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NO. 68726-3-I

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

PREMERA BLUE CROSS and
LIFEWISE OF WASHINGTON,

Appellants,

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.

RESPONDENT'S OPENING BRIEF

Richard E. Spoonemore (WSBA #21833)
Eleanor Hamburger (WSBA #26478)
SIRIANNI YOUTZ
SPOONEMORE HAMBURGER
999 Third Avenue, Suite 3650
Seattle, WA 98104
Tel. 206.223.0303, Fax 206.223.0246
Email: rspoonemore@sylaw.com
ehamburger@sylaw.com
Attorneys for Respondent A.G.

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---	----

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I. INTRODUCTION

The Mental Health Parity Act requires coverage for mental health services, including neurodevelopmental therapies, in all health plans *provided* that the therapy is designed to treat a qualified mental health condition. RCW 48.44.341. The Neurodevelopmental Therapy Mandate, in contrast, requires that certain insured group health plans provide neurodevelopmental therapies for insureds with both physical and mental conditions through the age of six. RCW 48.44.450.

Premera argues that that the two mandates “conflict” such that the Neurodevelopmental Therapy Mandate overrides the Parity Act. 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 [the Neurodevelopmental Therapy Mandate] 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).¹

Judge Lasnik is not alone. 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 Z.D. v. Group Health*, 2012 WL 1997705, *10, fn. 11 (W.D. Wa., June 1, 2012), (“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 directly conflict, such that they

¹ 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.

CP 185-186, *Z.D. v. Group Health*, Dkt. No. 36, December 20, 2011; *see also Z.D. v. Group Health*, 2012 WL 1997705, *10 (W.D. Wash. 2012) (same).

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.*, 829 F.Supp 2d at 1013-14 (citing to same cases); *Mortell v. State*, 118 Wn. App. 846, 849, 78 P.3d 197 (2003).

The trial court here properly applied these longstanding rules of construction and found 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 CP 544, ¶ 4. Premera can – and therefore must – comply with both statutes. It is not permitted to pick and chose which statute to follow, ignoring the other. The trial court should be affirmed.

II. ISSUES PRESENTED

1. Does the plain language of Washington's Mental Health Parity Act require Premera to cover medically necessary neurodevelopmental therapies when used to treat insureds with DSM-IV-TR mental health conditions?

Answer: Yes. The Parity Act requires health carriers, such as Premera, to "provide coverage" for "Mental Health Services." RCW 48.44.341(2). "Mental Health Services" are defined in the Parity Act as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the [DSM-IV-TR]." RCW 48.44.341(1). Because neurodevelopmental therapies are often "medically necessary outpatient ... services provided to treat mental disorders covered by the [DSM-IV-TR]," Premera cannot enforce a blanket exclusion of all such therapies, eliminating coverage for the services even when medically necessary.

2. Does the Neurodevelopmental Therapy Act conflict with the Mental Health Parity Act such that Premera can ignore the coverage requirements in the Parity Act?

Answer: No. There is no conflict between the two statutes. The Neurodevelopmental Therapy Mandate requires coverage for neurodevelopmental therapy for children through age six to treat physical

or mental conditions on certain group plans. It does not require exclusion of those therapies after age six, nor does it require exclusion of these therapies on individual plans. The Parity Act sets forth a different requirement – coverage of all medically necessary mental health services on group and individual plans for certain mental health conditions. A conflict only exists where it is impossible to comply with the directives of two statutes. Here, Premera can – and therefore must – comply with the requirements of both statutes. *See, e.g., Z.D.*, 829 F.Supp.2d at 1014.

III. STATEMENT OF THE CASE

A. Identity of Respondent.

A.G. is the 13-year-old son of J.G. and K.G., who live in Renton, Washington. CP 187. In 2006, A.G. was diagnosed with autism by a licensed psychologist and speech language pathologist, both at Seattle Children’s Hospital. *Id.*, ¶ 3. In 2007, A.G.’s pediatrician, Dr. MacPherson, referred A.G. to Valley Medical Center’s Children’s Therapy Program (“Valley”) for neurodevelopmental evaluation and therapy. CP 188, ¶ 4. The evaluations by Valley’s therapists recommended that A.G. receive weekly occupational therapy and speech therapy. *Id.*, ¶ 5.

B. Identity of Appellants.

A.G. has been insured under an individual policy issued by LifeWise Health Plan of Washington since at least January 1, 2006. CP 187, ¶ 2; *see* CP 28. Premera Blue Cross is the nonprofit owner of LifeWise Health Plan of Washington. CP 222. Both Premera Blue Cross and LifeWise Health Plan of Washington are licensed health care service contractors in Washington, also known as “health carriers.” *Id.*; *see* RCW 48.43.005(23).

As “health carriers,” Premera and LifeWise issue “health plans” or “health benefit plans.” RCW 48.43.005(24) (“‘Health plan’ or ‘health benefit plan’ means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse or pay for health care services”). Premera and LifeWise are “alter egos.” *See McKinnon v. Blue Cross-Blue Shield of Alabama*, 691 F.Supp. 1314, 1319 (1988), *aff’d*, 874 F.2d 820 (11th Cir. 1989). They are collectively referred to in this brief as “Premera.”

