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**NO. 69724-2-I**

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

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REGENCE BLUESHIELD,

Petitioners-Defendants,

v.

O.S.T., by and through his parents, G.T. and E.S.; and L.H. by and  
through his parents, M.S. and K.H., each on his own behalf and on behalf  
of all similarly situated individuals,

Respondents-Plaintiffs.

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**RESPONDENTS' OPENING BRIEF**

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## I. INTRODUCTION

Plaintiffs' health benefit plans, like others issued by defendant Regence Blue Shield ("Regence"), exclude coverage of neurodevelopmental therapies even when medically necessary to treat mental conditions listed in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-IV-TR").<sup>1</sup> This exclusion violates Washington's Mental Health Parity Act, RCW 48.44.341.<sup>2</sup> As a matter of law, neurodevelopmental therapies to treat covered DSM-IV-TR conditions are "mental health services" under the Parity Act and cannot be excluded.

This exact issue was adjudicated by Judge Robert Lasnik in similar litigation against Group Health Cooperative.<sup>3</sup> *See Z.D. v. Group Health Coop.*, 829 F.Supp.2d 1009, 1013-14 (W.D. Wash. 2011). Judge Lasnik determined that the Parity Act requires coverage of medically necessary neurodevelopmental therapies even when the explicit terms of the health

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<sup>1</sup> Regence's individual policies wholly exclude neurodevelopmental therapies. *See, e.g.*, CP 53; CP 22-23, ¶ 4. Regence's non-ERISA group policies exclude all coverage of neurodevelopmental therapies to persons over the age of six. CP 22-23, ¶ 4; CP 56.

<sup>2</sup> The Parity Act is actually four separate statutes. *See* RCW 48.44.341 (covering health care service contractors like Regence); RCW 48.46.241 (covering HMOs like Group Health Cooperative); RCW 41.05.600 (covering public employees' health benefit plans); and RCW 70.47.200 (covering the Basic Health Plan).

<sup>3</sup> All major health carriers in Washington use the same or similar exclusions in their health benefit plans. *See, e.g., Z.D. v. Group Health Cooperative*, No. 2:11-cv-01119 (W.D. Wash., J. Lasnik); *A.G. v. Premera Blue Cross et al.*, No. 11-2-30233-4 SEA (King Cty. Sup. Ct., J. Trickey).

benefit plan exclude that coverage. That is because the Mental Health Parity Act is incorporated into the terms and conditions of the contract:

It is true that the literal terms of the Plan, as written, do not require coverage for the mental health treatment of individuals over the age of six. ***The problem for Defendants lies in the fact that Washington law governs the Plan.*** And, as alleged by Plaintiffs, Washington law, specifically RCW 48.46.291(2) [the Mental Health Parity Act as applied to HMOs], requires Defendants to provide coverage for the mental health services at issue in this case.

*Id.* at 1012-13 (internal citations omitted, emphasis added).

Regence argues that neurodevelopmental therapies to treat DSM-IV-TR conditions are not “mental health services.” Its position is contradicted by the plain language of the Parity Act itself. Under the Act, if a service is provided to treat a DSM-IV-TR mental health condition, it is a “mental health service”:

“[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). These mental health services must be covered by health insurers such as Regence:

***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. v. Group Health*, 2012 WL 1997705, \*11 (W.D. Wn., June 1, 2012) (“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).

Despite the plain language of the Parity Act, Regence argues that since the Neurodevelopmental Therapy Mandate does not require coverage in individual plans (or for children older than six), Regence is excused from providing any coverage for mental health related neurodevelopmental therapy under the Parity Act. This is a non-sequitur. The fact that one statute does not mandate coverage in no way prevents another statute from requiring additional coverage. *Z.D.*, 829 F.Supp.2d at 1013 (“the mere fact that the statutes overlap does not mean that both cannot apply.”). Thus, Judge Lasnik concluded that the Parity Act expanded coverage of neurodevelopmental therapies beyond what was required under the Neurodevelopmental Therapy Mandate, RCW 48.44.450:

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.” [citations omitted] There does not exist even a close question as to whether there is a conflict between the statutes under established Washington law.

*Z.D.*, 2012 WL 1997705, \*10.

## **II. ISSUES PRESENTED**

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

Answer: Yes. The Parity Act requires that health carriers, such as Regence, 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],” Regence 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 Regence 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, Regence can – and therefore must – comply with the requirements of both statutes. *See Z.D.*, 829 F.Supp.2d at 1014.

