment policies. The final section documents some of the inequities between general health care and mental health care and describes efforts to correct them through legislative regulation and financing changes.

The confidentiality of all health care information has emerged as a core issue in recent years, as concerns regarding the accessibility of health care information and its uses have risen. As Chapter 7 illustrates, privacy concerns are particularly keenly felt in the mental health field, beginning with the importance of an assurance of confidentiality in individual decisions to seek mental health treatment. The chapter reviews the legal framework governing confidentiality and potential problems with that framework, and policy issues that must be addressed by those concerned with the confidentiality of mental health and substance abuse information.

Chapter 8 concludes, on the basis of the extensive literature that the Surgeon General's report reviews and summarizes, that *the efficacy of mental health treatment is well-documented*. Moreover, there exists a range of treatments from which people may choose a particular approach to suit their needs and preferences. Based on this finding, the report's principal recommendation to the American people is to *seek help if you have a mental health problem or think you have symptoms of mental illness*. The chapter explores opportunities to overcome barriers to implementing the recommendation and to have seeking help lead to effective treatment.

## Chapter Conclusions

### Chapter 2: The Fundamentals of Mental Health and Mental Illness

The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

1. The extraordinary pace and productivity of scientific research on the brain and behavior;
2. The introduction of a range of effective treatments for most mental disorders;
3. A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
4. The emergence of powerful consumer and family movements.

*Scientific Research.* The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. Molecular and cellular biology and molecular genetics, which are complemented by sophisticated cognitive and behavioral sciences, are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for "bottom-up" studies of the brain. This term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person's genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processes go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is "top-down" research; here, as the term suggests, the aim is to understand the broader behavioral context of the brain's cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

*Effective Treatments.* As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research

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opportunity—to discover, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (fMRI) that can observe actual brain activity. Such a collaboration would permit investigators to monitor the specific protein molecules intended as the “targets” of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new “integrative neuroscience” of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Mental health clinical research encompasses studies that involve human participants, conducted, for example, to test the efficacy of a new treatment. A noteworthy feature of contemporary clinical research is the new emphasis being placed on studying the effectiveness of interventions in actual practice settings. Information obtained from such studies increasingly provides the foundation for services research concerned with the cost, cost-effectiveness, and “deliverability” of interventions and the design—including economic considerations—of service delivery systems.

*Organization and Financing of Mental Health Care.* Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system

is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. Its configuration reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

*Consumer and Family Movements.* The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness.

Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions:

1. The multifaceted complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological experiences are recorded ultimately in the brain and that all psychological phenomena reflect biological processes, the modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain, and mind.
2. Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
3. Few lesions or physiologic abnormalities define the mental disorders, and for the most part their causes remain unknown. Mental disorders, instead, are defined by signs, symptoms, and functional impairments.
4. Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders.
5. About one in five Americans experiences a mental disorder in the course of a year. Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
6. A range of treatments of well-documented efficacy exists for most mental disorders. Two broad types of intervention include psychosocial treatments—for example, psychotherapy or counseling—and psychopharmacologic treatments; these often are most effective when combined.
7. In the mental health field, progress in developing preventive interventions has been slow because, for most major mental disorders, there is insufficient understanding about etiology (or causes of illness) and/or there is an inability to alter the *known* etiology of a particular disorder. Still, some successful strategies have emerged in the absence of a full understanding of etiology.
8. About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups. Yet critical gaps exist between those who need service and those who receive service.
9. Gaps also exist between optimally effective treatment and what many individuals receive in actual practice settings.
10. Mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
11. The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.
12. The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts; and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice.

#### *Mental Health and Mental Illness Across the Lifespan*

The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how

# Exhibit G

CERTIFICATION OF ENROLLMENT  
SUBSTITUTE HOUSE BILL 1154

Chapter 6, Laws of 2005

59th Legislature  
2005 Regular Session

MENTAL HEALTH

EFFECTIVE DATE: 7/24/05

Passed by the House January 28, 2005  
Yeas 67 Nays 25

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 3, 2005  
Yeas 40 Nays 9

BRAD OWEN

President of the Senate

Approved March 9, 2005.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is SUBSTITUTE HOUSE BILL 1154 as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAPZIGER

Chief Clerk

FILED

March 9, 2005 - 3:49 p.m.

Secretary of State  
State of Washington



1 significant. Additionally, the legislature declares that it is not  
2 cost-effective to treat persons with mental disorders differently than  
3 persons with medical and surgical disorders.

4 Therefore, the legislature intends to require that insurance  
5 coverage be at parity for mental health services, which means this  
6 coverage be delivered under the same terms and conditions as medical  
7 and surgical services.

8 NEW SECTION. Sec. 2. A new section is added to chapter 41.05 RCW  
9 to read as follows:

10 (1) For the purposes of this section, "mental health services"  
11 means medically necessary outpatient and inpatient services provided to  
12 treat mental disorders covered by the diagnostic categories listed in  
13 the most current version of the diagnostic and statistical manual of  
14 mental disorders, published by the American psychiatric association, on  
15 the effective date of this section, or such subsequent date as may be  
16 provided by the administrator by rule, consistent with the purposes of  
17 this act, with the exception of the following categories, codes, and  
18 services: (a) Substance related disorders; (b) life transition  
19 problems, currently referred to as "V" codes, and diagnostic codes 302  
20 through 302.9 as found in the diagnostic and statistical manual of  
21 mental disorders, 4th edition, published by the American psychiatric  
22 association; (c) skilled nursing facility services, home health care,  
23 residential treatment, and custodial care; and (d) court ordered  
24 treatment unless the authority's or contracted insuring entity's  
25 medical director determines the treatment to be medically necessary.

26 (2) All health benefit plans offered to public employees and their  
27 covered dependents under this chapter that provide coverage for medical  
28 and surgical services shall provide:

29 (a) For all health benefit plans established or renewed on or after  
30 January 1, 2006, coverage for:

31 (i) Mental health services. The copayment or coinsurance for  
32 mental health services may be no more than the copayment or coinsurance  
33 for medical and surgical services otherwise provided under the health  
34 benefit plan. Wellness and preventive services that are provided or  
35 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
36 than other medical and surgical services are excluded from this  
37 comparison; and

1 (ii) Prescription drugs intended to treat any of the disorders  
2 covered in subsection (1) of this section to the same extent, and under  
3 the same terms and conditions, as other prescription drugs covered by  
4 the health benefit plan.

5 (b) For all health benefit plans established or renewed on or after  
6 January 1, 2008, coverage for:

7 (i) Mental health services. The copayment or coinsurance for  
8 mental health services may be no more than the copayment or coinsurance  
9 for medical and surgical services otherwise provided under the health  
10 benefit plan. Wellness and preventive services that are provided or  
11 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
12 than other medical and surgical services are excluded from this  
13 comparison. If the health benefit plan imposes a maximum out-of-pocket  
14 limit or stop loss, it shall be a single limit or stop loss for  
15 medical, surgical, and mental health services; and

16 (ii) Prescription drugs intended to treat any of the disorders  
17 covered in subsection (1) of this section to the same extent, and under  
18 the same terms and conditions, as other prescription drugs covered by  
19 the health benefit plan.

20 (c) For all health benefit plans established or renewed on or after  
21 July 1, 2010, coverage for:

22 (i) Mental health services. The copayment or coinsurance for  
23 mental health services may be no more than the copayment or coinsurance  
24 for medical and surgical services otherwise provided under the health  
25 benefit plan. Wellness and preventive services that are provided or  
26 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
27 than other medical and surgical services are excluded from this  
28 comparison. If the health benefit plan imposes a maximum out-of-pocket  
29 limit or stop loss, it shall be a single limit or stop loss for  
30 medical, surgical, and mental health services. If the health benefit  
31 plan imposes any deductible, mental health services shall be included  
32 with medical and surgical services for the purpose of meeting the  
33 deductible requirement. Treatment limitations or any other financial  
34 requirements on coverage for mental health services are only allowed if  
35 the same limitations or requirements are imposed on coverage for  
36 medical and surgical services; and

37 (ii) Prescription drugs intended to treat any of the disorders

1 covered in subsection (1) of this section to the same extent, and under  
2 the same terms and conditions, as other prescription drugs covered by  
3 the health benefit plan.

4 (3) In meeting the requirements of subsection (2)(a) and (b) of  
5 this section, health benefit plans may not reduce the number of mental  
6 health outpatient visits or mental health inpatient days below the  
7 level in effect on July 1, 2002.

8 (4) This section does not prohibit a requirement that mental health  
9 services be medically necessary as determined by the medical director  
10 or designee, if a comparable requirement is applicable to medical and  
11 surgical services.

12 (5) Nothing in this section shall be construed to prevent the  
13 management of mental health services.

14 (6) The administrator will consider care management techniques for  
15 mental health services, including but not limited to: (a) Authorized  
16 treatment plans; (b) preauthorization requirements based on the type of  
17 service; (c) concurrent and retrospective utilization review; (d)  
18 utilization management practices; (e) discharge coordination and  
19 planning; and (f) contracting with and using a network of participating  
20 providers.

21 NEW SECTION. Sec. 3. A new section is added to chapter 48.21 RCW  
22 to read as follows:

23 (1) For the purposes of this section, "mental health services"  
24 means medically necessary outpatient and inpatient services provided to  
25 treat mental disorders covered by the diagnostic categories listed in  
26 the most current version of the diagnostic and statistical manual of  
27 mental disorders, published by the American psychiatric association, on  
28 the effective date of this section, or such subsequent date as may be  
29 provided by the insurance commissioner by rule, consistent with the  
30 purposes of this act, with the exception of the following categories,  
31 codes, and services: (a) Substance related disorders; (b) life  
32 transition problems, currently referred to as "V" codes, and diagnostic  
33 codes 302 through 302.9 as found in the diagnostic and statistical  
34 manual of mental disorders, 4th edition, published by the American  
35 psychiatric association; (c) skilled nursing facility services, home  
36 health care, residential treatment, and custodial care; and (d) court

1 ordered treatment unless the insurer's medical director or designee  
2 determines the treatment to be medically necessary.

3 (2) All group disability insurance contracts and blanket disability  
4 insurance contracts providing health benefit plans that provide  
5 coverage for medical and surgical services shall provide:

6 (a) For all health benefit plans established or renewed on or after  
7 January 1, 2006, for groups of more than fifty employees coverage for:

8 (i) Mental health services. The copayment or coinsurance for  
9 mental health services may be no more than the copayment or coinsurance  
10 for medical and surgical services otherwise provided under the health  
11 benefit plan. Wellness and preventive services that are provided or  
12 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
13 than other medical and surgical services are excluded from this  
14 comparison; and

15 (ii) Prescription drugs intended to treat any of the disorders  
16 covered in subsection (1) of this section to the same extent, and under  
17 the same terms and conditions, as other prescription drugs covered by  
18 the health benefit plan.

19 (b) For all health benefit plans established or renewed on or after  
20 January 1, 2008, for groups of more than fifty employees coverage for:

21 (i) Mental health services. The copayment or coinsurance for  
22 mental health services may be no more than the copayment or coinsurance  
23 for medical and surgical services otherwise provided under the health  
24 benefit plan. Wellness and preventive services that are provided or  
25 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
26 than other medical and surgical services are excluded from this  
27 comparison. If the health benefit plan imposes a maximum out-of-pocket  
28 limit or stop loss, it shall be a single limit or stop loss for  
29 medical, surgical, and mental health services; and

30 (ii) Prescription drugs intended to treat any of the disorders  
31 covered in subsection (1) of this section to the same extent, and under  
32 the same terms and conditions, as other prescription drugs covered by  
33 the health benefit plan.

34 (c) For all health benefit plans established or renewed on or after  
35 July 1, 2010, for groups of more than fifty employees coverage for:

36 (i) Mental health services. The copayment or coinsurance for  
37 mental health services may be no more than the copayment or coinsurance  
38 for medical and surgical services otherwise provided under the health

1 benefit plan. Wellness and preventive services that are provided or  
2 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
3 than other medical and surgical services are excluded from this  
4 comparison. If the health benefit plan imposes a maximum out-of-pocket  
5 limit or stop loss, it shall be a single limit or stop loss for  
6 medical, surgical, and mental health services. If the health benefit  
7 plan imposes any deductible, mental health services shall be included  
8 with medical and surgical services for the purpose of meeting the  
9 deductible requirement. Treatment limitations or any other financial  
10 requirements on coverage for mental health services are only allowed if  
11 the same limitations or requirements are imposed on coverage for  
12 medical and surgical services; and

13 (ii) Prescription drugs intended to treat any of the disorders  
14 covered in subsection (1) of this section to the same extent, and under  
15 the same terms and conditions, as other prescription drugs covered by  
16 the health benefit plan.

17 (3) In meeting the requirements of subsection (2)(a) and (b) of  
18 this section, health benefit plans may not reduce the number of mental  
19 health outpatient visits or mental health inpatient days below the  
20 level in effect on July 1, 2002.

21 (4) This section does not prohibit a requirement that mental health  
22 services be medically necessary as determined by the medical director  
23 or designee, if a comparable requirement is applicable to medical and  
24 surgical services.

25 (5) Nothing in this section shall be construed to prevent the  
26 management of mental health services.

27 NEW SECTION. Sec. 4. A new section is added to chapter 48.44 RCW  
28 to read as follows:

29 (1) For the purposes of this section, "mental health services"  
30 means medically necessary outpatient and inpatient services provided to  
31 treat mental disorders covered by the diagnostic categories listed in  
32 the most current version of the diagnostic and statistical manual of  
33 mental disorders, published by the American psychiatric association, on  
34 the effective date of this section, or such subsequent date as may be  
35 provided by the insurance commissioner by rule, consistent with the  
36 purposes of this act, with the exception of the following categories,  
37 codes, and services: (a) Substance related disorders; (b) life

1 transition problems, currently referred to as "V" codes, and diagnostic  
2 codes 302 through 302.9 as found in the diagnostic and statistical  
3 manual of mental disorders, 4th edition, published by the American  
4 psychiatric association; (c) skilled nursing facility services, home  
5 health care, residential treatment, and custodial care; and (d) court  
6 ordered treatment unless the health care service contractor's medical  
7 director or designee determines the treatment to be medically  
8 necessary.