C. A.G.’s Medical Condition Requires Treatment With Neurodevelopmental Therapies.

The Washington Department of Health describes Autism and Autism Spectrum Disorders (ASDs) as follows:

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.

CP 227. Treatment of individuals, particularly children, is critical. As the United States Surgeon General notes:

Because autism is a severe, chronic developmental disorder, which result 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.

CP 232 (excerpt from DHS, *Mental Health: A Report of the Surgeon General*, p. 163 (1999)).

ASD has no known cure. However, it can effectively be treated. In particular, speech therapy and occupational therapy are often essential therapies to improve functioning in children with autism. These therapies are so critical that coverage of speech, occupational and physical therapies were among the top priorities for the Department of Health's Autism Task Force. CP 238. *See also* CP 516 (DOH findings: "Neurodevelopmental therapies are effective in treating ASD.").

D. Premera Pays, and Then Retroactively Denies, Nearly \$24,000 in A.G.'s Neurodevelopmental Therapy Bills.

A.G. received speech and occupational therapy from Valley Medical Center's Children's Therapy Clinic since 2007. CP 188, ¶¶ 4-5. Valley routinely submitted the bills for A.G.'s speech and occupational therapy services to Premera, which paid for the services, at least for the first twenty visits. CP 189, ¶ 9. Premera never questioned their medical necessity. *Id.*

In late July, 2011, A.G.'s parents received an envelope with forms called "Explanations of Benefits" (EOBs) from Premera. CP 194-208. These documents revealed that Premera had conducted a retrospective review of the neurodevelopmental therapy provided to A.G. since January 1, 2010, and determined that *all* of the therapy was incorrectly covered. *Id.* The EOBs stated, "[O]ur medical staff reviewed this claim and determined this service is not covered by your plan." *Id.* Premera determined that nearly \$24,000 in neurodevelopmental therapies had been improperly paid, and that A.G.'s parents—not the insurance company—were financially responsible for all of the treatment. *Id.* It clawed back payment from the providers. CP 189-190, ¶¶ 11, 18.

A.G.'s father called Premera to object to the determination and to request an explanation. CP 189, ¶¶ 12-14. On August 12, 2011, Premera

sent J.G. a letter confirming the decision. Premera maintained that there was no coverage for neurodevelopmental therapies:

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.

CP 212. Premera included a copy of the relevant section of A.G.'s contract which contained the exclusion:

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*.

CP 212-213, Contract pp. 30-31 (emphasis added); *see also* CP 57-58.

Once LifeWise retroactively denied coverage of A.G.'s therapy services, his parents were forced to eliminate his speech therapy. CP 189. 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 regarding the nearly \$24,000 in outstanding bills. *Id.*

E. Premera/LifeWise Has a Standard Policy of Excluding Neurodevelopmental Therapy Services.

Premera's official policy excludes coverage of neurodevelopmental therapy services, either entirely in its individual policies, or for

persons over the age of six in its group policies. CP 217-220 (WEA Premera group policy); CP 48-49 (A.G.'s LifeWise policy). Premera does not dispute this. *See* CP 494; 501.

F. Proceedings Below.

Faced with a demand to pay some \$24,000 and the inability to secure continuing therapy for their son, A.G.'s parents brought suit against Premera. They alleged, on their own behalf and on behalf of a putative class, that Premera's exclusion of medically necessary neurodevelopmental therapies violated the Parity Act and the Consumer Protection Act, and breached their contracts of insurance. CP 1-11.

Premera moved to dismiss on the basis that it did not have to comply with the Parity Act because the Neurodevelopmental Therapy Mandate statute did not require coverage. CP 12-21. A.G. cross-moved for summary judgment and sought a preliminary injunction enjoining Premera from continuing to deny payment of his medically necessary care. CP 156-74.

The trial court granted A.G.'s motion for partial summary judgment and injunctive relief in a letter ruling dated March 27, 2012. CP 543-44. Premera's motion was denied. *Id.* A formal Order was entered on April 17, 2012. CP 545-53. The Order voided Premera's blanket exclusion and ordered Premera to process and pay A.G.'s claim as

a mental health benefit.² CP 552. Premera sought discretionary review, granted by Commissioner Neel, who concluded that “this is a recurring issue, and other insurers and insureds will benefit from an appellate decision on this issue.” CP 595-98.

IV. ARGUMENT

A. **Washington’s Mental Health Parity Act Requires Coverage of Medically Necessary Neurodevelopmental Therapies to Treat Covered DSM-IV-TR Conditions.**

Washington’s Parity Act was designed to end the historic discrimination by health insurers against persons with mental disorders. As the U.S. Surgeon General noted, this discrimination had infected health insurance coverage:

Stigmatization of people with mental disorders has persisted through history *It deters the public from seeking, and wanting to pay for care.* In its most overt and egregious form, stigma results in outright discrimination.