### **III. STATEMENT OF THE CASE**

#### **A. Identity of Respondents.**

##### **1. O.S.T.**

O.S.T. is the seven-year-old son of G.T. and E.S. CP 1, ¶ 2. O.S.T. has been diagnosed with a feeding disorder and autism. CP 1-2, ¶¶ 4-5; CP 5-21. O.S.T. has received neurodevelopmental therapies (speech, occupational and physical therapy) to treat his feeding disorder,

phonological disorder and autism. CP 1-2, ¶¶ 6-9; CP 915, ¶ 5; CP 98-102. O.S.T.'s neurodevelopmental therapies were denied by Regence under the neurodevelopmental therapy exclusion in his Regence contract. CP 1-3, ¶¶ 7, 9; CP 686, ¶¶ 12, 13; CP 643-51. O.S.T.'s parents paid for the therapy services instead. CP 2-3; *see, e.g.*, CP 115.

## 2. L.H.

L.H., who is three years old, became insured under a Regence individual plan as of April 1, 2012. CP 1044; CP 1039, ¶ 14. L.H. was diagnosed with Expressive Language Disorder (DSM-IV-TR 315.31) before he moved to Washington. CP 1044; CP 629. This diagnosis was confirmed by Patricia Moroney, M.S., CCC-SLP, who also confirmed that L.H. requires neurodevelopmental speech therapy to treat the disorder.<sup>4</sup> CP 698, ¶ 4; CP 697-98.

Regence issued L.H. a policy describing his medical benefits. *See* CP 631. It excludes coverage of speech, occupational and physical therapies when those therapies treat “neurodevelopmental delays.”

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<sup>4</sup> Such assessment and evaluation is entirely consistent with Ms. Moroney's scope of practice. *See* WAC 246-828-105 (“licensed speech-language pathologists are independent practitioners who provide a comprehensive array of services related to the *identification, assessment, habilitation/rehabilitation of communication disorders* and dysphagia”). Ms. Moroney's evaluation and diagnostic conclusions regarding L.H.'s communication disorder is, in fact, the standard of practice in Washington State. CP 925-26, ¶ 8.

CP 635. *See also* CP 640 (definitions of “illness” and “injury” does “not include any state of mental health or mental disorder”).<sup>5</sup>

**B. Identity of Appellants.**

Regence is a licensed health care service contractor in Washington state, also known as a “health carrier.” CP 595-96, ¶ 3; CP 1037, ¶ 3; *see* RCW 48.43.005(23). As a “health carrier,” Regence issues “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....”).

**C. Regence Excludes Neurodevelopmental Therapy Services on its Contracts.**

The literal written terms of O.S.T.’s policy exclude neurodevelopmental therapy services. CP 53, Sect. 6.5.37 (under “LIMITATIONS AND EXCLUSIONS,” O.S.T.’s Regence contract lists “Treatment for neurodevelopmental therapy”). Likewise, L.H.’s Regence

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<sup>5</sup> Moreover, L.H.’s therapies cannot be covered under Regence’s rehabilitation benefit. That benefit is limited to only the provision of therapies to treat *injury* or *illness* (as defined by the Regence policy) to “restore” or “improve” lost function:

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to *restore or improve lost function* caused by *Injury or Illness*.

*Id.* p. 13 (emphasis added). *See also* CP 105 (Regence: “The contractual requirements for coverage under the rehabilitation benefit are not met, as the condition being treated is not the result of a specific injury, illness or congenital anomaly.... Criteria for speech therapy under the rehabilitation benefit is not met.”); CP 107.

contract excludes all neurodevelopmental therapies. CP 635. These are standard policy provisions on all of Regence's individual plans.<sup>6</sup> CP 22-23, ¶¶ 4-5.

#### IV. ARGUMENT

##### A. **Commissioner Neel *Rejected* Regence's Request To Add An Appeal of Standing Issues to this Discretionary Review.**

On March 21, 2013, Commissioner Mary Neel *denied* Regence's request for additional discretionary review on (1) the trial court's denial of Regence's Motion for Dismissal of Claims due to L.H.'s alleged lack of standing; and (2) the trial court's certification of a class. *See Appendix A, Notation Ruling*, dated March 21, 2013. Commissioner Neel's determination was provided to Regence well in advance of the due date for its opening brief, April 8, 2013. Despite the Notation Ruling, Regence argues that the trial court erred when it determined that O.S.T. and L.H. have standing to challenge Regence's Neurodevelopmental Therapy exclusion. Regence Br., pp. 10-14. ***This issue was never selected for discretionary review.*** As Commissioner Neel concluded:

Regence also seeks review of that part of the order denying its motion to dismiss standing ...

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<sup>6</sup> On its non-ERISA group plans, Regence excludes all neurodevelopmental therapies after the age of six. CP 22-23, ¶ 4.