9 (2) All health service contracts providing health benefit plans  
10 that provide coverage for medical and surgical services shall provide:

11 (a) For all health benefit plans established or renewed on or after  
12 January 1, 2006, for groups of more than fifty employees coverage for:

13 (i) Mental health services. The copayment or coinsurance for  
14 mental health services may be no more than the copayment or coinsurance  
15 for medical and surgical services otherwise provided under the health  
16 benefit plan. Wellness and preventive services that are provided or  
17 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
18 than other medical and surgical services are excluded from this  
19 comparison; and

20 (ii) Prescription drugs intended to treat any of the disorders  
21 covered in subsection (1) of this section to the same extent, and under  
22 the same terms and conditions, as other prescription drugs covered by  
23 the health benefit plan.

24 (b) For all health benefit plans established or renewed on or after  
25 January 1, 2008, for groups of more than fifty employees coverage for:

26 (i) Mental health services. The copayment or coinsurance for  
27 mental health services may be no more than the copayment or coinsurance  
28 for medical and surgical services otherwise provided under the health  
29 benefit plan. Wellness and preventive services that are provided or  
30 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
31 than other medical and surgical services are excluded from this  
32 comparison. If the health benefit plan imposes a maximum out-of-pocket  
33 limit or stop loss, it shall be a single limit or stop loss for  
34 medical, surgical, and mental health services; and

35 (ii) Prescription drugs intended to treat any of the disorders  
36 covered in subsection (1) of this section to the same extent, and under  
37 the same terms and conditions, as other prescription drugs covered by  
38 the health benefit plan.

1 (c) For all health benefit plans established or renewed on or after  
2 July 1, 2010, for groups of more than fifty employees coverage for:

3 (i) Mental health services. The copayment or coinsurance for  
4 mental health services may be no more than the copayment or coinsurance  
5 for medical and surgical services otherwise provided under the health  
6 benefit plan. Wellness and preventive services that are provided or  
7 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
8 than other medical and surgical services are excluded from this  
9 comparison. If the health benefit plan imposes a maximum out-of-pocket  
10 limit or stop loss, it shall be a single limit or stop loss for  
11 medical, surgical, and mental health services. If the health benefit  
12 plan imposes any deductible, mental health services shall be included  
13 with medical and surgical services for the purpose of meeting the  
14 deductible requirement. Treatment limitations or any other financial  
15 requirements on coverage for mental health services are only allowed if  
16 the same limitations or requirements are imposed on coverage for  
17 medical and surgical services; and

18 (ii) Prescription drugs intended to treat any of the disorders  
19 covered in subsection (1) of this section to the same extent, and under  
20 the same terms and conditions, as other prescription drugs covered by  
21 the health benefit plan.

22 (3) In meeting the requirements of subsection (2)(a) and (b) of  
23 this section, health benefit plans may not reduce the number of mental  
24 health outpatient visits or mental health inpatient days below the  
25 level in effect on July 1, 2002.

26 (4) This section does not prohibit a requirement that mental health  
27 services be medically necessary as determined by the medical director  
28 or designee, if a comparable requirement is applicable to medical and  
29 surgical services.

30 (5) Nothing in this section shall be construed to prevent the  
31 management of mental health services.

32 NEW SECTION. Sec. 5. A new section is added to chapter 48.46 RCW  
33 to read as follows:

34 (1) For the purposes of this section, "mental health services"  
35 means medically necessary outpatient and inpatient services provided to  
36 treat mental disorders covered by the diagnostic categories listed in  
37 the most current version of the diagnostic and statistical manual of

1 mental disorders, published by the American psychiatric association, on  
2 the effective date of this section, or such subsequent date as may be  
3 provided by the insurance commissioner by rule, consistent with the  
4 purposes of this act, with the exception of the following categories,  
5 codes, and services: (a) Substance related disorders; (b) life  
6 transition problems, currently referred to as "V" codes, and diagnostic  
7 codes 302 through 302.9 as found in the diagnostic and statistical  
8 manual of mental disorders, 4th edition, published by the American  
9 psychiatric association; (c) skilled nursing facility services, home  
10 health care, residential treatment, and custodial care; and (d) court  
11 ordered treatment unless the health maintenance organization's medical  
12 director or designee determines the treatment to be medically  
13 necessary.

14 (2) All health benefit plans offered by health maintenance  
15 organizations that provide coverage for medical and surgical services  
16 shall provide:

17 (a) For all health benefit plans established or renewed on or after  
18 January 1, 2006, for groups of more than fifty employees coverage for:

19 (i) Mental health services. The copayment or coinsurance for  
20 mental health services may be no more than the copayment or coinsurance  
21 for medical and surgical services otherwise provided under the health  
22 benefit plan. Wellness and preventive services that are provided or  
23 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
24 than other medical and surgical services are excluded from this  
25 comparison; and

26 (ii) Prescription drugs intended to treat any of the disorders  
27 covered in subsection (1) of this section to the same extent, and under  
28 the same terms and conditions, as other prescription drugs covered by  
29 the health benefit plan.

30 (b) For all health benefit plans established or renewed on or after  
31 January 1, 2008, for groups of more than fifty employees coverage for:

32 (i) Mental health services. The copayment or coinsurance for  
33 mental health services may be no more than the copayment or coinsurance  
34 for medical and surgical services otherwise provided under the health  
35 benefit plan. Wellness and preventive services that are provided or  
36 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
37 than other medical and surgical services are excluded from this

1 comparison. If the health benefit plan imposes a maximum out-of-pocket  
2 limit or stop loss, it shall be a single limit or stop loss for  
3 medical, surgical, and mental health services; and  
4 (ii) Prescription drugs intended to treat any of the disorders  
5 covered in subsection (1) of this section to the same extent, and under  
6 the same terms and conditions, as other prescription drugs covered by  
7 the health benefit plan.  
8 (c) For all health benefit plans established or renewed on or after  
9 July 1, 2010, for groups of more than fifty employees coverage for:  
10 (i) Mental health services. The copayment or coinsurance for  
11 mental health services may be no more than the copayment or coinsurance  
12 for medical and surgical services otherwise provided under the health  
13 benefit plan. Wellness and preventive services that are provided or  
14 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
15 than other medical and surgical services are excluded from this  
16 comparison. If the health benefit plan imposes a maximum out-of-pocket  
17 limit or stop loss, it shall be a single limit or stop loss for  
18 medical, surgical, and mental health services. If the health benefit  
19 plan imposes any deductible, mental health services shall be included  
20 with medical and surgical services for the purpose of meeting the  
21 deductible requirement. Treatment limitations or any other financial  
22 requirements on coverage for mental health services are only allowed if  
23 the same limitations or requirements are imposed on coverage for  
24 medical and surgical services; and  
25 (ii) Prescription drugs intended to treat any of the disorders  
26 covered in subsection (1) of this section to the same extent, and under  
27 the same terms and conditions, as other prescription drugs covered by  
28 the health benefit plan.  
29 (3) In meeting the requirements of subsection (2)(a) and (b) of  
30 this section, health benefit plans may not reduce the number of mental  
31 health outpatient visits or mental health inpatient days below the  
32 level in effect on July 1, 2002.  
33 (4) This section does not prohibit a requirement that mental health  
34 services be medically necessary as determined by the medical director  
35 or designee, if a comparable requirement is applicable to medical and  
36 surgical services.  
37 (5) Nothing in this section shall be construed to prevent the  
38 management of mental health services.

1        NEW SECTION. Sec. 6. A new section is added to chapter 70.47 RCW  
2 to read as follows:

3        (1) For the purposes of this section, "mental health services"  
4 means medically necessary outpatient and inpatient services provided to  
5 treat mental disorders covered by the diagnostic categories listed in  
6 the most current version of the diagnostic and statistical manual of  
7 mental disorders, published by the American psychiatric association, on  
8 the effective date of this section, or such subsequent date as may be  
9 determined by the administrator, by rule, consistent with the purposes  
10 of this act, with the exception of the following categories, codes, and  
11 services: (a) Substance related disorders; (b) life transition  
12 problems, currently referred to as "V" codes, and diagnostic codes 302  
13 through 302.9 as found in the diagnostic and statistical manual of  
14 mental disorders, 4th edition, published by the American psychiatric  
15 association; (c) skilled nursing facility services, home health care,  
16 residential treatment, and custodial care; and (d) court ordered  
17 treatment, unless the Washington basic health plan's or contracted  
18 managed health care system's medical director or designee determines  
19 the treatment to be medically necessary.

20        (2)(a) Any schedule of benefits established or renewed by the  
21 Washington basic health plan on or after January 1, 2006, shall provide  
22 coverage for:

23        (i) Mental health services. The copayment or coinsurance for  
24 mental health services may be no more than the copayment or coinsurance  
25 for medical and surgical services otherwise provided under the schedule  
26 of benefits. Wellness and preventive services that are provided or  
27 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
28 than other medical and surgical services are excluded from this  
29 comparison; and

30        (ii) Prescription drugs intended to treat any of the disorders  
31 covered in subsection (1) of this section to the same extent, and under  
32 the same terms and conditions, as other prescription drugs covered  
33 under the schedule of benefits.

34        (b) Any schedule of benefits established or renewed by the  
35 Washington basic health plan on or after January 1, 2008, shall provide  
36 coverage for:

37        (i) Mental health services. The copayment or coinsurance for  
38 mental health services may be no more than the copayment or coinsurance

1 for medical and surgical services otherwise provided under the schedule  
2 of benefits. Wellness and preventive services that are provided or  
3 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
4 than other medical and surgical services are excluded from this  
5 comparison. If the schedule of benefits imposes a maximum out-of-  
6 pocket limit or stop loss, it shall be a single limit or stop loss for  
7 medical, surgical, and mental health services; and

8 (ii) Prescription drugs intended to treat any of the disorders  
9 covered in subsection (1) of this section to the same extent, and under  
10 the same terms and conditions, as other prescription drugs covered  
11 under the schedule of benefits.

12 (c) Any schedule of benefits established or renewed by the  
13 Washington basic health plan on or after July 1, 2010, shall include  
14 coverage for:

15 (i) Mental health services. The copayment or coinsurance for  
16 mental health services may be no more than the copayment or coinsurance  
17 for medical and surgical services otherwise provided under the schedule  
18 of benefits. Wellness and preventive services that are provided or  
19 reimbursed at a lesser copayment, coinsurance, or other cost sharing  
20 than other medical and surgical services are excluded from this  
21 comparison. If the schedule of benefits imposes a maximum out-of-  
22 pocket limit or stop loss, it shall be a single limit or stop loss for  
23 medical, surgical, and mental health services. If the schedule of  
24 benefits imposes any deductible, mental health services shall be  
25 included with medical and surgical services for the purpose of meeting  
26 the deductible requirement. Treatment limitations or any other  
27 financial requirements on coverage for mental health services are only  
28 allowed if the same limitations or requirements are imposed on coverage  
29 for medical and surgical services; and

30 (ii) Prescription drugs intended to treat any of the disorders  
31 covered in subsection (1) of this section to the same extent, and under  
32 the same terms and conditions, as other prescription drugs covered  
33 under the schedule of benefits.

34 (3) In meeting the requirements of subsection (2)(a) and (b) of  
35 this section, the Washington basic health plan may not reduce the  
36 number of mental health outpatient visits or mental health inpatient  
37 days below the level in effect on July 1, 2002.

1 (4) This section does not prohibit a requirement that mental health  
2 services be medically necessary as determined by the medical director  
3 or designee, if a comparable requirement is applicable to medical and  
4 surgical services.

5 (5) Nothing in this section shall be construed to prevent the  
6 management of mental health services.

7 Sec. 7. RCW 48.21.240 and 1987 c 283 s 3 are each amended to read  
8 as follows:

9 (1) For groups not covered by section 3 of this act, each group  
10 insurer providing disability insurance coverage in this state for  
11 hospital or medical care under contracts which are issued, delivered,  
12 or renewed in this state (~~on or after July 1, 1986,~~) shall offer  
13 optional supplemental coverage for mental health treatment for the  
14 insured and the insured's covered dependents.

15 (2) Benefits shall be provided under the optional supplemental  
16 coverage for mental health treatment whether treatment is rendered by:  
17 (a) ~~A ((physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~  
18 ~~psychologist licensed under chapter 18.83))~~ licensed mental health  
19 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225  
20 RCW; ((-(-)) (b) a community mental health agency licensed by the  
21 department of social and health services pursuant to chapter 71.24 RCW;  
22 or ((-(-)) (c) a state hospital as defined in RCW 72.23.010. The  
23 treatment shall be covered at the usual and customary rates for such  
24 treatment. The insurer((, health care service contractor, or health  
25 maintenance organization)) providing optional coverage under the  
26 provisions of this section for mental health services may establish  
27 separate usual and customary rates for services rendered by  
28 ((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists  
29 licensed under chapter 18.83 RCW, and community mental health centers  
30 licensed under chapter 71.24 RCW and state hospitals as defined in RCW  
31 72.23.010)) the different categories of providers listed in (a) through  
32 (c) of this subsection. However, the treatment may be subject to  
33 contract provisions with respect to reasonable deductible amounts or  
34 copayments. In order to qualify for coverage under this section, a  
35 licensed community mental health agency shall have in effect a plan for  
36 quality assurance and peer review, and the treatment shall be

1 supervised by (~~a physician licensed under chapter 18.71 or 18.57 RCW~~  
2 ~~or by a psychologist licensed under chapter 18.83 RCW~~) one of the  
3 categories of providers listed in (a) of this subsection.

4 (3) For groups not covered by section 3 of this act, the group  
5 disability insurance contract may provide that all the coverage for  
6 mental health treatment is waived for all covered members if the  
7 contract holder so states in advance in writing to the insurer.

8 (4) This section shall not apply to a group disability insurance  
9 contract that has been entered into in accordance with a collective  
10 bargaining agreement between management and labor representatives prior  
11 to March 1, 1987.

12 Sec. 8. RCW 48.44.340 and 1987 c 283 s 4 are each amended to read  
13 as follows:

14 (1) For groups not covered by section 4 of this act, each health  
15 care service contractor providing hospital or medical services or  
16 benefits in this state under group contracts for health care services  
17 under this chapter which are issued, delivered, or renewed in this  
18 state (~~on or after July 1, 1986,~~) shall offer optional supplemental  
19 coverage for mental health treatment for the insured and the insured's  
20 covered dependents.