CP 245 (emphasis added).

² 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. The court 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. CP 548-552.

Passage of the Parity Act was intended to wipe out such discrimination. The Legislature required insurance coverage for mental disorders in just the same way that other physical conditions are covered:

The legislature finds that the potential benefits of improved access to mental health services are significant. Additionally, the legislature declares that it is not cost-effective to treat persons with mental disorders differently than persons with medical and surgical disorders.

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.

CP 262-263 (emphasis added). *See also id.*, CP 288 (“[T]hat 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.”). Of particular legislative concern was coverage for children. CP 283 (“The impact on children and adolescents is particularly important”).

1. The Parity Act Imposes a Baseline Coverage Requirement for Mental Health Care Services.

The Mental Health Parity Act is succinct and clear. In unambiguous language, the Parity Act sets forth a baseline coverage requirement for every health plan which covers medical and surgical services:

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.*, 2012 WL 1997705, *11 (“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 coverage mandate is triggered if a health benefit plan generally provides “coverage for medical and surgical services.” RCW 48.44.341(2) (“All health service contracts providing health benefit plans that provide coverage for medical and surgical services”). The coverage mandate is not linked to any specific medical or surgical benefit, but to the existence of those services generally.

If Premera provides coverage for medical and surgical services to insureds generally – and it certainly does – then it is prohibited from

excluding *any* medically necessary mental health service.³ As the Ninth Circuit just explained under California’s Parity Act, *coverage* is the paramount requirement:

It is undisputed that [plaintiff’s] Plan “provides hospital, medical, or surgical coverage” and so comes within the scope of the Act.

Subsection (a) contains *the Act’s basic mandate*. Briefly summarized, subsection (a) states that all plans that come within the scope of the Act “*shall provide coverage for ... medically necessary severe mental illnesses....*” That is, if treatment for a “severe mental illness” is “medically necessary,” *a plan that comes within the scope of the Act must pay for that treatment*.

Harlick v. Blue Shield of Cal., 686 F.3d 699, 711 (9th Cir. 2012).⁴

The Act therefore precludes an insurer from imposing a blanket exclusion on a mental health care service because “that would defeat the very purpose of the statute: *providing coverage.*” *Z.D.*, 2012 WL

³ Washington’s Parity Act is consistent with the federal Mental Health Parity Act, which likewise requires that any exclusions imposed on a mental health service be applied to “substantially all” medical and surgical benefits. *See* 29 U.S.C. § 1185a(a)(3); 26 U.S.C. § 9812(a)(3). *See also Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, 75 FR 5410-01, p. 5413 (“[A]ny treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than the *predominant treatment limitations applied to substantially all medical/surgical benefits.*”) (emphasis added).

⁴ California’s Parity Act provides that “[e]very health care service plan contract ... that provides hospital, medial, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illness of a person of any age ... under the same terms and conditions applied to other medical conditions....” Cal. Health & Safety Code, § 1374.72.

199705, *12 (emphasis added). Thus, if Premera provides coverage for medical and surgical services to insureds generally – and it does – then it is prohibited from completely excluding *any* medically necessary mental health service.

2. Neurodevelopmental Therapies, When Used to Treat Insureds with DSM-IV-TR Mental Health Conditions, Are “Mental Health Services.”

Premera argues that “[t]he Parity Act is general in scope; it addresses ‘mental health services,’ *which it does not define.*” Premera Br., p. 17 (emphasis added). In truth, the Parity Act defines exactly what “Mental Health Services” must be covered:

“[M]ental health services” means 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, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005....

RCW 48.44.341(1) (emphasis added). The version of the DSM published on July 24, 2005 is the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Ed. Text Revision (the “DSM-IV-TR”). There has been no update yet, and the Insurance Commissioner has not, by rule, adopted a different version of the DSM.

Plaintiff A.G. is autistic. CP 187, ¶ 3. Autism is a DSM-IV-TR condition, and is therefore a “mental disorder” as defined by the Parity Act. CP 295-298. *See also* CP 228 (“Autism spectrum disorder is a disorder included in the DSM.”). The disorder can be treated with neurodevelopmental therapy. CP 232-233; 235-239; 241-259. Therefore, 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.⁵

It is undisputed that neurodevelopmental therapies may be medically necessary to treat individuals with autism. Premera’s Dr. Moat admits this:

Premera covers neurodevelopmental therapy in some, but not all, of its health plans....subject to review for medical necessity. [It] was designed to provide services specifically for children with developmental disorders – such as Autism Spectrum Disorder

⁵ Premera has already determined that A.G.’s neurodevelopmental therapies are medically necessary. Premera covered A.G.’s therapies for years, finding that the therapies met Premera’s medical necessity standards. *See* CP 189, ¶ 9. Indeed, the only basis for Premera’s retroactive determination that the services were wrongly paid was Premera’s contract exclusion. CP 193-213.