21 (2) Benefits shall be provided under the optional supplemental  
22 coverage for mental health treatment whether treatment is rendered by:  
23 (a) A (~~physician licensed under chapter 18.71 or 18.57 RCW,~~ (b) a  
24 ~~psychologist licensed under chapter 18.83~~) licensed mental health  
25 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225  
26 RCW; ((c)) (b) a community mental health agency licensed by the  
27 department of social and health services pursuant to chapter 71.24 RCW;  
28 or ((d)) (c) a state hospital as defined in RCW 72.23.010. The  
29 treatment shall be covered at the usual and customary rates for such  
30 treatment. The ((insurer,)) health care service contractor ((or  
31 health maintenance organization)) providing optional coverage under the  
32 provisions of this section for mental health services may establish  
33 separate usual and customary rates for services rendered by  
34 ((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists  
35 licensed under chapter 18.83 RCW, and community mental health centers  
36 licensed under chapter 71.24 RCW and state hospitals as defined in RCW  
37 72.23.010)) the different categories of providers listed in (a) through

1 (c) of this subsection. However, the treatment may be subject to  
2 contract provisions with respect to reasonable deductible amounts or  
3 copayments. In order to qualify for coverage under this section, a  
4 licensed community mental health agency shall have in effect a plan for  
5 quality assurance and peer review, and the treatment shall be  
6 supervised by ~~((a physician licensed under chapter 18.71 or 18.57 RCW~~  
7 ~~or by a psychologist licensed under chapter 18.83 RCW))~~ one of the  
8 categories of providers listed in (a) of this subsection.

9 (3) For groups not covered by section 4 of this act, the group  
10 contract for health care services may provide that all the coverage for  
11 mental health treatment is waived for all covered members if the  
12 contract holder so states in advance in writing to the health care  
13 service contractor.

14 (4) This section shall not apply to a group health care service  
15 contract that has been entered into in accordance with a collective  
16 bargaining agreement between management and labor representatives prior  
17 to March 1, 1987.

18 Sec. 9. RCW 48.46.290 and 1987 c 283 s 5 are each amended to read  
19 as follows:

20 (1) For groups not covered by section 5 of this act, each health  
21 maintenance organization providing services or benefits for hospital or  
22 medical care coverage in this state under group health maintenance  
23 agreements which are issued, delivered, or renewed in this state ~~((on~~  
24 ~~or after July 1, 1986,))~~ shall offer optional supplemental coverage for  
25 mental health treatment to the enrolled participant and the enrolled  
26 participant's covered dependents.

27 (2) Benefits shall be provided under the optional supplemental  
28 coverage for mental health treatment whether treatment is rendered by  
29 the health maintenance organization or the health maintenance  
30 organization refers the enrolled participant or the enrolled  
31 participant's covered dependents for treatment ~~((to))~~ by: (a) A  
32 ~~((physician licensed under chapter 18.71 or 18.57 RCW, (b) a~~  
33 ~~psychologist licensed under chapter 18.83))~~ licensed mental health  
34 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225  
35 RCW; ((-e-)) (b) a community mental health agency licensed by the  
36 department of social and health services pursuant to chapter 71.24 RCW;  
37 or ((-d-)) (c) a state hospital as defined in RCW 72.23.010. The

1 treatment shall be covered at the usual and customary rates for such  
2 treatment. The ~~((insurer, health care service contractor, or))~~ health  
3 maintenance organization providing optional coverage under the  
4 provisions of this section for mental health services may establish  
5 separate usual and customary rates for services rendered by  
6 ~~((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists  
7 licensed under chapter 18.83 RCW, and community mental health centers  
8 licensed under chapter 71.24 RCW and state hospitals as defined in RCW  
9 72.23.010))~~ the different categories of providers listed in (a) through  
10 (c) of this subsection. However, the treatment may be subject to  
11 contract provisions with respect to reasonable deductible amounts or  
12 copayments. In order to qualify for coverage under this section, a  
13 licensed community mental health agency shall have in effect a plan for  
14 quality assurance and peer review, and the treatment shall be  
15 supervised by ~~((a physician licensed under chapter 18.71 or 18.57 RCW  
16 or by a psychologist licensed under chapter 18.83 RCW))~~ one of the  
17 categories of providers listed in (a) of this subsection.

18 (3) For groups not covered by section 5 of this act, the group  
19 health maintenance agreement may provide that all the coverage for  
20 mental health treatment is waived for all covered members if the  
21 contract holder so states in advance in writing to the health  
22 maintenance organization.

23 (4) This section shall not apply to a group health maintenance  
24 agreement that has been entered into in accordance with a collective  
25 bargaining agreement between management and labor representatives prior  
26 to March 1, 1987.

27 NEW SECTION. Sec. 10. A new section is added to chapter 48.02 RCW  
28 to read as follows:

29 The insurance commissioner may adopt rules to implement sections 3  
30 through 5 of this act, except that the rules do not apply to health  
31 benefit plans administered or operated under chapter 41.05 or 70.47  
32 RCW.

33 NEW SECTION. Sec. 11. A new section is added to chapter 70.47 RCW  
34 to read as follows:

35 The administrator may adopt rules to implement section 6 of this  
36 act.

1        NEW SECTION. Sec. 12. A new section is added to chapter 41.05 RCW  
2 to read as follows:

3        The administrator may adopt rules to implement section 2 of this  
4 act.

5        NEW SECTION. Sec. 13. If any provision of this act or its  
6 application to any person or circumstance is held invalid, the  
7 remainder of the act or the application of the provision to other  
8 persons or circumstances is not affected.

      Passed by the House January 28, 2005.

      Passed by the Senate March 3, 2005.

      Approved by the Governor March 9, 2005.

      Filed in Office of Secretary of State March 9, 2005.

# Exhibit H

*Information, Summary and Recommendations*

# Mental Health Parity Mandated Benefits Sunrise Review

November 1998



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Mary C. Selecky  
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## EXECUTIVE SUMMARY

### PROPOSAL FOR SUNRISE REVIEW

SB 6566 was referred to the department in 1998 for review under the mandated benefits sunrise review law, RCW 48.47. (A revised version of the bill, H-0001, was referred to the department and was used in the review. For simplification, "SB 6566" will be used throughout this report to represent the proposal under review. See Appendix A.) The applicant is the Coalition for Insurance Parity, a statewide group representing mental health providers, consumers, and advocacy organizations around the state. The proposal would require group health plans and the public employees benefit board health plan to (a) provide mental health coverage if they currently do not and (b) cover mental health at the same level that physical health is covered.

The requirement for mental health coverage is broad--"all mental disorders included in the diagnostic and statistical manual of mental disorders"--but the insurance policy may make mental health coverage subject to prior authorization and medical necessity requirements, the same as other services.

The requirement for parity in coverage is also broadly worded, so that it applies to both treatment limitations and various forms of financial participation. (By comparison, the national mental health parity law only restricts annual and lifetime dollar limits.) For example, if there is a \$10 co-pay for office visits, the co-pay for mental health visit must not be more than \$10. In addition, there could be no maximum number of visits on either an inpatient or out patient basis, unless similar requirements were imposed on coverage for medical and surgical services.

### CURRENT REGULATION AND PRACTICE

There are currently no state requirements for either providing mental health coverage or specific mandates on the level of coverage, if offered, among the plans that would be covered by this proposal. There is, however, a Federal parity law for groups over 50 (but it does not mandate coverage, only parity if there is coverage), and state mandated offering laws for all groups subject to state Insurance Code. The meaning of "parity" in the federal law is narrow; annual or lifetime dollar limits for mental health services may not be lower than those for medical and surgical care.

Information provided to the department indicates that most health plans, including those impacted by this proposal, if enacted, do cover mental health services but nearly all do so with limits on visits, days, cumulative cost, or other parameters.

## FINDINGS AND ANALYSIS

### General

1. Applicants made a clear, persuasive case, based on scientific evidence, consumer testimony and experience, and a reasonable actuarial study. The Washington Association of Health Plans expressed reservations about timing in relation to marketplace trends in Washington. Other concerns expressed by commenters appear to be addressed through amendments the applicants are willing to support.
2. Neither federal legislation nor Washington's limited "mandated offering" law has adequately addressed the issues brought forward in the applicant report: mandated coverage for mental health services, and parity with physical health services in the level of coverage provided and the amounts paid by enrollees.

### Social Impact

Mental health problems have high prevalence, with variable but often very high impact on health and productive life. Compared to many much narrower proposals for mandated benefits, the potential social benefit from improving access to mental health treatment is unusually high. Evidence presented by the applicant, and independent research conducted by the department, suggests that:

1. A significant portion of the population could, at any time, suffer from a mental disorder;
2. Many persons with mental illness are not receiving adequate treatment, or are receiving treatment later in the development of their disorder, due to lack of insurance coverage;
3. Not being treated early or sufficiently creates secondary problems, such as reduced productivity, homelessness, additional or exacerbated "somatic" problems, and heightened risk of suicide;
4. While it is difficult to gauge "public demand" in the purely economic sense (which would require evidence of willingness to pay), there appears to be high public support for mental health parity, as indicated by surveys, the range of organizations working for the proposal, and indirectly by those who could benefit from it.
5. Mentally ill individuals and their families now often incur severe financial hardships in order to pay the complete cost of treatment for mental illness. Mental health parity would even out this burden through use of the insurance principle, as occurs in the case of other catastrophic illness (for example, cancer).
6. The impact on children and adolescents is particularly important, with potential benefits related to a wide range of self-destructive or acting-out behavior which is of concern to the public and legislators. A recent RAND study (Sturm, 1997 JAMA article) concluded that

children are the main beneficiaries of removing or greatly increasing annual limits for mental health care (which is likely to be one consequence of SB 6566).

#### Financial Impact

The cost impacts of the proposed legislation are not negligible, and therefore considerable effort was devoted to understanding them. The department concludes that financial impacts are lower than commonly believed, and are fairly presented in the actuarial report and other information presented by the applicant report. Financial impacts also are lower than they would have been a decade ago (when both treatment effectiveness and experience in managing behavioral health benefits were less advanced). The department arrived at its conclusions using the following logic, which attempts to track the range of cost-related question in the statutory sunrise criteria:

1. *Price:* There was no clear evidence provided that the price per unit of mental health services (for example, per visit or hospital day) would either increase or decrease.
2. *Total and "appropriate" service use:* Better coverage would increase the total use of mental health services. It is likely that mental health parity will also increase *appropriate* use of such services for two main reasons: earlier initiation of treatment by individuals who have insurance but now delay treatment for financial reasons, and the influence of managed care practices. The evidence on mental health services offsetting other health care (discussed below) suggests that mental health parity may also decrease the misuse (as well as the cost) of other medical and social services.

The department has no evidence about whether mental health parity would also increase *inappropriate* use of mental health services, but any such tendency would be factored into the empirical (actuarial and research) studies discussed below. In other words, if this happens, its effect is not ignored in the dollar estimates.

3. *Total cost for mental health services only:* All studies reviewed agree that a broad mental health parity mandate, such as the proposal, will increase the total spent for mental health services to some extent. This is the first question regarding financial impact—but not the last question, since increasing mental health services also can reduce or offset spending for other health services, as discussed below (5).

But starting with the narrower question, how much would SB 6566 increase mental health treatment expenditures? The applicant's actuary, PriceWaterhouseCoopers (PWC), analyzed impacts of the proposed mandate separately for different types of health insurance, from fee-for-service (15% of the market) to HMO's or other managed care with a gatekeeper (20% of market). PWC concluded that the overall "composite" impact for all group health insurance would amount to a cost increase of 2.1%. Depending on type of insurance the impact would be from 1.3% to 2.7% (and the added cost per member per month would range from \$1.21 to \$3.47). Note that the 2.1% figure assumes that the mixture of insurance types would stay the same. The increase would be less if some employers or other groups opt for "more

managed" forms of insurance. That would change the mix of insurance types and reduce the composite cost impact. Other relevant studies tend to agree with PWC that comprehensive parity only would increase costs of insurance for mental health parity only should increase about 1% in HMOs or other *tightly managed* systems of care.

As required by the mandated benefit sunrise law, the Health Care Authority provided advice on "the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit." HCA's October 8, 1998 letter indicates concurrence with the conclusions of their actuarial consultant, William M. Mercer, Inc. (Mercer), who stated, "we believe that the estimates contained in the PWC report are at the low end of a 'most likely' range ... [of] 2 to 4% increase in total health care costs."

Mercer also posed several questions, without quantitatively tying them to cost impact. Some are addressed by suggested amendments (See Appendix: F). One question deals with the impact of the existing federal and state mandates. Since PWC and other studies use an assessment of actual insurance coverage in the state as their starting point, any impact of the state's "mandated offering" of limited mental health coverage (enacted over ten years ago) would be included. There is no explicit adjustment for the much more recent federal Mental Health Parity Act in the PWC analysis, but if such an adjustment were needed, it would lower the cost impact of SB 6566 by reducing the gap between the status quo and comprehensive parity.

PWC also presented a summary of recent actuarial cost analyses from several national and state-specific studies. The results are in the range suggested by Mercer, 2-4%. (See Appendix E)

PWC analysis also summarized the actual cost experience in states that implemented mental health parity statutes. Cost impacts ranged from downward (in two states) to under 0.5% in three. Not all of these mandates are as comprehensive as SB 6566.

A letter from the Association of Washington Health Plans (AWHP) states that "estimates of cost increases associated with implementing mental health parity measures have ranged from as low as 1.3% to as high as 10%." AWHP does not take a position on where in this range the impact of SB 6566 would be, and some of the studies at the "high end" appear to deal with different legislative proposals, older data, and/or market areas with less managed care (and thus higher cost impacts) than Washington.

Based on the total information available to reviewers, the department concludes that both the applicants' actuarial study and Mercer's broader range of 2-4% cost increase, are reasonable estimates of cost impact *before allowing for changes in the extent to which behavioral health is managed*. Without further documentation, estimates above 4% are not as convincing.

4. *Premiums for the mental health portion of coverage:* The PWC actuarial study prepared for the applicants makes a distinction between the "gross benefit cost" of the mandated

benefit and the "net benefit cost," including responses by employers (or other groups) intended to keep the premium down. Using the same assumptions as are typically used by Congressional Budget Office, CBW estimated a composite "net benefit cost" impact of less than 1% (and a composite increase in premiums of less than \$1 per member per month). However, some of the methods available to restrain premiums would shift cost to employees through cost sharing, reduction of other benefits (including lower wage increases), or even dropping coverage. Therefore, the department concludes that available analysis of the impact on premiums presents an incomplete view.