CP 494, ¶ 5. The Washington Legislature agrees. *See* RCW 48.44.450(3). So does the Washington Department of Health,⁶ the American Academy of Pediatrics,⁷ the U.S. Surgeon General,⁸ and courts across the country.⁹

Because neurodevelopmental therapies can be medically necessary, Premera's blanket exclusion of the service is illegal. CP 547 ("Since neurodevelopmental therapies may be medically necessary to treat autism, Defendants cannot use a blanket exclusion to deny coverage for those therapies.").

The only evidence Premera offered to dispute plaintiff's showing that neurodevelopmental therapies can be medically necessary to treat DSM-IV conditions was from its employee, Dr. Moat. She stated that neurodevelopmental therapies, while covered by Premera subject to

⁶ CP 516 ("Neurodevelopmental therapies are effective in treating ASD [Autism Spectrum Disorders].").

⁷ CP 522-523 ("People with ASDs have deficits in social communication and treatment by a speech-language pathologist usually is appropriate;" "traditional occupational therapy is often provided to promote development of self-care skills....").

⁸ CP 232 ("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.").

⁹ *See, e.g., McHenry v. PacificSource Health Plans*, 679 F.Supp.2d 1226, 1233 (D. Or. 2010) (health plan covered "services related to conditions which may be symptoms of autism, such as speech, physical, and occupational therapy"); *Bails v. Blue Cross/Blue Shield of Illinois*, 438 F.Supp.2d 914, 929 (N.D. Ill. 2006) (insurer required to cover medically necessary speech therapy services for autistic child); *Wheeler v. Aetna Life Ins. Co.*, 2003 WL 21789029 (N.D. Ill. 2003) (same).

medical necessity, are also considered “educational” and therefore are never medically necessary. *Compare* CP 494, ¶ 5 with CP 495, ¶ 7. Aside from the inherent contradiction in her statement, Premera cannot use its authorization to make “medical necessity” decisions (*see* RCW 48.44.341(4)) to narrow the statutory definition of “Mental Health Services” in order to exclude all services for an entire class of people, *e.g.*, those with developmental disabilities. Nor may it unilaterally narrow the statutory definition of “Mental Health Services” to only psychological or psychiatric services, or to only services provided by certain behavioral, psychiatric or psychological providers, even if Dr. Moat believes that is “uniformly accepted practice.” *See* CP 495, ¶ 7.

The Legislature – not Dr. Moat or Premera – defines the breadth of the mandate. The Legislature adopted a broad coverage mandate which was not limited to only psychiatric conditions or services. RCW 48.44.341(1); CP 282 (Legislative Sunrise Review: “The requirement for mental health coverage is broad– ‘all mental disorders included in the diagnostic and statistical manual of mental disorders’”).

Consistent with its breadth, every court to consider this issue has found that the Parity Act prohibits blanket contractual exclusions of “mental health services” designed to treat persons with developmental disabilities. *See Z.D.*, 829 F.Supp.2d at 1013 (“Washington law,

specifically [the Mental Health Parity Act], requires Defendants to provide coverage for the mental health [neurodevelopmental] services at issue in this case”); CP 525-529, *D.F. v. Washington Health Care Authority, et al.*, No. 10-2-29400-7 SEA (“specific exclusions...that exclude coverage of Applied Behavior Analysis therapy, even when medically necessary and performed by licensed health providers, do not comply with Washington’s Mental Health Parity Act....”).

This issue was litigated in *Markiewicz*. See *Markiewicz v. State Health Benefits Comm'n*, 915 A.2d 553, 560 (N.J. App. 2007). There, the state public employee health plan applied a neurodevelopmental therapy exclusion in its contract to deny coverage of speech therapy for an insured child with pervasive developmental disorder, (PDD) a DSM-IV condition. *Id.* at 555. While New Jersey’s mental health parity law is narrower than Washington’s (limited to “biologically-based mental illness”), it includes autism and PDD. *Id.* at 558. The appellate court found:

... [A]n exclusion from coverage for claims based upon occupational, speech and physical therapy offered to developmentally disabled children would render meaningless the specific inclusion of PDD and autism within those biologically-based mental illnesses subject to the parity statute. The Legislature surely could not have intended that the principal treatments for developmental disabilities be excluded from coverage simply because those treatments differ in their essential nature from treatments applicable to other biologically-based mental illnesses, such as the use of psychiatric or psychological

therapy and drugs. The fact that biologically-based mental illnesses affect development in some and other neurological functions in others should not be the determinant of coverage.

Id. at 560 (emphasis added). *See also Micheletti v. State Health Benefits Comm'n*, 913 A.2d 842, 851 (N.J. App. 2007) (same).

This Court should not sanction Premera's discriminatory exclusion of services to treat developmental disabilities when its justification is that such discrimination is "uniformly accepted" and "consistent with the prevailing understanding among insurers in Washington." CP 560, ¶ 7; Premera Br., p. 17. The broad statutory language – which controls the scope of the services covered – was designed to end just this type of rank discrimination. *See* CP 288 (broad insurance parity is "a matter of fairness").