5. Total cost of health services. There is significant evidence that increased mental health coverage leads to offsets: reductions in the cost of other components of health care. This is documented in the applicant's report, but these cost reductions are not included in the PWC or other actuarial studies. Some of the studies cited in the applicant report are methodologically strong; but they deal with specific areas of mental health treatment and cannot be assumed to hold for the full breadth of such treatment. The applicant report also documents that there are large, prominent national employers which have concluded that their own choice to institute comprehensive mental health parity in their employee coverage resulted in minimal net cost (or even net savings), when offsets are included. Neither the applicants nor the department estimated overall "offset" for mental health parity legislation.

The department concludes that SB 6566 would lead to reductions in other health care costs, resulting in net impact of SB 6566 lower than otherwise estimated in (3) above. Consideration of offsets makes the applicants' 2.1% estimate more reasonable, and estimates over 4% less believable.

6. *Costs and offsets to state government programs.* SB 6566 will apply to both Medicaid managed care provided by state regulated health plans and to state employee health care (including the Uniform Medical Plan.) The cost impact on Medicaid will be lower than indicated in the applicant report because Medicaid already covers all medically necessary mental health care with minimal individual cost-sharing. As written, SB 6566 does not apply to Basic Health Plan (though the Coalition for Insurance Parity is considering seeking to include it). The bill's impacts on costs for covering public employees would be similar to those for other large employed groups, but no specific estimate is available.

Mental health parity in private health coverage also may reduce public sector costs in two ways: by delaying or (more rarely) avoiding some individuals' need to fall back on Medicaid as a source of payment for severe mental illness (often in conjunction with SSI disability status); and by possibly averting some episodes of treatment in state mental hospitals. Both of these impacts are quite plausible in cases where private insurance coverage leads to earlier and thereby more effective treatment interventions. The department has no basis to estimate the magnitude of this impact.

Putting aside the issue of including BHP in the bill—see Recommendations—the department finds that mental health parity will not increase, and may reduce, expenditures in DSHS (which provides financial support for both Medicaid and state mental hospitals). It

should be noted, however, that mental health parity has the potential, especially in the short term, to increase the costs HCA and Public Employee Benefits Board pay for state employee coverage.

7. *Financial impact on small businesses and their employees:* The cost of SB 6566 will be higher in small groups than in large groups due to the greater risk of adverse selection in small groups, generally higher administrative "load," and relative lack of power to negotiate cost concessions or changes to plans that would compensate for any higher mental health premium costs. The potential differential impact on employees of small firms is serious enough that it receives attention in the department's recommendations.

8. *Affordability of health care coverage:* Affordability refers to the overall ability of businesses, other insurance groups and individuals to buy health care coverage. Affordability depends a great deal on context—what else is going on in the marketplace. Because these conditions change, there is a question of timing concerning this mandate, which is addressed in recommendations. After any short-term changes closely following implementation of a mental health mandate, the department believes that the impact on affordability will likely be small. However, some studies indicate that for every 1% increase in health premiums, approximately 2700 persons in Washington state may lose all health insurance coverage.

#### Service Efficacy

1. Vast amounts of scientific research exist to indicate that many specific mental health services are effective when appropriately used, and provide meaningful treatment to patients. The mental health field is too broad to make a categorical statement about the effectiveness of all services, but the same is true of non-behavioral medical care.
2. General health status is likely to be improved by the implementation of parity in mental health coverage.

#### Balancing Benefits and Costs

The department's recommendation is based on a considered judgment that the large and widely distributed benefits of mental health coverage parity outweigh the costs.

## RECOMMENDATIONS

1. Because the benefits outweigh the costs, the department recommends enactment of SB 6566, with amendments (See Appendix F) that would:

- a. clarify that "V" codes within DSM IV are not included in the mandate
- b. exclude chemical dependency DSM codes from the mandate
- c. not require a health plan to impose annual cost-sharing if none exists
- d. specify that medical necessity is to be determined by the plan's medical director or designee.

### Rationale:

- The department's overall basis for assessing benefits and costs is discussed in Findings and Analysis.
- The argument that physical and mental illnesses should be treated the same in insurance coverage, as a matter of fairness has ethical appeal that goes beyond the sunset criteria.
- The bill requires covering "all mental disorders included in the diagnostic and statistical manual of mental disorders IV or subsequent revisions." That manual (commonly called DSM-IV) includes a variety of codes which are not strictly diagnoses of mental disorders. One major improvement that would go far in reducing ambiguity would be to exclude so-called "V codes," which often deal with exacerbating situations that are not a mental disorder. Such factors clearly should be taken into account in determining appropriate treatment, but would not by themselves constitute a mental condition requiring coverage under the mandate.
- The applicant group has stated that they did not intend to require coverage of substance abuse treatment, but such treatment has coding in DSM-IV. Another proposed amendment would clarify that point.
- Clear definition of medical necessity in relation to the role of health plan medical directors, and modification of overly restrictive language regarding forms of enrollee cost participation, would bring the bill back to its intent of permitting the same kinds of managed care approaches used in general medical care to be applied to behavioral health care, so long as they are not applied in a way that singles out mental disorders.

The department also makes the following suggestions, which are beyond the scope of the sunrise statute and therefore are not formal recommendations.

1. The effective date of SB 6566 needs careful consideration, especially as related to small insurance groups. The department's favorable recommendation above (subject to suggested amendment) is based on a long-term assessment that benefits outweigh costs, in relation to the criteria in statute. However, there are immediate concerns about timing because health insurance premium increases for next year are larger than they have been for several years. The reasons are beyond the scope of this report, but probably include a combination of underlying medical cost inflation, cyclic trends (the "underwriting cycle"), and an adverse risk spiral in some areas of the market. In combination, this may be an especially poor year to institute the mandate. The impact on small businesses and their employees would be especially significant, as discussed in Findings.

This caution about timing does not change the department's recommendation that the mandate be passed, with amendments. The department believes that, long term, the mandate is sensible and should become law. Delayed implementation, especially for small insurance groups, may be adequate response.

2. While SB 6566 does not include the Basic Health Plan, the applicant report asked the department to consider recommending that it be added. The department is not prepared to make a recommendation on adding BHP to the bill at this time. The access benefits would be substantial. Neither the applicant's actuarial analysis nor other available information addresses cost impact in BHP. However, the applicant's consulting actuary verbally confirmed, during the hearing, the department panel's belief that cost impact in BHP would be higher than the "composite" for all insurance, because the starting point in BHP includes substantial limitations. Managing subsidized BHP within appropriated funds with comprehensive mental health parity mandate in place might require serious across-the-board restrictions. This would amount to shifting burden from one group of low-income patients to another in order to strengthen mental health coverage. Additionally, any increases in BHP cost sharing could have a substantial negative impact on affordability of BHP to low-income people, given previous analyses and actual experience.

As for the unsubsidized BHP program, it is a form of individual (not group) insurance—otherwise exempt from the proposed mandate. Unsubsidized BHP is experiencing a premium spiral based on apparent adverse selection, probably as a symptom of other problems in the individual insurance market, which could be exacerbated by adding a major new benefit that would, naturally, draw in new enrollees who need mental health care.

On balance, both because the statutory scope of the review process specifically excludes BHP, and the department does not believe there is adequate information to recommend extending the scope of SB 6566 to either the subsidized or unsubsidized Basic Health Plan, no recommendation is included in this report.

## SUMMARY OF MAJOR INFORMATION SOURCES

### *The report of the applicant group (Washington Coalition for Insurance Parity)*

The applicant group submitted a thorough report (See Attachment I) which addresses all statutory sunrise criteria. It is well-argued and addresses many specific topics not highlighted in this report.

### *Other supportive testimony*

The department received letters and testimony supporting the mandate from:

- Consumers and consumer advocates
- Mental health professionals
- Washington State Labor Council and Snohomish Labor Council

Summaries of these comments are in Attachment G. Most of the general points made in these comments are addressed and documented in the applicant group's report. The department's panelists felt they received important additional information from the testimony regarding personal impacts of mental illness, the status of children's mental health care, the views of organized labor, concerns of managed care plans, and coalition efforts underway in some communities including King County and Snohomish County. The testimony also adds evidence of broad, long-standing interest.

### *Actuarial and cost impact studies*

The applicant's actuarial study, Attachment E, related comments of the Health Care Authority and Association of Washington Health Plans (See Attachment G) and other major sources of information on financial impact are discussed in the "Findings and Analysis" section of this report.

### *Testimony expressing concerns*

The comments received from the Health Care Authority, Association of Washington Health Plans, and Group Health Cooperative of Puget Sound address several topics:

- The overall cost impact of SB 6566 (addressed in "Findings and Analysis");
- More technical issues related to cost impact analysis (effect of previous mandates, effect of publicity related to the mandate, costs and savings in non-behavioral health care);
- The overall status of health insurance in Washington, impacts on small employers and their workers (see timing recommendation);

- The breadth of coverage required and whether it includes substance abuse (see Recommendations);
- Apparent drafting errors which would restrict typical managed care approaches to financial participation (see recommended amendments) and create ambiguity about the meaning of "medical necessity" (see Recommendations).

*Evidence from other literature reviewed*

A large volume of material was submitted by the applicants or obtained by the department (Appendix H) based on the applicants' citations (Appendix I) or other leads. Much of this information was digested where relevant in the applicant's report. The department did not have the time or specialized expertise to undertake a comprehensive independent review, but some members of the review panel read the more rigorous studies with a critical eye in order to improve their basis for making a judgment call.

## PARTICIPANTS

Brad Powell, Ret. Psychiatrist  
Andrea Stephenson, WA Coalition of Insurance Parity  
Judy Thompson, Consumer  
Chris Ingersoll, National Assoc. of Social Workers  
Laura Groshong, WSSCSW  
Laurie Bennett, KPS Health Plans  
Seth Dawson, WA St. Council of Child & Adolescent Psychiatrists  
Shirley Stallings  
Mike Golden, MD, Overlake Hospital  
Ken Bertrand, Group Health

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Nancee Wildermuth, PacificCare of WA  
Tom Bristow, QualMed  
Barb Lisaius, Regence BlueShield  
Eleanor Owen, WAMI  
Steve Norsen, DSHS  
Jim Legaz, Catholic Conference  
Tom Richardson, National Alliance for Mentally Ill/WAMI  
Jim Howe, National Alliance for Mentally Ill/WAMI  
Tina Sellers, WAMHC  
Jim Goche, Washington State Psychiatric Association  
Suzanne Petersen, WCMHC  
Melanie Stewart, WAMHC  
Timothy Keller, WSPA  
Laurie Lippold, Children's Home Society  
Diana Dodds, RN, Skagit Valley Depressive-Manic Depressive Support Group  
Kathi Schneekloth, RN, Skagit Valley Depressive-Manic Depressive Support Group  
Carolyn Benjamin, Skagit Bi-Polar Support Group  
Gail McGaffick, Washington State Psychological Association  
Betty Schweiterman, WA Protection & Advocacy System  
Lucy Homans, EdD, Washington State Psychological Association  
Ronald Bachman, Actuary, PriceWaterhouse Coopers  
Andrew Benjamin, Washington State Psychological Association

REVIEW PANEL

Steve Boruchowitz, DOH, Health Systems Quality Assurance

Dan Rubin, DOH, Office of the Secretary

Carol Neva, DOH, Health Systems Quality Assurance

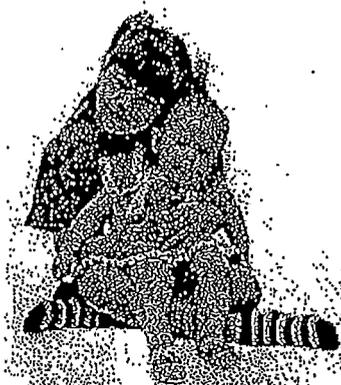
Lisa Anderson, DOH, Health Systems Quality Assurance

# Exhibit I



Centers for Disease Control and Prevention  
Your Online Source for Credible Health Information

## Diagnostic Criteria



The American Psychiatric Association's Diagnostic and Statistical Manual-IV, Text Revision (DSM-IV-TR) 1 provides standardized criteria to help diagnose ASDs.

### Diagnostic Criteria for 299.00 Autistic Disorder

- Six or more items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
  - qualitative impairment in social interaction, as manifested by at least two of the following:
    - marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
    - failure to develop peer relationships appropriate to developmental level
    - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
    - lack of social or emotional reciprocity
  - qualitative impairments in communication as manifested by at least one of the following:
    - delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
    - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
    - stereotyped and repetitive use of language or idiosyncratic language
    - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
  - restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
    - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
    - apparently inflexible adherence to specific, nonfunctional routines or rituals

- stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects
- Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.



#### **Diagnostic Criteria for 299.80 Asperger's Disorder**

- Qualitative impairment in social interaction, as manifested by at least two of the following:
  - marked impairment in the use of multiple nonverbal behaviors such as eye-to eye gaze, facial expression, body postures, and gestures to regulate social interaction
  - failure to develop peer relationships appropriate to developmental level
  - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
  - lack of social or emotional reciprocity
- Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:
  - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity of focus
  - apparently inflexible adherence to specific, nonfunctional routines or rituals
  - stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
  - persistent preoccupation with parts of objects

- The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
- There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).
- There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.
- Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

**299.80 Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)**

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" - presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

**Diagnostic Criteria for 299.80 Rett's Disorder**

- All of the following:
  - apparently normal prenatal and perinatal development
  - apparently normal psychomotor development through the first 5 months after birth
  - normal head circumference at birth
- Onset of all of the following after the period of normal development:
  - deceleration of head growth between ages 5 and 48 months
  - loss of previously acquired purposeful hand skills between 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)
  - loss of social engagement early in the course ( although often social interaction develops later)
  - appearance of poorly coordinated gait or trunk movements
  - severely impaired expressive and receptive language development with severe psychomotor retardation

**Diagnostic Criteria for 299.10 Childhood Disintegrative Disorder**

- Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

- Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:
  - expressive or receptive language
  - social skills or adaptive behavior
  - bowel or bladder control
  - play
  - motor skills
- Abnormalities of functioning in at least two of the following areas:
  - qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
  - qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
  - restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, including motor stereotypes and mannerisms
- The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia

## Related Pages

- [Healthcare Provider Homepage \(/ncbddd/autism/hcp.html\)](/ncbddd/autism/hcp.html)
- [Child Development \(/ncbddd/child/\)](/ncbddd/child/)
- [Developmental Disabilities \(/ncbddd/dd/\)](/ncbddd/dd/)
- ["Learn the Signs. Act Early." Campaign \(http://www.cdc.gov/actearly\)](http://www.cdc.gov/actearly)
- [CDC's National Center on Birth Defects and Developmental Disabilities \(/ncbddd/index.html\)](/ncbddd/index.html)

## References

1 American Psychiatric Association. (2000). Pervasive developmental disorders. In Diagnostic and statistical manual of mental disorders (Fourth edition---text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 69-70.