B. Premera's Blanket Exclusion Breaches the Contract.

It is fundamental insurance law that the "terms of" insurance policies include requirements or restrictions imposed by state law. Russ, Lee R., Segalla, Thomas F., COUCH ON INSURANCE 3D, *Statutory Law as Part of Contract*, § 19:1 (2011). If the written words of a policy do not comply with the requirements of state law, the law will supersede the written terms of the contract:

As a general rule, stipulations in a contract of insurance in conflict with, or repugnant to, statutory provisions which are applicable to the contract are invalid since contracts

cannot change existing statutory laws. *If the terms of an insurance policy do not comport with the statutory requirements, the statutory requirements supersede the conflicting policy provisions and become part of the insurance policy itself.*

Id., § 19:3 (footnotes omitted) (emphasis added). See also *Brown v. Snohomish County Physicians Corp.*, 120 Wn.2d 747, 753, 845 P.2d 334 (1993). This is codified in Washington law. RCW 48.18.510.

Not only is the Parity Act incorporated as “terms of” the plan as a matter of state law, it is expressly incorporated into A.G.’s policy as a matter of contract law:

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.*

CP 345 (emphasis added). Here, as in *Z.D.*, “The problem for Defendants lies in the fact that Washington law governs the Plan. ... Washington law, specifically [the Mental Health Parity Act, RCW 48.44.341(2)], requires Defendants to provide coverage for the mental health services at issue in this case.” *Z.D.*, 829 F.Supp.2d at 1013 (internal citations omitted). Premera has not only violated the Parity Act, it has breached its contract of insurance with A.G.

C. The Mental Health Parity Act and the Neurodevelopmental Therapy Act Do Not Conflict.

Premera argues that because coverage of neurodevelopmental therapies is not required on individual plans by the Neurodevelopmental Therapy Mandate, it does not have to provide any coverage for those therapies under the Parity Act. It claims that the Neurodevelopmental Therapy Mandate conflicts with and trumps the Parity Act's broad coverage mandate. *See* Premera Br., pp. 14-17. Premera's argument has been rejected by every single court to consider it. *See Z.D.*, 2012 WL 1997705, *10, fn. 11. This Court should reject it as well.

The two statutes are easily read together and harmonized.¹⁰ Where statutes stand *in pari materia*, they "are to be read together as constituting a unified whole ... which maintains the integrity of the respective statutes." *Hallauer v. Spectrum Properties, Inc.*, 143 Wn.2d 126, 146, 18 P.3d 540 (2001). Thus, "effect will be given to both to the extent

¹⁰ Premera argues that "the specific terms of the NDT Mandate control over the general terms of the Parity Act." Premera Br., p. 17. Premera misconstrues the rule of statutory construction. A more specific statute may only supersede a general one *when there is an irreconcilable conflict*. *Walker*, 155 Wn. App. at 208; *ETCO, Inc. v. Dep't of Labor & Indus.*, 66 Wn. App. 302, 306, 831 P.2d 1133 (1992) ("Where two statutes dealing with the same subject matter are in apparent conflict, established rules of statutory construction require giving preference to the more specific statute.") (cited by Premera). Where, as here, there is no conflict and both can be given full meaning, the general-specific rule of statutory construction simply does not apply. *Id.*

possible” and “efforts will be made to harmonize statutes.” *Walker v. Wenatchee Valley Truck and Auto Outlet, Inc.*, 155 Wn. App. 199, 208, 229 P.3d 871 (2010). 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); *Mortell v. State*, 118 Wn. App. 846, 849, 78 P.3d 197, 198 (2003) (“Statutes relating to the same subject matter will be read as complimentary.”).

In 1985, Washington passed a Neurodevelopmental Therapy Mandate which required employer-sponsored group plans in Washington to provide some minimal coverage of neurodevelopmental therapies to children under the age of seven. RCW 48.44.450. The statute did not address whether or how neurodevelopmental therapies would be covered in individual policies, such as A.G.’s. *Id.* It only set forth legislative intent with respect to the *minimum amount* of coverage a carrier must offer on certain group plans:

Each employer-sponsored group contract for comprehensive health care service which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

RCW 48.44.450(1). This mandate is not, as Premera suggests, an expression of legislative intent with respect to coverage of neurodevelopmental therapy services above the established minimum. Premera Br., p. 14 (erroneously asserting that Premera’s exclusion is “expressly permitted by the Neurodevelopmental Therapy Mandate”). As Judge Lasnik concluded:

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.

Z.D., 829 F.Supp.2d at 1014.

The mandate established a “floor, not a ceiling.” *Id.* After the mandate was passed, an insurer was certainly free to offer neurodevelopmental benefits to insureds in the individual market or children over the age of six without running afoul of any legislative directive. Premera (and the other major health carriers), however, chose to provide the barest minimum, excluding neurodevelopmental therapy coverage entirely in its individual market plans, and for persons over the age of six in its group plans. *See, e.g.*, CP 58, 220.

Put simply, the fact that, in 1985, the Legislature chose not to regulate the provision of neurodevelopmental mental health services to

insureds in individual plans, does not prevent the Legislature from taking such action at a later date. The Legislature was and remains free to enact new mandates. That is exactly what the Legislature did when it expanded the application of the Parity Act to individual plans in 2008.