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Page last reviewed: August 17, 2009  
 Page last updated: August 17, 2009  
 Content source: [Division of Birth Defects, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention](#)

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Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA  
 30333, USA  
 800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -  
[cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)



# Exhibit E

HON. MICHAEL J. TRICKEY  
Noted for Consideration: April 26, 2012  
Without Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and  
K.G., on his own behalf and on behalf of all  
similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF  
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

RESPONSE TO DEFENDANTS'  
MOTION TO CERTIFY ORDER FOR  
DISCRETIONARY REVIEW

I. INTRODUCTION

Piecemeal litigation is anathema to our system. Only in the most rare and exceptional circumstances should an appeal be certified prior to final judgment. *See Coopers & Lybrand v. Livesay*, 437 U.S. 463, 475, 98 S. Ct. 2454, 2461 (1978) (movant has to show "exceptional circumstances justify a departure from the basic policy of postponing appellate review until after the entry of a final judgment.") (*quoting Fisons, Ltd. v. United States*, 458 F.2d 1241, 1248 (7th Cir. 1972)).

That is not our case. The straightforward issue raised by Premera - the alleged "conflict" between the Mental Health Parity Act and the Neurodevelopmental Therapy Mandate - does not rise to the requisite "extraordinary" standard justifying certification. In terms of RAP 2.3(b)(4), there is no "substantial ground for a difference of opinion" concerning the interplay between the two statutes.



1           **B.     The Question of Whether Premera Must Comply With the Parity Act**  
2           **and Cover, at Parity, Neurodevelopmental Mental Health Services is**  
3           **Not a Close Question Justifying Certification.**

4           The legal principles which apply to determine whether two statutes are in  
5           conflict are well-known. Those principles are settled, and provide ample guidance to  
6           this Court. *See Walker v. Wenatchee Valley Truck & Auto Outlet, Inc.*, 115 Wn. App. 199,  
7           58 P.3d 919 (2010); *Davis v. King County*, 77 Wn.2d 930, 468 P.2d 679 (1970). Applying  
8           those longstanding rules of construction here is straightforward - there is simply no  
9           irreconcilable conflict between the statutes:

10                     The Court does not have to invalidate RCW 48.44.450,  
11                     the Neurodevelopmental Therapy Act, to reach this result.  
12                     RCW 48.44.450 only creates a minimum level of required  
13                     coverage. Both the Neurodevelopmental Therapy Act and  
14                     the Mental Health Parity Act can be read together and  
15                     harmonized. Defendants must meet the requirements of  
16                     both Acts.

17           *See Order (1) Granting Plaintiff's Motion for Partial Summary Judgment, (2) Denying*  
18           *Defendants' Motion to Dismiss, and (3) Issuing Preliminary Injunction (4/17/12), p. 4,*

19           ¶3. As Judge Lasnik likewise noted:

20                     By its plain terms, RCW 48.44.450 evidences legislative  
21                     intent to establish a minimum mandatory level of "coverage  
22                     for neurodevelopmental therapies for covered individuals  
23                     age six and under." Equally plain, however, is that RCW  
24                     48.44.450 does not preclude providers from extending that  
25                     same coverage to individuals older than six. *The statute*  
26                     *establishes a floor, not a ceiling.*

                   When it enacted [the Mental Health Parity Act], Washington  
                   raised the minimum standard by *further* requiring that  
                   mental health coverage "be delivered under the same terms  
                   and conditions as medical and surgical services." *This new*  
                   *burden does not conflict with RCW 48.44.450.*

*Z.D., ex rel. J.D. v. Group Health Coop.*, \_\_\_ F. Supp. 2d \_\_\_, 2011 WL 5299592, \*4 (W.D.  
                   Wash. Nov. 4, 2011) (emphasis added).

1           Premera can – and must – follow both statutes. *Walker*, 115 Wn. App. at 208 (“In  
2 the case of multiple statutes or provisions governing the same subject matter, effect will  
3 be given to both to the extent possible.”). Premera utterly fails to indicate how it is  
4 unable to follow the requirements of both statutes. Longstanding Washington law  
5 demands compliance with both statutes – a carrier does not get to pick and choose  
6 which statute to follow when it can fully comply with both mandates.

7           Ignoring the plain language of the Parity Act, Premera claims that this legal  
8 question is somehow unsettled because there have been legislative efforts to expand  
9 the age limit under Neurodevelopmental Mandate. Defs.’ Mem., p. 2.<sup>2</sup> But Premera  
10 never comes to terms with the plain language of the Parity Act and, under  
11 Washington’s “plain meaning” rule, legislative intent is first derived from the language  
12 of the statute itself.<sup>3</sup> *State Dept. of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 9-10,  
13 43 P.3d 4, 9 (2002) (“if the statute’s meaning is plain on its face, then the court must  
14

15  
16           <sup>2</sup> Initially, given that the Neurodevelopmental Therapy Mandate is not limited to those with mental  
17 health conditions, it does not cover the identical population covered by the Parity Act. As Judge Lasnik  
18 concluded, “The fact that the Washington legislature is apparently considering expanding the  
19 Neurodevelopmental Therapy Mandate to require coverage up to the age of 18 has no bearing on  
whether the legislature intended to require parity coverage under RCW 48.46.291 – the statute in  
question.” *Z.D. v. Group Health Cooperative, Appendix A*, p. 3.

20           <sup>3</sup> None of the arguments offered by Premera are, in fact, legislative history. Rather, Premera  
21 attempts to rely upon activity after the law was passed to argue that the Parity Act means something  
22 different than its plain language demands. The actual legislative history indicates that the Legislature  
23 knew full well that it was covering all mental health services under the Parity Act, including services  
24 designed to treat those with developmental disabilities. Hamburger Decl. (01/13/12), *Exh. G*, p. 1-2  
25 (“Therefore the legislature intends to require that insurance coverage be at parity for mental health  
26 services, which means this coverage be delivered under the same terms and conditions as medical and  
surgical services.”); Hamburger Decl. (01/13/12), *Exh. H*, p. 1. (“The requirement for mental health  
coverage is broad—“all mental disorders included in the diagnostic and statistical manual of mental  
disorders”. . . . The requirement for parity in coverage is also broadly worded, so that it applies to both  
treatment limitations and various forms of financial participation.”); *see also id.* (Parity Act “would  
require group health plans and the public employees benefit board health plan to (a) provide mental  
health coverage if they currently do not, and (b) cover mental health at the same level that physical  
health is covered.”).

1 give effect to that plain meaning as an expression of legislative intent"). Under this  
2 rule, legislative history is irrelevant if the language of the statute is unambiguous:

3           If the plain language is subject to only one interpretation,  
4           our inquiry ends because plain language does not require  
5           construction. "Where statutory language is plain and  
6           unambiguous, a statute's meaning must be derived from the  
7           wording of the statute itself."

7 *HomeStreet, Inc. v. State*, 166 Wn.2d 444, 451, 210 P.3d 297, 300 (2009) (citations omitted).

8           Likewise, failed legislation does not support an argument concerning legislative  
9           intent. See *State v. Conte*, 159 Wn.2d 797, 813, 154 P.3d 194 (2007) (the failure of the  
10           Legislature to take action on a proposed bill is not evidence of any legislative intent);  
11           *Spokane County Health Dist. v. Brockett*, 120 Wn.2d at 140, 153, 839 P.2d 324 (1992)  
12           ("[W]hen the Legislature rejects a proposed amendment, as they did here, we will not  
13           speculate as to the reason for the rejection"). The legislature may have determined that  
14           action was not necessary given the requirements of the Mental Health Parity Act.

15           In fact, with respect to the state Department of Health's recommendation to  
16           raise the age limit for neurodevelopmental therapy benefits for children with autism,  
17           the Department of Health actually offered a number of potential alternatives for access  
18           to care. Significantly, one of those options was to seek coverage under the Mental  
19           Health Parity Act:

20                   ASD [Autism Spectrum Disorder] is defined as a developmental  
21                   disorder in the Diagnostic and Statistical Manual of Mental  
22                   Disorders (DSM). Psychiatric and psychological care is plainly  
23                   envisioned by the proposed bill. Other therapies, such as ABA,  
24                   appear to have significant mental health components. *Treatment  
25                   related to mental health care or provided by mental health  
26                   providers should be covered by this [parity] mandate.*

1 Washington Department of Health, *Treatment of Autism Spectrum Disorders Mandated*  
2 *Benefit Sunrise Review*, pp. 16-17 (emphasis added (available at  
3 <http://www.doh.wa.gov/hsqa/sunrise/Documents/Autism.pdf>).

4 Not surprisingly, every court considering this issue has found that the Parity  
5 Act prohibits such contractual exclusions of neurodevelopmental or behavioral services  
6 because those services are “mental health services” and can be medically necessary to  
7 treat covered DSM-IV conditions. See *Z.D.*, 2011 WL 5299592 (“Washington law,  
8 specifically [the Mental Health Parity Act], requires Defendants to provide coverage for  
9 the mental health [neurodevelopmental] services at issue in this case”); Supp.  
10 Hamburger Decl. (2/24/12), *Exh. L, D.F. v. Washington Health Care Authority, et al.*, No.  
11 10-2-29400-7 SEA, p. 4 (“specific exclusions...that exclude coverage of Applied  
12 Behavior Analysis therapy, even when medically necessary ... do not comply with  
13 Washington’s Mental Health Parity Act...”).<sup>4</sup>

14  
15  
16 <sup>4</sup> This same issue has been litigated in other states as well. See *Markiewicz v. State Health Benefits*  
17 *Comm'n*, 915 A.2d 553, 560 (App. Div. 2007). There, the state public employee health plan applied a  
18 neurodevelopmental therapy exclusion in its contract to deny coverage of speech therapy for an insured  
19 child with pervasive developmental disorder, (PDD) a DSM-IV condition. *Id.* at 555. While New Jersey’s  
20 mental health parity law is narrower than Washington’s (limited to “biologically-based mental illness”),  
21 it includes autism and PDD. *Id.* at 558. The appellate court found:

22 ...[A]n exclusion from coverage for claims based upon occupational,  
23 speech and physical therapy offered to developmentally disabled children  
24 would render meaningless the specific inclusion of PDD and autism  
25 within those biologically-based mental illnesses subject to the parity  
26 statute. The Legislature surely could not have intended that the principal  
27 treatments for developmental disabilities be excluded from coverage  
28 simply because those treatments differ in their essential nature from  
29 treatments applicable to other biologically-based mental illnesses, such as  
30 the use of psychiatric or psychological therapy and drugs. The fact that  
31 biologically-based mental illnesses affect development in some and other  
32 neurological functions in others should not be the determinant of  
33 coverage.

34 *Id.* at 560 (emphasis added). See also *Micheletti v. State Health Benefits Comm'n*, 913 A.2d 842, 851 (N.J.  
35 App. 2010).

1 This is not a close question. The statute is clear, and Premera can – and must –  
2 comply with both the Parity Act and the Neurodevelopmental Therapy Act.

3 **C. A Stay Would Prejudice the Plaintiff and the Putative Class.**

4 This case is brought as a class action. It seeks, among other relief, to prevent  
5 Premera from denying medically necessary neurodevelopmental therapies to  
6 *thousands* of its insureds. Declaration of Frank Fox, Ph.D. (2/20/12), ¶9 (thousands  
7 impacted). As a practical matter, certification would delay this case – and the delivery  
8 of critical mental health services to Premera’s insureds – for years. That may be in  
9 Premera’s interest, but it is not in the interest of the putative class members or in the  
10 interest of justice. Delay itself can undermine effective relief, and any request for  
11 certification must be balanced against that inherent delay:

12 Certification of an interlocutory appeal would probably delay  
13 that trial for at least a year and possibly much more. There would  
14 almost certainly be a second appeal from this Court's judgment  
15 following that trial, and final resolution of the issues would be over  
16 three years away. For these reasons, we are loath to depart from the  
17 sound and well-established policy of avoiding piecemeal appeals as  
embodied in the final judgment rule, and deny applicants' motion  
for certification of an interlocutory appeal pursuant to § 1292(b).

18 *United States v. Am. Soc’y of Composers, Authors & Publishers*, 333 F. Supp. 2d 215, 221  
19 (S.D.N.Y. 2004).

20 **III. CONCLUSION**

21 Defendants facing class certification often seek ways to delay the adjudication of  
22 certification, and of the case itself. Premera’s motion is just such an attempt, and it  
23 should be denied. With trial less than a year away Premera will soon have an  
24 opportunity to seek review of any decision under which it feels aggrieved. At this  
25 stage, the plaintiff (and the class, if certified) should be permitted to seek timely and  
26 effective relief.

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DATED: April 24, 2012.

SIRIANNI YOUTZ SPOONEMORE

/s/ Richard E. Spoonemore

Eleanor Hamburger (WSBA #26478)  
Richard E. Spoonemore (WSBA #21833)  
Attorneys for Plaintiffs

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on April 24, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

Barbara J. Duffy	<input checked="" type="checkbox"/>	By United States Mail
Gwendolyn C. Payton	<input type="checkbox"/>	By Legal Messenger
Ryan P. McBride	<input checked="" type="checkbox"/>	By Email
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DATED: April 24, 2012, at Seattle, Washington.

/s/ Richard E. Spoonemore  
Richard E. Spoonemore (WSBA #21833)

# Appendix A

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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

Z.D., by and through her parents and  
guardians, J.D. and T.D., individually, on  
behalf of THE TECHNOLOGY ACCESS  
FOUNDATION HEALTH BENEFIT  
PLAN, and on behalf of similarly situated  
individuals,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, *et.*  
*al.*,

Defendants.

No. C11-1119RSL

ORDER DENYING  
DEFENDANTS'  
MOTION TO CERTIFY

This matter comes before the Court on Defendants' "Motion to Certify Washington State Law Question to the Supreme Court of Washington" (Dkt. # 31). Defendants disagree with the Court's conclusion that RCW 48.46.291 does not conflict with Washington's previously enacted Neurodevelopmental Therapy Mandate, RCW 48.44.450. They would like the Washington Supreme Court to rule on whether Defendant can "readily comply with both statutes simply by comports with the parity requirements of RCW 48.46.291 for all covered individuals, keeping in mind that RCW 48.44.450 confers a more specific and more onerous requirement upon Defendants to provide 'neurodevelopmental therapies for covered individuals age six and under' without regard for parity." Order (Dkt. # 30) at 8-9. The Court DENIES the motion.

ORDER DENYING DEFENDANTS' MOTION TO CERTIFY - 1

1 The Court described the background facts underlying this matter in the Court's  
2 prior Order (Dkt. # 30). It will not repeat those facts here.

3 As Defendants contend, the Court has discretion to certify controlling issues of  
4 state law that are either novel or unsettled to the Washington Supreme Court. RCW  
5 2.60.020; Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1, 294 F.3d 1085,  
6 1086–87 (9th Cir. 2002). Certification is particularly appropriate when the question  
7 may have far-reaching effect or carries important public policy ramifications. Kremen  
8 v. Cohen, 325 F.3d 1035, 1037 (9th Cir. 2003) (“The certification procedure is reserved  
9 for state law questions that present significant issues, including those with important  
10 public policy ramifications, and that have not yet been resolved by the state courts.”).

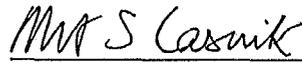
11 Notably, however, courts look with disfavor upon requests that come only after a  
12 federal court has ruled against the movant. “There is a presumption against certifying a  
13 question to a state supreme court after the federal district court has issued a decision.”  
14 Thompson v. Paul, 547 F.3d 1055, 1065 (9th Cir. 2008). “A party should not be  
15 allowed ‘a second chance at victory’ through certification . . . after an adverse district  
16 court ruling.” Id.; accord In re Complaint of McLinn, 744 F.2d 677, 681 (9th Cir. 1984)  
17 (“Ordinarily such a movant should not be allowed a second chance at victory when, as  
18 here, the district court employed a reasonable interpretation of state law.”); Cantwell v.  
19 Univ. of Mass., 551 F.2d 879, 880 (1st Cir. 1977) (“We do not look favorably, either on  
20 trying to take two bites at the cherry by applying to the state court after failing to  
21 persuade the federal court, or on duplicating judicial effort.”); In re Mortg. Elec.  
22 Registration Sys. (MERS) Litig., No. 09–2119–JAT, 2011 WL 4571663, \*1 (D. Ariz.  
23 October 3, 2011) (“[F]ederal courts disapprove of a party’s request to certify an issue  
24 that has already been adversely decided against it . . .”).

24 Arguably, the Court could hang its hat on this presumption alone. Thompson,  
25 547 F.3d at 1065. The Court notes though that, even ignoring this “strong  
26 presumption,” the Court sees no justification for certifying. As the Court concluded in

1 its previous Order (Dkt. # 30), this is not a close question. Applying common and well-  
2 accepted principles of statutory construction, the Court readily concluded that no  
3 conflict exists between the Neurodevelopmental Therapy Mandate, RCW 48.44.450,  
4 and the Mental Health Parity Act, RCW 48.46.291. *Id.* at 8–9. The fact that the  
5 Washington legislature is apparently considering expanding the Neurodevelopmental  
6 Therapy Mandate to require coverage up to the age of 18, Mot. (Dkt. # 31) at 8, has no  
7 bearing on whether the legislature intended to require parity coverage under RCW  
8 48.46.291—the statute in question. To the contrary, it merely suggests that Washington  
9 is considering raising the floor of required coverage even higher.

10 Accordingly, Defendants' Motion is DENIED.

11 DATED this 19th day of December, 2011.

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15 Robert S. Lasnik  
16 United States District Judge  
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# Exhibit F

P.A. 000220

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HON. MICHAEL J. TRICKEY  
Noted for Hearing: March 2, 2012 at 10:00 a.m.  
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G.,  
on his own behalf and on behalf of all similarly  
situated individuals,  
  
Plaintiff,  
  
v.  
  
PREMERA BLUE CROSS and LIFEWISE OF  
WASHINGTON, Washington corporations,  
  
Defendants.

NO. 11-2-30233-4 SEA  
  
SUPPLEMENTAL DECLARATION OF  
ELEANOR HAMBURGER IN SUPPORT  
OF MOTION FOR PARTIAL SUMMARY  
JUDGMENT

I, Eleanor Hamburger, declare that:

1. I am a partner at Sirianni Youtz Spoonemore and am one of the attorneys for Plaintiff in this action.
2. Attached are true and correct copies of the following documents, with underlining where appropriate for the Court's convenience:

Exhibit	Description
J	Excerpt from the Washington State Department of Health's <i>Information Summary and Recommendations concerning Treatment of Autism Spectrum Disorders Mandated Benefits Sunrise Review</i> dated January 2009.
K	Excerpts from Scott M. Myers, M.D., Chris Plache Johnson, M.D., M.Ed., "Management of Children with Autism Spectrum Disorders" Clinical Report, American Academy of Pediatrics, 120 PEDIATRICS 5 (2007).
L	Order in <i>D.F. et al., v. Washington State Health Care Authority, et al.</i> , No.10-2-29400-7 SEA, dated June 7, 2011.

SUPPLEMENTAL DECLARATION OF  
ELEANOR HAMBURGER - 1

SIRIANNI YOUTZ SPOONEMORE  
999 THIRD AVENUE, SUITE 3650  
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TEL. (206) 223-0303 FAX (206) 223-0246  
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I declare under penalty of perjury of the laws of the State of Washington and the United States of America that the foregoing is true and correct.

DATED: February 24, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger  
Eleanor Hamburger (WSBA #26478)

CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on February 24, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

Barbara J. Duffy	<input checked="" type="checkbox"/>	By United States Mail
Gwendolyn C. Payton	<input type="checkbox"/>	By Legal Messenger
Ryan P. McBride	<input checked="" type="checkbox"/>	By Email
LANE POWELL PC		Tel. 206.223.7000
1420 Fifth Avenue, Suite 4100		<a href="mailto:duffy@lanepowell.com">duffy@lanepowell.com</a>
Seattle, WA 98101		<a href="mailto:payton@lanepowell.com">payton@lanepowell.com</a>
<i>Attorneys for Defendants</i>		<a href="mailto:mcbride@lanepowell.com">mcbride@lanepowell.com</a>

DATED: February 24, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger  
Eleanor Hamburger (WSBA #26478)

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# Exhibit J

P.A. 000224

*Information Summary and Recommendations*

# Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



## FINDINGS

- Autism Spectrum Disorder (ASD) affects as many as one in 150 children. It's as common as juvenile diabetes, and more common than childhood cancer, Down syndrome, deafness, or cystic fibrosis.
- In many cases, intensive early intervention enables children with ASD to enter mainstream classes in school and to grow into contributing members of society. Without treatment, both families and the state are often required to provide extensive support services for the rest of the child's life.
- Over half of the children institutionalized in Washington have ASD.
- Intensive remediation for autism is not covered by most health insurance plans.
- Many children in Washington with ASD go without treatment and services because the costs are so high and insurance coverage is not generally available.
- The high costs of treatments for ASD cause severe financial hardships for families.
- There have been studies proving efficacy of applied behavior analysis.
- Neurodevelopmental therapies are effective in treating ASD.
- We did not receive information on the efficacy of other treatments for ASD.
- Current coverage included in plans under the neurodevelopmental and mental health parity mandates are often insufficient for treatment of ASD.
- A number of states have enacted insurance mandates for autism spectrum disorders. Some specifically require coverage of applied behavior analysis.
- The limited treatment available in schools is designed, by law to be educationally relevant and allow the child to participate in the educational program. The therapy does not include skills the child may need in other environments such as the home, work place, and community.

## DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The legislature should not enact the proposed bill in its current form. Children with autism spectrum disorder (ASD) clearly need increased access and funding for treatment. However, the language of this bill is too vague to allow the department to determine whether the benefits outweigh the costs. In addition, in its current form, the bill would likely fail to offer meaningful guidance to insurers, providers or Department of Health.

The proposed bill poses the following concerns:

1. The bill does not specify what treatments will be covered. The vague and over-broad language in section (3)(m) of the proposed bill does not provide sufficient guidance for insurers, providers, or consumers. The blurred lines between the medical, behavioral, and mental health aspects of ASD would likely cause extensive disputes regarding applicability and appropriate coverage. In addition there are numerous treatment modalities referenced for which there is no proof of efficacy.
2. The bill does not specify what providers could be compensated. Section (3)(o) requires the department to “establish standards to be utilized by health plans for the credentialing of autism service providers.” However, it does not require the department to have licensing or regulatory authority over those providers. Once again, the lack of clarity would likely result in extensive disputes regarding what providers and which services were covered by the mandate.
3. There are existing mandates that should be reviewed that may provide the coverage these families are seeking. These are the neurodevelopmental therapy mandate and the mental health parity mandate.
4. The costs to implement this mandate as proposed are difficult, if not impossible, to determine as is demonstrated by the three vastly different cost estimates.

The concerns listed above could be addressed in the following ways:

1. Expand the neurodevelopmental therapy mandate to:
  - a. Require increased coverage amounts. Currently many health plans limit the dollar amount and/or the number of visits available for these therapies. The limits do not meet the needs of children with ASD.
  - b. Require coverage for applied behavior analysis (ABA) when performed by (or under the supervision of) nationally certified providers. ABA is an effective treatment for ASD when provided by appropriately-educated and experienced professionals. Current standards for national certification ensure adequate training.
  - c. Raise or eliminate the age limit for benefits. Currently, benefits under this mandate end at age seven. Children with ASD often need therapy far past that age in order to become self-sufficient members of society. Treatment should be allowed for a significantly longer period.<sup>18</sup>
  - d. Match services currently available to low income children on Medicaid in Washington state.

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<sup>18</sup> In 2001, the department conducted a sunrise review that recommended in favor of removing the age limit of six and under for the neurodevelopmental therapy mandate.

- Allow all professional fees to be covered when providing services for children with a diagnosis on the autism spectrum.
- Allow the treating licensed physician along with families, to determine the treatment plan; not the health plan.
- Allow the full extent of “medical necessity” needs of children on the autism spectrum to be in the purview of the health plans. It is not within the scope of the educational system in Washington State to provide for and meet the full extent of needs of persons with autism. Routinely, school districts deny therapeutic services if it is found to be of “medical necessity”.

CHILD wrote that they repeatedly experience families being informed by their school districts that they will not provide therapeutic interventions that fall beyond the scope of special education services mandated in the current RCW. Often this leaves the child lacking access to the critical services that have been identified in the medical care plan by the child’s primary care physician because there is no financial support for the therapies. Allowing all providers to be financially supported for providing the needed therapy assures children receive needed services, both early intervention and continued throughout childhood. In the end, this will result in decreased costs for the family and the community, as the individual learns new skills to be successful in school, at home, and in life.

CHILD also reinforced the fact that autism is a “neuro-biological medical condition” and the individuals with this diagnosis deserve the same type of support as any other medical condition with financial coverage from health plans. They acknowledged that the proposed legislation will not cover all children; yet wrote that they believe it is a great beginning to help many families who otherwise face insurmountable barriers because of the lack of resources.

### Written comments from the insurance industry

The Association of Washington Healthcare Plans (AWHP’s) submitted the following comments about the proposal:

“Our members, too, are concerned about the challenges faced by children with autism and their families. We want to approach this issue in a manner that is in their best interest, as well as that of all those we serve. Accordingly, we offer the following input for your consideration.

- **ABA Therapy is generally recognized as being more educational and school-based, rather than medical/mental health in nature.** A major focus of the proposed benefit mandate is ABA therapy, which consists of intensive behavior modification services designed to help improve school readiness and developmental functioning. Accordingly, private insurers should not be solely responsible for providing and covering these services. It is our understanding that the federal Individuals with Disabilities in Education Act (IDEA) guarantees ‘free and appropriate public education’. As part of that requirement, school districts must conduct outreach to pre-school children ages 0 – 3 who may be disabled and need special early intervention services. In addition to identifying children with autism spectrum disorder through this process, the district is expected to supply services to these children and set-up an “individual education program” for disabled children aged 3 – 21. The district must also submit compliance reports to the U.S. Department of Education<sup>48</sup>.
- **Development of a best practice intervention model with special focus on diagnosis and evaluation is needed.** This model should make use of evidence based research and include a comprehensive evaluation or re-evaluation of the child consistent with recommendations of the American Academy of Pediatrics. The treatment plan should be individualized and developed

with input and collaboration from a myriad of different disciplines. The model should also allow for utilization review, case management, medical necessity review, and other care coordination techniques, as appropriate. Additionally, to prevent inappropriate cost-shifting, the model should allow for close coordination with schools and other resources. We want to ensure appropriate optimization and utilization of existing resources and seamless delivery of care across the spectrum of services for the individual.

- **Treatment should be limited to licensed and/or certified providers.** To ensure quality treatment and patient safety, any person or entity providing treatment of autism spectrum disorders should be licensed or certified, and health plans should have the tools necessary to credential those providers. Additionally, we recommend that ABA therapy be provided by behavior specialists that are board certified, such as by the Behavior Analyst Certification Board.
- **Proposed legislation should maintain consistency with the mental health parity statute of 2005; for which autism is one of the covered mental health conditions.** This should include maintaining consistency with all medical necessity and certificate of coverage requirements. Washington's current mental health parity law allows healthcare plans to manage utilization, make medical necessity decisions regarding treatment, and exclude coverage for experimental/investigational treatment – as with any other disease or disorder.
- **Requiring carriers to provide for the coverage of autism care will increase the cost of healthcare and insurance premiums.** Each benefit mandate adds to the overall cost of healthcare and insurance premiums. And, in a time when we are collectively looking to make healthcare more affordable, we believe employers should be able to determine their own benefit plans without additional state mandates. Financial impacts must be strongly considered for any benefit mandate proposal, especially given current economic conditions in our state and the fact that many families and employers are already struggling to afford coverage.
- **Washington already has mandates in place that cover services for individuals diagnosed with autism spectrum disorders --- including the mental health parity statute of 2005, and the neurodevelopmental benefit mandate. We note that some states with new autism mandates, like Arizona, did not previously have such mandates.**

In addition to offering the above input, we would also like to request clarification regarding which populations the proposed legislation would cover.”