After the Mental Health Parity Act took effect (and was extended to individual plans), health carriers were required to re-consider their provision of neurodevelopmental therapies in light of the minimum requirements mandated by the Parity Act. Thus, health carriers could no longer exclude medically necessary neurodevelopmental therapies for individuals with DSM-IV conditions. In essence, the Parity Act raised the “floor” to expand coverage with respect to individuals with mental health conditions (but not for non-mental health conditions). As Judge Lasnik explained:

Defendant can readily comply with both statutes simply by comports with the parity requirements of [RCW 48.44.341] 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.

Z.D., 829 F.Supp.2d at 1014. This is not a close question. Denying Group Health’s request that this issue be certified to the Washington Supreme Court, Judge Lasnik determined:

... [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.*

CP 185-186 (emphasis added).

Premera does not get to choose which state mandate it wants to follow while ignoring the other. It is required to follow both. *Z.D.*, 829 F.Supp.2d at 1013 (“the mere fact that the statutes overlap does not mean that both cannot apply.”). Here, providing mental health services required by the Parity Act does not in any way jeopardize Premera’s compliance with the neurodevelopmental mandate. Nor does complying with the Neurodevelopmental Mandate jeopardize compliance with the Parity Act. The statutes are complimentary, and both can – and should – be enforced as written. *Id.* at 1014.

D. Legislative History Does Not Contradict the Plain Language of the Parity Act.

1. The Plain Language of a Statute is the Best Indication of Legislative Intent, and Legislative History is Only Relevant In the Event of a Statutory Ambiguity.

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 Br.*, pp. 17-20. But under Washington's "plain meaning" rule, legislative intent is derived, first and foremost, from the language of the statute itself. *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). *See also Roberts v. Johnson*, 137 Wn.2d 84, 91, 969 P.2d 446, 449 (1999) ("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.").

Premera does not even attempt to make a threshold showing of statutory ambiguity before launching into its prolonged discussion of legislative history. *State v. Hahn*, 83 Wn. App. 825, 831-32, 924 P.2d 392 (1996) ("[Defendants] fail to show why the language of [the statute] is ambiguous. Without a threshold showing of ambiguity, the court derives a statute's meaning from its language alone."). Here, the Parity Act is unambiguous: it requires coverage for services designed to treat mental

health conditions, such as neurodevelopmental therapies to treat A.G.'s autism. The Legislature expressed its intent in plain statutory language.

2. The Legislature Knew How to Exempt Certain Mental Health Services, and Did Not Exempt Neurodevelopmental Therapies from its Mandate.

The Parity Act specifically defines “mental health services” to include all services that are “medically necessary ... to treat mental disorders covered by” the DSM-IV-TR. RCW 48.44.341(1). The Legislature carefully crafted the definition broadly to include within its scope neurodevelopmental mental health services. *Id.*

Significantly, the Legislature knew how to exempt specific services from its mandate *and did so*. *Id.* (“substance related disorders” and “life transition problems” specifically excluded from definition). Neurodevelopmental therapies were not excluded from the broad definition of “mental health services.” CP 282.

The fact that the Legislature explicitly excluded certain conditions, such as substance abuse treatment or “V codes” described in the DSM-IV, is evidence that the Legislature intended all remaining conditions, including developmental conditions, to be covered. *State v. Delgado*, 148 Wn. 2d 723, 729, 63 P.3d 792 (2003).

3. Failed Legislation is Not Evidence of Legislative Intent.

Contrary to Premera's argument, failed legislation is not evidence of legislative intent. Premera Br., p. 18; *see State v. Conte*, 159 Wn.2d 797, 813, 154 P.3d 194 (2007) (the failure of the Legislature to take action on a proposed bill is not evidence of any legislative intent); *Spokane County Health Dist. v. Brockett*, 120 Wn.2d 140, 153, 839 P.2d 324 (1992) (“[W]hen the Legislature rejects a proposed amendment, as they did here, we will not speculate as to the reason for the rejection.”).

Even the cases cited by Premera do not stand for the proposition that subsequent legislative action can override the plain language of a statute. Premera Br., p. 18. *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); *Impehoven 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).

a. Health Insurers and the DOH Recognized that the Parity Act Covered Autism, Rendering Further Legislation Unnecessary.

If anything, the failed efforts to expand the Neurodevelopmental Therapy Mandate and enact an autism coverage mandate show that the

legislature recognized that the services sought in those bills *were already mandated* by the Parity Act, rendering the proposed legislation unnecessary.

Premera argues that a 2008 report created by a “Blue-Ribbon” panel concluded, based on meetings between 2005 and 2008, that “[t]here is no mandate for insurance coverage within Washington State.” Premera Br., p. 19. Of course, a task force – even one with a blue ribbon – is not an agency to which this Court should defer, particularly when there is no evidence that it ever actually analyzed the scope of the Parity Act. RCW 34.05.010(2) (Caring for Washington Individuals Task Force is not an “agency”); *American Ass’n of People with Disabilities v. Hood*, 278 F.Supp.2d 1337, 1343 (M.D. Fla. 2003) (“Task Force’s conclusions cannot be considered as an expression of the Department’s construction ... [T]he Task Force was convened primarily for the purpose of gathering information and providing recommendations.”).