## Comments in opposition to proposal

(These comments appear as written)

“It appears that the goal is to make health insurance increasingly expensive, until almost no one can afford it. Then, the nanny-state can intervene and impose socialized medicine "in our best interest", along with all its mandates and intrusions into our lives. The reason so many insurance companies already refuse to write health coverage in Washington State is because of the level of bureaucracy. It would be much better to allow the free market to work.

The proposed system will only create one more expensive, cumbersome, monstrous bureaucracy.

There is no perfect solution to all problems. There is a lot of erroneous thinking. It appears some individuals live in a fantasy world where they believe government can solve all their problems. They do not understand that dollars are a finite quantity. Every dollar spent on one purchase may not be available for a higher priority purchase. Some people seem to believe that if they cannot afford to pay their bills that I can afford to pay mine and theirs, too. Another fallacy is that health is directly proportional to the amount of access and health care coverage an individual has. Possibly with the

# Exhibit K

P.A. 000230



CLINICAL REPORT

## Management of Children With Autism Spectrum Disorders

Guidance for the Clinician in Rendering  
Pediatric Care

Scott M. Myers, MD, Chris Plauché Johnson, MD, MEd, the Council on Children With Disabilities

### ABSTRACT

Pediatricians have an important role not only in early recognition and evaluation of autism spectrum disorders but also in chronic management of these disorders. The primary goals of treatment are to maximize the child's ultimate functional independence and quality of life by minimizing the core autism spectrum disorder features, facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families. To assist pediatricians in educating families and guiding them toward empirically supported interventions for their children, this report reviews the educational strategies and associated therapies that are the primary treatments for children with autism spectrum disorders. Optimization of health care is likely to have a positive effect on habilitative progress, functional outcome, and quality of life; therefore, important issues, such as management of associated medical problems, pharmacologic and nonpharmacologic intervention for challenging behaviors or coexisting mental health conditions, and use of complementary and alternative medical treatments, are also addressed.

### INTRODUCTION

The term autism spectrum disorders (ASDs) has been used to include the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*<sup>1</sup> diagnostic categories autistic disorder, Asperger disorder, and pervasive developmental disorder—not otherwise specified.<sup>2</sup> Recent estimates of the prevalence of ASDs are in the range of 6.5 to 6.6 per 1000, and pediatricians, therefore, are likely to care for children and adolescents with these diagnoses.<sup>3-5</sup> In the companion document to this clinical report,<sup>2</sup> the American Academy of Pediatrics has summarized pertinent background information on ASDs and emphasized the importance of surveillance and screening as well as other potential physician roles in the diagnostic process. However, the role of the primary health care professional extends beyond recognizing signs of ASDs, referring for diagnostic evaluation, conducting an etiologic investigation, providing genetic counseling, and educating caregivers about ASDs and includes ongoing care and management.

ASDs, similar to other neurodevelopmental disabilities, are generally not "curable," and chronic management is required. Although outcomes are variable and specific behavioral characteristics change over time, most children with ASDs remain within the spectrum as adults and, regardless of their intellectual functioning, continue to experience problems with independent living, employment, social relationships, and mental health.<sup>6-8</sup> The primary goals of treatment are to minimize the core features and associated deficits, maximize functional indepen-

www.pediatrics.org/cgi/doi/10.1542/  
peds.2007.2362

doi:10.1542/peds.2007-2362

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

#### Key Words

autism, autism spectrum disorders, Asperger syndrome, pervasive developmental disorders, complementary and alternative medicine, early intervention

#### Abbreviations

ASD—autism spectrum disorder  
TEACCH—Treatment and Education of Autistic and Related Communication Handicapped Children  
ABA—applied behavior analysis  
DTT—discrete trial training  
DIR—developmental, individual-difference, relationship-based  
RDI—relationship-development intervention  
RT—responsive teaching  
SI—sensory integration  
EEG—electroencephalography  
SSRI—selective serotonin-reuptake inhibitor  
CAM—complementary and alternative medicine

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2007 by the American Academy of Pediatrics

the deficits. The Denver model, for example, is based largely on remediating key deficits in imitation, emotion sharing, theory of mind, and social perception by using play, interpersonal relationships, and activities to foster symbolic thought and teach the power of communication.<sup>12</sup> This program has shifted from a center-based treatment unit to service delivery in homes and inclusive school environments. Several studies have demonstrated improvements in cognitive, motor, play, and social skills beyond what would be expected on the basis of initial developmental rates in children who are treated according to the Denver model, but controlled trials are lacking.<sup>51-54</sup>

Relationship-focused early intervention models include Greenspan and Wieder's developmental, individual-difference, relationship-based (DIR) model,<sup>55</sup> Gutstein and Sheely's relationship-development intervention (RDI),<sup>56</sup> and the responsive-teaching (RT) curriculum developed by Mahoney et al.<sup>57,58</sup> The DIR approach focuses on (1) "floor-time" play sessions and other strategies that are purported to enhance relationships and emotional and social interactions to facilitate emotional and cognitive growth and development and (2) therapies to remediate "biologically based processing capacities," such as auditory processing and language, motor planning and sequencing, sensory modulation, and visual-spatial processing. Published evidence of the efficacy of the DIR model is limited to an unblinded review of case records (with significant methodologic flaws, including inadequate documentation of the intervention, comparison to a suboptimal control group, and lack of documentation of treatment integrity and how outcomes were assessed by informal procedures<sup>55</sup>) and a descriptive follow-up study of a small subset (8%) of the original group of patients.<sup>59</sup> RDI focuses on activities that elicit interactive behaviors with the goal of engaging the child in a social relationship so that he or she discovers the value of positive interpersonal activity and becomes more motivated to learn the skills necessary to sustain these relationships.<sup>56</sup> Some reviewers have praised the face validity of this model, which targets the core impairment in social reciprocity. However, the evidence of efficacy of RDI is anecdotal; published empirical scientific research is lacking at this time. One study reported beneficial effects of RT on young children with ASDs or other developmental disabilities.<sup>58</sup> Parents were taught to use RT strategies to encourage their children to acquire and use pivotal developmental behaviors (attention, persistence, interest, initiation, cooperation, joint attention, and affect). Children in both groups improved significantly on nonstandardized play-based measures of cognition and communication and standardized parent ratings of socioemotional functioning. Although a control group was lacking and the potential role of concurrent educational services was unclear, the improvements

were beyond what the authors expected from maturational factors alone.<sup>58</sup>

#### Speech and Language Therapy

A variety of approaches have been reported to be effective in producing gains in communication skills in children with ASDs.<sup>9,17,20</sup> Didactic and naturalistic behavioral methodologies (eg, DTT, verbal behavior, natural language paradigm, pivotal response training, milieu teaching) have been studied most thoroughly, but there is also some empirical support for developmental-pragmatic approaches (eg, Social Communication Emotional Regulation Transactional Support, Denver model, RDI, Hanen model).

People with ASDs have deficits in social communication, and treatment by a speech-language pathologist usually is appropriate. Most children with ASDs can develop useful speech, and chronologic age, lack of typical prerequisite skills, failure to benefit from previous language intervention, and lack of discrepancy between language and IQ scores should not exclude a child from receiving speech-language services.<sup>60</sup> However, traditional, low-intensity pull-out service delivery models often are ineffective, and speech-language pathologists are likely to be most effective when they train and work in close collaboration with teachers, support personnel, families, and the child's peers to promote functional communication in natural settings throughout the day.<sup>60</sup>

The use of augmentative and alternative communication modalities, including gestures, sign language, and picture communication programs, often is effective in enhancing communication.<sup>17,20,61</sup> The Picture Exchange Communication System (PECS)<sup>62,63</sup> is used widely. The PECS method incorporates ABA and developmental-pragmatic principles, and the child is taught to initiate a picture request and persist with the communication until the partner responds. Some nonverbal people with ASDs may benefit from the use of voice-output communication aids, but published evidence for these aids is scant.<sup>20,64</sup> Introduction of augmentative and alternative communication systems to nonverbal children with ASDs does not keep them from learning to talk, and there is some evidence that they may be more stimulated to learn speech if they already understand something about symbolic communication.<sup>61,62,65</sup>

#### Social Skills Instruction

There is some objective evidence to support traditional and newer naturalistic behavioral strategies and other approaches to teaching social skills.<sup>22-24,66-68</sup> Joint attention training may be especially beneficial in young, preverbal children with ASDs, because joint attention behaviors precede and predict social language development.<sup>69,70</sup> A recent randomized, controlled trial demonstrated that joint attention and symbolic play skills can be taught and that these skills generalize to different

settings and people.<sup>71</sup> Families can facilitate joint attention and other reciprocal social interaction experiences throughout the day in the child's regular activities. Examples of these techniques are described in the American Academy of Pediatrics parent booklet "Understanding Autism Spectrum Disorders."<sup>72</sup>

A social skills curriculum should target responding to the social overtures of other children and adults, initiating social behavior, minimizing stereotyped perseverative behavior while using a flexible and varied repertoire of responses, and self-managing new and established skills.<sup>10</sup> Social skills groups, social stories, visual cueing, social games, video modeling, scripts, peer-mediated techniques, and play and leisure curricula are supported primarily by descriptive and anecdotal literature, but the quantity and quality of research is increasing.<sup>10,15,73</sup> A number of social skills curricula and guidelines are available for use in school programs and at home.<sup>10,66,74,75</sup>

#### Occupational Therapy and Sensory Integration Therapy

Traditional occupational therapy often is provided to promote development of self-care skills (eg, dressing, manipulating fasteners, using utensils, personal hygiene) and academic skills (eg, cutting with scissors, writing). Occupational therapists also may assist in promoting development of play skills, modifying classroom materials and routines to improve attention and organization, and providing prevocational training. However, research regarding the efficacy of occupational therapy in ASDs is lacking. Sensory integration (SI) therapy often is used alone or as part of a broader program of occupational therapy for children with ASDs. The goal of SI therapy is not to teach specific skills or behaviors but to remediate deficits in neurologic processing and integration of sensory information to allow the child to interact with the environment in a more adaptive fashion. Unusual sensory responses are common in children with ASDs, but there is not good evidence that these symptoms differentiate ASDs from other developmental disorders, and the efficacy of SI therapy has not been demonstrated objectively.<sup>76-78</sup> Available studies are plagued by methodologic limitations, but proponents of SI note that higher-quality SI research is forthcoming.<sup>79</sup> "Sensory" activities may be helpful as part of an overall program that uses desired sensory experiences to calm the child, reinforce a desired behavior, or help with transitions between activities.

#### Comparative Efficacy of Educational Interventions for Young Children

All treatments, including educational interventions, should be based on sound theoretical constructs, rigorous methodologies, and empirical studies of efficacy.<sup>15</sup> Proponents of behavior analytic approaches have been the most active in using scientific methods to evaluate their work, and most studies of comprehensive treat-

ment programs that meet minimal scientific standards involve treatment of preschoolers using behavioral approaches.<sup>16,38</sup> However, there is still a need for additional research, including large controlled studies with randomization and assessment of treatment fidelity. Empirical scientific support for developmental models and other interventions is more limited, and well-controlled systematic studies of efficacy are needed.

Most educational programs available to young children with ASDs are based in their communities, and often, an "eclectic" treatment approach is used, which draws on a combination of methods including applied behavior analytic methods such as DTT; structured teaching procedures; speech-language therapy, with or without picture communication or related augmentative or alternative communication strategies; SI therapy; and typical preschool activities. Three studies that compared intensive ABA programs (25-40 hours/week) to equally intensive eclectic approaches have suggested that ABA programs were significantly more effective.<sup>31,32,34</sup> Another study that involved children with ASDs and global developmental delay/mental retardation retrospectively compared a less intensive ABA program (mean: 12 hours) to a comparably intensive eclectic approach and found statistically significant but clinically modest outcomes that favored those in the ABA group.<sup>33</sup> Although the groups of children were similar on key dependent measures before treatment began, these studies were limited because of parent-determined rather than random assignment to treatment group. Additional studies to evaluate and compare educational treatment approaches are warranted.

#### Programs for Older Children and Adolescents

Some model programs provide programming throughout childhood and into adulthood.<sup>11</sup> More commonly, the focus of specialized programs is on early childhood, and published research evaluating comprehensive educational programs for older children and adolescents with ASDs is lacking. However, there is empirical support for the use of certain educational strategies, particularly those that are based on ABA, across all age groups to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations.<sup>13,21,28</sup>

When children with ASDs move beyond preschool and early elementary programs, educational intervention continues to involve assessment of existing skills, formulation of individualized goals and objectives, selection and implementation of appropriate intervention strategies and supports, assessment of progress, and adaptation of teaching strategies as necessary to enable students to acquire target skills. The focus on achieving social communication competence, emotional and be-

# Exhibit L

P.A. 000234

HON. SUSAN J. CRAIGHEAD  
Noted for Hearing: June 8, 2011  
Without Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON  
FOR KING COUNTY

D.F. and S.F., by and through their parents,  
A.F. and R.F.; S.M.-O., by and through his  
parents, S.M. and D.O.; on their own behalf  
and on behalf of all similarly situated  
individuals,

Plaintiffs,

v.

WASHINGTON STATE HEALTH CARE  
AUTHORITY; PUBLIC EMPLOYEES  
BENEFITS BOARD; DOUG PORTER,  
Administrator of the Washington State  
Health Care Authority and Chairman of the  
Public Employees Benefits Board, in his  
official capacity;

Defendants.

NO. 10-2-29400-7 SEA

~~PROPOSED~~ ORDER:

- (1) GRANTING, IN PART,  
PLAINTIFFS' MOTION FOR  
PARTIAL SUMMARY  
JUDGMENT AND
- (2) DENYING DEFENDANTS'  
SUMMARY JUDGMENT MOTION

THIS MATTER came before the Court upon plaintiffs' Motion for Partial Summary Judgment and Permanent Injunction and defendants' Cross-Motion for Summary Judgment. The Court heard oral argument on February 4, 2011. Plaintiffs D.F., S.F. and S.M.-O., by and through their parents, were represented by Eleanor Hamburger and Richard E. Spoonemore, SIRIANNI YOUTZ SPOONEMORE. Defendants Washington State Health Care Authority, Public Employees Benefits Board and Doug Porter, in his official capacity as Administrator of the Washington State Health Care Authority and Chairman of the Public Employees Benefits Board (collectively

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION  
FOR SUMMARY JUDGMENT, AND DENYING  
DEFENDANTS' SUMMARY JUDGMENT MOTION - 1

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1 "defendants"), were represented by Melissa A. Burke-Cain and Kristen K. Culbert,  
2 OFFICE OF THE ATTORNEY GENERAL.