More than that, the task force’s comment in **2007** was addressed in **2008** when the Legislature *expanded the Parity Act* to include all individual plans. As a result, in 2009, after this expansion, the DOH and the health insurance industry recognized that the Parity Act would provide expanded coverage for autism sought by the pending mandate proposals. The Association of Washington Healthcare Plans (AWHP)–of which

Premera is a member–opposed an additional autism coverage mandate because it argued the Parity Act *already provided expanded coverage*:

Washington already has mandates in place that cover services for individuals’ diagnosis 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.

CP 519 (emphasis added). With the 2009 expansion of the Parity Act, the DOH agreed that coverage of therapies to treat DSM-IV conditions like autism may already 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*.

* * *

The concerns listed above could be addressed in the following ways: ...

Expand and/or *clarify the mental health parity mandate* to include treatment for ASD. ASD is defined as a developmental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Psychiatric and psychological care is plainly envisioned by the proposed bill. Other therapies, such as ABA, appear to have significant mental health components. *Treatment related to mental health care or provided by mental health providers should be covered by this mandate.*

CP 490-91, 517. This case, and others like it, are providing the clarification that the DOH recognized was necessary.

***b. The Neurodevelopmental Therapy Mandate
Is Different Than the Parity Act.***

The Neurodevelopmental Mandate, unlike the Parity Act, is not restricted to children with a DSM-IV-TR mental health diagnosis. Under the Neurodevelopmental Mandate, a child in need of physical therapy without a DSM-IV-TR diagnosis would not be covered under the Parity Act. Given the different scopes of the two statutes – and despite some overlap – the failure to expand coverage under the Neurodevelopmental Mandate is irrelevant to legislative intent regarding treatment of individuals with DSM-IV-TR mental health conditions. The Legislature could have simply concluded that insureds without mental health conditions do not require expanded access. As Judge Lasnik properly observed, “The 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.” CP 186.

4. The Legislative History Is Consistent with the Plain Language of the Statute.

The actual legislative history indicates that the Legislature knew full well that it was passing an extraordinarily broad mandate, limited only by a few explicit exceptions:

The legislature finds that the costs of leaving mental disorders untreated or undertreated are significant, and often include: ... deteriorating school performance, increased use of other health services, treatment delays leading to more costly treatments, suicide, family breakdown and impoverishment, and institutionalization
....

... [T]he legislature declares that it is not cost-effective to treat persons with mental disorders differently than persons with medical and surgical disorders.

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.

CP 262-263 (emphasis added). *See Spokane County Health Dist.*, 120 Wn. 2d at 151 (“[T]he preamble or statement of intent can be crucial to interpretation of a statute”). The breadth of the mandate is also reflected in the Legislative Sunrise Review:

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.

CP 282. *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”). In contrast, there is

absolutely *nothing* in the legislative history of the Parity Act which suggests that the legislature wanted to exclude neurodevelopmental conditions or therapies from this broad mandate, as it expressly did for “substance related disorders” and “life transition problems.” RCW 48.44.341(1).

E. Neither the OIC Nor the DOH Has Adopted Premera’s Interpretation of the Parity Act.

Premera claims that the Court should defer to “agency interpretations” by the Department of Health (DOH) and Office of the Insurance Commissioner (OIC) that the Neurodevelopmental Therapy Mandate trumps the Parity Act. Premera Br., pp. 19-21. There are at least four problems with this argument.

First, agency deference is only accorded when a statute is ambiguous, and the Parity Act is not. *Postema v. Pollution Control Hearings Bd.*, 142 Wn. 2d 68, 77, 11 P.3d 726 (2000).

Second, the DOH Sunrise Review and OIC’s *inaction* are not “interpretive statements” by the agencies meriting any deference. RCW 34.05.010(8).

Third, as noted above, the DOH actually found that the Neurodevelopmental Therapy Mandate and the Parity Act likely work together (just as Judge Lasnik describes in *Z.D.*) to provide the services

sought in the 2009 Autism Services Mandate bill. CP 517 (“There are existing mandates that should be reviewed that may provide the coverage these families are seeking [for treatment for ASD]. These are the *neurodevelopmental therapy mandate and the mental health parity mandate.*”) (emphasis added).

Fourth, under RCW 48.18.510, Premera’s non-complying contract provisions are *automatically invalidated*, whether or not the OIC takes enforcement action. The statute ensures that the practical limitations on the OIC’s enforcement efforts (*i.e.*, limited staffing and funding) do not prevent courts from ensuring full compliance with the Insurance Code. *See Seattle-First Nat’l Bank v. Wn. Ins. Guaranty Assoc.*, 94 Wn. App. 744, 753, 972 P.2d 1282 (1999).

Nonetheless, the OIC is now taking true “agency action” in this arena. Late last year, the OIC has announced its first 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* (WSR) 12-22-070 (Nov. 7, 2012). More recently, the OIC has promulgated emergency rules that expressly *require coverage of neurodevelopmental therapies to treat DSM-IV conditions consistent with the mental health parity mandate*, as part of health care reform. *See* WSR 13-07-022, Emergency Rules, WAC 284-43-878(7)(c)(iii)

(March 12, 2013), p. 16 (“When habilitative services [speech, occupational and physical therapies] are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, *the mental health parity requirements apply...*”). The same language is also included in the OIC’s permanent rulemaking. *See* WSR 13-07-064 (March 19, 2013).

F. Premera’s Position Undermines the Mental Health Parity Act.

Even if both statutes could not be simultaneously followed—and they can—the Parity Act more accurately reflects present legislative intent with respect to insurance coverage for mental health services. Society has made progress towards understanding and addressing the inherent discrimination in a health care system which treats mental illness differently than physical illness since the 1989 Neurodevelopmental Mandate. The Parity Act, in fact, was widely recognized as the major accomplishment of the 2005 legislative session. *See* www.SeattleTimes.com/html/localnews/2002196411_parity04m.html (last visited 5/6/13).

This societal change, reflected in the plain language and legislative intent of the Parity Act itself, cannot be ignored:

Since legislative policy changes as economic and sociological conditions change, the relevant legislative acts

which are nearer in time to the enactment in question are more indicative of legislative intent than those which are more remote.

Connick v. City of Chehalis, 53 Wn.2d 288, 291, 333 P.2d 647, 649 (1958). *See also State v. Wright*, 84 Wn.2d 645, 650, 529 P.2d 453, 457 (1974) (“Also, the entire sequence of statutes relating to a given subject matter should be considered, since legislative policy changes as economic and sociological conditions change.”).

The Parity Act should be seen for what it is: an expression of contemporary public policy condemning discriminatory disparate insurance coverage practices which have historically infected health plans issued by Washington’s health carriers, including Premera. Premera’s coverage approach – a construction that would allow Premera to continue to exclude all coverage of the predominant treatment for developmental disabilities – would gut the Parity Act and undermine its very purpose. Premera seeks judicial approval for its continued discrimination against persons with developmental disabilities, something that the Parity Act was designed to end.

V. CONCLUSION

The Parity Act requires coverage of “Mental Health Services” – services which are “provided to treat mental disorders covered by [the DSM-IV-TR].” Neurodevelopmental therapy for autism is one such

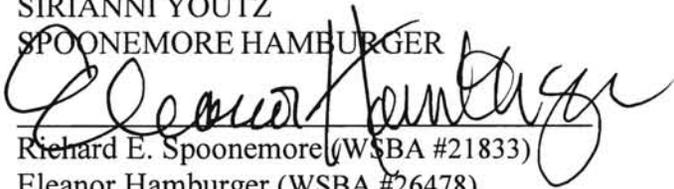
service. Under the Parity Act, Premera's exclusion of all such therapies, even when medically necessary to treat a DSM-IV-TR condition, is illegal and a breach of contract. The separate Neurodevelopmental Therapy Mandate, which only applied to group plans, does not change this result. Complying with the Parity Act does not create any conflict with the Neurodevelopmental Therapy Mandate. Premera can, and must, comply with both statutory requirements.

The decision of the trial court should be affirmed.

DATED: May 6, 2013.

SIRIANNI YOUTZ

SPOONEMORE HAMBURGER


Richard E. Spoonemore (WSBA #21833)

Eleanor Hamburger (WSBA #26478)

999 Third Avenue, Suite 3650, Seattle, WA 98104

Tel. 206.223.0303, Fax 206.223.0246

Email: rspoonemore@sylaw.com

ehamburger@sylaw.com

Attorneys for Respondent-Plaintiff A.G.

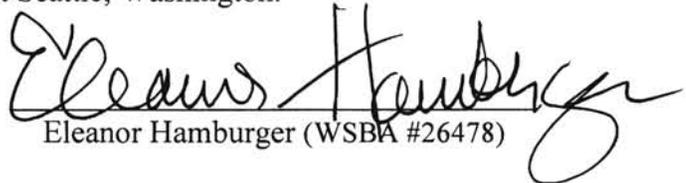
CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the State of Washington, that on May 6, 2013, a true copy of the foregoing RESPONDENT'S OPENING BRIEF was served upon counsel as indicated below:

Barbara J. Duffy
Gwendolyn C. Payton
Ryan P. McBride
LANE POWELL PC
1420 Fifth Avenue, Suite 4100
Seattle, WA 98101
Attorneys for Petitioners-Defendants

By United States Mail
 By Legal Messenger
 By Email
Tel. 206.223.7000
duffy@lanepowell.com
payton@lanepowell.com
mcbri@lanepowell.com

DATED: May 6, 2013, at Seattle, Washington.


Eleanor Hamburger (WSBA #26478)