3 In their motion, defendants seek an order declaring that the Washington  
4 State Health Care Authority's health care coverage, which lists Applied Behavior  
5 Analysis therapy as a specific exclusion, complies with Washington's Mental Health  
6 Parity Act, RCW 41.05.600. Defendants also seek summary judgment on plaintiffs'  
7 claims for the failure to exhaust their administrative remedies. Plaintiffs, in their  
8 motion, seek partial summary judgment and an injunction declaring that defendants  
9 are required to cover Applied Behavior Analysis when the service is medically  
10 necessary, and that defendants' exclusion of Applied Behavior Analysis is illegal under  
11 the Mental Health Parity Act.

12 Along with oral argument, the Court reviewed and considered the  
13 pleadings and record herein, including:

- 14 • Plaintiffs' Motion for Partial Summary Judgment and Permanent  
15 Injunction;
- 16 • the Declaration of Lynda Gable and any exhibits attached thereto;
- 17 • the Declaration of Jeffrey D. Mills and any exhibits attached thereto;
- 18 • the Declaration of Richard E. Spoonemore and any exhibits attached  
19 thereto;
- 20 • the Declaration of A.F., mother of D.F. and S.F. and any exhibits attached  
21 thereto;
- 22 • Defendants' Cross-Motion for Summary Judgment and any exhibits  
23 attached thereto;
- 24 • the Declaration of Joleen McMahon and any exhibits attached thereto;
- 25 • the Declaration of Melissa Burke-Cain and any exhibits attached thereto;
- 26 • the Declaration of Nicole Oishi and any exhibits attached thereto;

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION  
FOR SUMMARY JUDGMENT, AND DENYING  
DEFENDANTS' SUMMARY JUDGMENT MOTION - 2

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- Plaintiffs' Response to Defendants' Cross-Motion for Summary Judgment;
- the Second Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of J.M. and any exhibits attached thereto;
- the Second Declaration of A.F. and any exhibits attached thereto;
- Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment and Injunctive Relief re: Mental Health Parity Act;
- the Declaration of Melissa Burke-Cain in Support of Defendants' Opposition to Plaintiffs' Partial Summary Judgment Motion and any exhibits attached thereto;
- the Declaration and Amended Declaration of Eliana Gall and any exhibits attached thereto;
- Defendants' Reply Brief in Support of Defendants' Cross-Motion for Summary Judgment;
- Plaintiffs' Reply in Support of Their Motion for Partial Summary Judgment and Injunctive Relief re: Violation of the Mental Health Parity Act;
- the Third Declaration of A.F. and any exhibits attached thereto;
- the Declaration of Allison Lowy Apple and any exhibits attached thereto;
- the Third Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of Michael A. Fabrizio, M.A. and any exhibits attached thereto; and
- the Declaration of Stacey Shook, Ph.D., B.C.B.A.-D., C.M.H.C. and any exhibits attached thereto.

Based upon the foregoing, the Court hereby GRANTS, in part, plaintiffs' Motion for Partial Summary Judgment and DENIES, in total, defendants' Motion for Summary Judgment.

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT, AND DENYING DEFENDANTS' SUMMARY JUDGMENT MOTION - 3

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1 As set forth in a letter ruling dated May 23, 2011, which is incorporated  
2 herein at Exhibit A, the Court concludes that, as a matter of law, plaintiffs are entitled  
3 to a declaration that specific exclusions contained in health benefit plans administered  
4 by the defendants that exclude coverage of Applied Behavior Analysis therapy, even  
5 when medically necessary and performed by licensed health providers, do not comply  
6 with Washington's Mental Health Parity Act, RCW 41.05.600. The Court further  
7 declares that under the Mental Health Parity Act defendants are required to cover  
8 medically necessary Applied Behavior Analysis therapy, as determined on an  
9 individualized basis, when provided by licensed providers.

10 The Court reserves ruling, at this time, whether defendants are required  
11 to cover Applied Behavior Analysis therapy when provided by certified or registered —  
12 as opposed to licensed — health providers.

13 The Court denies, without prejudice, plaintiffs' request for injunctive  
14 relief at this time. The Court anticipates that an evidentiary hearing may need to be  
15 conducted after a ruling on class certification to determine whether an injunction  
16 should issue against defendants as to the individual plaintiffs or a class of plaintiffs.

17 The Court denies defendants' motion for summary judgment because  
18 (1) defendants have not complied with the Mental Health Parity Act (as set forth above  
19 and in the Court's May 24, 2011 letter ruling), and (2) defendants' exhaustion defense  
20 fails with respect to plaintiffs on summary judgment. The Court also concludes that  
21 there is no need for other putative class members exhaust administrative remedies, *as*  
*set forth in the Court's May 24, 2011 letter ruling.*

22 IT IS SO ORDERED.

23 DATED this 7<sup>th</sup> day of June, 2011.

24  
25   
26 Judge Susan J. Craighead  
Superior Court Judge

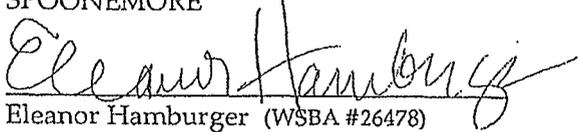
ORDER GRANTING, IN PART, PLAINTIFFS' MOTION  
FOR SUMMARY JUDGMENT, AND DENYING  
DEFENDANTS' SUMMARY JUDGMENT MOTION - 4

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P.A. 000238

1 Presented by:

2 SIRIANNI YOUTZ  
3 SPOONEMORE

4 

5 Eleanor Hamburger (WSBA #26478)  
6 Richard E. Spoonemore (WSBA #21833)  
Attorneys for Plaintiffs

7

8 Approved as to Form by:

9 ROBERT M. MCKENNA  
10 Attorney General

11

12

13 

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Melissa A. Burke-Cain (WSBA #12895)  
14 Kristen K. Culbert (WSBA #32930)  
Attorneys for Defendants

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ORDER GRANTING, IN PART, PLAINTIFFS' MOTION  
FOR SUMMARY JUDGMENT, AND DENYING  
DEFENDANTS' SUMMARY JUDGMENT MOTION - 5

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Superior Court for the State of Washington  
in and for the County of King

SUSAN J. CRAIGHEAD  
Judge

May 23, 2011

King County Courthouse  
Seattle, Washington 98104-2312  
E-mail: Susan.Craighead@kingcounty.gov

Mr. Richard E. Spoonemore  
Ms. Eleanor Hamburger  
Sirianni Youtz Meier & Spoonemore  
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Ms. Melissa A. Burke-Cain  
Ms. Kristen K. Culbert  
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Olympia, WA 98504

S.F., et al v. Washington State Health Care Authority, No. 10-2-29400-7 SEA  
*Cross-Motions for Summary Judgment*

Counsel,

Before the Court are cross-motions for summary judgment. The Washington Health Care Authority (HCA) seeks an order declaring that its coverage under its Uniform Medical Plan (UMP) complies with the mental health parity law, RCW 41.05.600; HCA also seeks summary judgment dismissing the action because plaintiffs failed to exhaust their administrative remedies. For the reasons set forth below, HCA's motion for summary judgment is denied.

Plaintiffs seek partial summary judgment in the form of an injunction requiring HCA to cover Applied Behavioral Analysis (ABA) for children with autism for whom the service is medically necessary. For the reasons set forth below, this motion is granted in part.

Plaintiffs are a putative class of children who have Autism Spectrum Disorder (ASD) whose families are insured through HCA; the named plaintiffs under UMP and Aetna. There is no dispute about the diagnosis. ABA therapy is an intensive, one-on-one intervention that has shown success with some children with ASD, assisting them changing behaviors that make it difficult for them to interact with others. Children spend between 25-40 hours per week undergoing therapy, at a cost of as much as \$50,000 per year. Plaintiffs contend that ABA therapy can enable children with ASD to attend school, even in mainstream classrooms, or avoid institutionalization. HCA contends that there is no scientific evidence establishing statistically significant improvement in children who have undergone ABA therapy. Both Aetna and UMP, in accordance with HCA's policy, flatly exclude ABA therapy from coverage.

S.F. and his family first enrolled in the Aetna Public Employees Plan in January 2009. His family had previously been insured through Premera Blue Cross. Premera provided limited coverage for ABA

therapy. S.F. and his brother, D.F., received ABA therapy through a program prescribed and monitored by Dr. Stephen Glass, a well-known pediatric neurologist. The program was implemented by Allison Apple, Ph.D., who is a licensed mental health provider. The boys' parents were initially told that this therapy would be covered by Aetna under a "transition of Care" benefit, but later Aetna declined coverage for a consulting appointment with Dr. Glass and all other therapy related to ABA on the grounds that ABA is not covered under the plan. The parents appealed the denial; HCA denied the appeal on the grounds that the treatment was not "medically necessary." At that point, the parents requested an Independent review of the dispute; this review found that ABA therapy is the standard medical care for children with autism and concluded that ABA therapy was medically necessary. After this review, Aetna paid for S.F.'s ABA therapy, which was provided by a master's level therapist who was a certified mental health counselor. However, as it had told S.F.'s parents it would, Aetna subsequently amended its certificate of coverage to specifically exclude ABA therapy, even if it was medically necessary.

HCA argues that it does not cover ABA therapy because it is provided by unlicensed practitioners. HCA contends that it only provides coverage for care performed by licensed health care providers, whether the care is for medical or mental health conditions. Plaintiffs acknowledge that many ABA therapists are not licensed by the State of Washington (although there is a voluntary national certification for ABA practitioners), but contend that HCA denied coverage in this case for care that would have been performed by licensed mental health providers. The crux of the plaintiffs' argument is that ABA is excluded from coverage by HCA regardless of who provides it and regardless of whether it is medically necessary for an individual child; in contrast, there is no similar blanket exclusion for any category of medical care. While HCA argues in this litigation that its concern is the licensure of the practitioners, it did not cite this basis as grounds for denying coverage to the named plaintiffs before the litigation began.

Both parties rely on language in the mental health parity law, RCW 41.05.600, to support their arguments. Plaintiffs cite RCW 41.05.600(1), which defines "mental health services" as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders..." and then lists certain categories of treatment that are expressly not included in the definition of "mental health services." Plaintiffs argue that this provision means that all other mental services are to be covered, without limitation. This, they argue, was the legislature's way of remedying past discrimination against mental health care.

HCA points to RCW 41.05.600(2)(c), which provides in part that "[t]reatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services." HCA argues that this provision allows it to restrict coverage to licensed mental health care providers, since only medical and surgical services performed by licensed providers are covered. HCA also notes RCW 41.05.600(4), which provides that a health plan may require that "mental health services be medically necessary...if a comparable requirement is applicable to medical and surgical services."

The court is not persuaded that the statute's definition of mental health services evidences a legislative intent that all services that purport to remedy mental health problems must be covered by HCA, regardless of medical necessity. Similarly, the court is not persuaded that the legislature intended to require HCA to cover services no matter the qualifications of the provider. It appears from the language cited by HCA above, that the legislature anticipated that restrictions could be placed on coverage for mental health services as long as they were the same type of restrictions placed on coverage for medical and surgical services.

Although both parties attempt to persuade the court of their respective positions on the medical necessity of ABA therapy, or lack thereof, that is not an issue that needs to be resolved to rule on the plaintiffs' motion. From the evidence presented to the court, it is apparent that ABA therapy may provide benefit to some individuals. The plaintiffs are seeking the opportunity to establish medical necessity on a case by case basis.

The court concludes as a matter of law that HCA is not in compliance with the Mental Health Parity Act insofar as it imposes a blanket exclusion of ABA therapy, even when provided by licensed therapists. HCA is required by the Act to cover medically necessary ABA therapy (as determined on an individualized basis) that is provided by licensed therapists. The court cannot determine as a matter of law that HCA is required to cover ABA therapy provided by certified or registered providers because on this record it is not clear whether HCA covers mental health services provided by counselors or therapists who hold certifications or registrations, but not licenses. Neither is it clear whether a national certification as is held by some ABA providers is equivalent to any certification for providers of other mental health services currently covered by HCA.

Exhaustion: HCA contends that plaintiffs have failed to exhaust their administrative and/or contractual remedies and, therefore, their claims should be dismissed. It does not appear that the Administrative Procedure Act applies to this dispute; the relationship among the parties is contractual, governed by the Certificates of Coverage. S.F. has exhausted his contractual remedies under the Certificate of Coverage, inasmuch as he appealed the denial of coverage for ABA services, prevailed before the IRO, only to have Aetna change the Certificate of Coverage to thwart the result of his appeal. There is no need for other putative class members to go through a similar exercise when it is plain that the result will be the same. HCA's exhaustion defense fails on summary judgment.

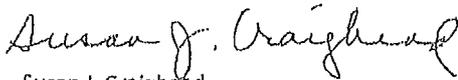
Request for a Permanent Injunction: The court has struggled with the plaintiffs' request for a permanent or, in the alternative, preliminary, injunction. The extent to which the court may resort to injunctive relief in the context of summary judgment is unclear; under CR 56, the court is not supposed to weigh facts, but the court must make findings of fact and conclusions of law to support entry of injunctive relief. The plaintiffs seek an injunction that would apply not only to them, but to other children with autism, yet this court has not yet been asked to certify this action as a class action. The parties advised the court at oral argument that the question of whether ABA therapy qualified as a neurodevelopmental therapy has yet to be litigated. While HCA has not presented any information contradicting plaintiffs' assertions that ABA therapy is medically necessary for them, plaintiffs have not

presented declarations from experts establishing medical necessity or the likelihood of irreparable harm, other than the fact that the IRO concluded that ABA therapy was medically necessary for S.F. It is certainly the opinion of the plaintiffs' parents that the lack of ABA therapy has caused and will continue to cause irreparable injury to them, but the court is not certain that this opinion alone can justify findings to support entry of injunctive relief. For these reasons, the court denies the request for injunctive relief without prejudice. The court anticipates that some type of evidentiary hearing could be conducted following a ruling on class certification to determine whether a preliminary injunction should issue, either as to these plaintiffs or as to a class of plaintiffs. The court welcomes suggestions from counsel regarding this procedure.

Counsel for plaintiffs is directed to present proposed orders to the court that include a list of all of the documents this court reviewed in connection with these cross-motions.

The court apologizes for the length of time it took this matter under advisement. I hope the parties can see the degree of care the court devoted to this very important case.

Sincerely,



Susan J. Craighead  
Judge