Regence has raised debatable issues, but it has not demonstrated probable error that substantially alters the status quo or substantially limits its freedom to act. Even if Regence demonstrated probable error, *it does not make practice sense for this court to take review of these issues now*. As noted above, the fundamental mental health parity issue is pending in two cases which are expected to be heard by a panel of judges in July 2012. If the insurers prevail, it appears that the litigation will terminate. If the insureds prevail, the litigation will presumably go forward, although the possibility of settlement may increase. Moreover, *the issue before the court on appeal is a discrete, legal issue*. Even if the parties were to comply with the expedited briefing schedule and also address the issues of class certification and standing, allowing review of these issues would unnecessarily complicate the appeal and make a timely decision on the fundamental statutory/parity issue more difficult.

*Appendix A*, Notation Ruling, p. 2 (emphasis added).

Regence's arguments on standing and justiciability were never certified by the trial court for appeal, or approved for discretionary review by this Court. They are not properly part of this appeal.

**B. Regence's Blanket Exclusion of Neurodevelopmental Therapies Violates the Parity Act and Breaches Its Contracts.**

**1. 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 experienced by 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 74 (emphasis added).

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 119-20 (emphasis added). *See also* CP 145 (“[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 140 (“The impact on children and adolescents is particularly important....”)

*a. 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). *See also* CP 898 (Senate Bill Report). The coverage mandate is not linked to any

specific medical or surgical benefit, but to the existence of those services generally.

If Regence 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.<sup>7</sup> 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).<sup>8</sup>

The Parity Act therefore precludes an insurer from imposing blanket exclusions on a mental health care service because “that would

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<sup>7</sup> 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).

<sup>8</sup> 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.

defeat the very purpose of the statute: *providing coverage.*” *Z.D.*, 2012 WL 1997705, \*12 (emphasis added).

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

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, 4<sup>th</sup> 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.

Regence argues that, under a different statute, providers authorized to deliver speech, occupational and physical therapies are not “mental health providers.” *Regence Br.*, p. 17. From that premise, Regence argues that it is not required to cover any of the services rendered by speech, occupational and physical therapists under the Parity Act because

neurodevelopmental therapies can never be “mental health services.” Regence Br., pp. 17-18. There are at least three problems with this argument.

*First*, the statute that Regence relies upon – RCW 48.43.087 – is expressly limited to only that provision of the insurance code. RCW 48.43.087(1). It does not purport to define the scope of any obligations under other provisions of the code. In fact, that statute contains a definition of “mental health services” which is different than, and directly conflicts with, the definition contained in the Parity Act. *Compare* RCW 48.43.087(1)(d) *with* RCW 48.44.341(1).

*Second*, under Parity Act, coverage is triggered by the nature of the service, not the provider type. The Act mandates coverage of “*services* provided to treat mental disorders.” It does limit, in any way, the type or category of provider who may render those mandated services. As a result, a speech therapist providing medically necessary services to treat a DSM-IV-TR language disorder is, under the Parity Act, providing a “service” to treat a” mental disorder.” Under the plain language of the Act, that service must be covered. RCW 48.44.341(1), (2).

*Third*, Regence’s interpretation has been flatly rejected by the Office of the Insurance Commissioner (“OIC”). The OIC has promulgated emergency rules that require coverage of

neurodevelopmental therapies to treat DSM-IV-TR conditions consistent with the mental health parity mandate, as part of health care reform. *See* Washington State Register (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...*”) (emphasis added). The same language is also included in the OIC’s proposed permanent rulemaking. *See* WSR 13-07-064 (March 19, 2013). The OIC properly recognizes that the Parity Act’s retirements are triggered by the type of service received, not the provider category. If neurodevelopmental services are rendered to treat a mental health condition, then “the mental health parity requirements apply.”

*c. Neurodevelopmental Therapies are Key Forms of Intervention for DSM-IV-TR Developmental Conditions and Can Be Medically Necessary.*

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

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.

CP 84 (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. CP 503, ¶ 7 (“It is standard medical practice to have young children suspected of having autism evaluated by neurodevelopmental therapists, and if such evaluations reveal significant delays, treated with speech, occupational and physical therapy”). Regence’s own Executive Medical Director conceded neurodevelopmental therapies can be medically necessary.

CP 175, 177, ¶¶ 3, 10 (In plans with a neurodevelopmental therapy benefit, Regence covers the therapies when medically necessary).<sup>9</sup>

These therapies are so critical that coverage of speech, occupational and physical therapies was among the top priorities for the State's Autism Task Force. CP 90. The Washington Department of Health further concluded that neurodevelopmental therapies, including speech, occupational and physical therapies, are essential components of effective, early intervention for children with autism. CP 63 (*"Neurodevelopmental therapies are effective* in treating ASD [Autism Spectrum Disorders]"). So did the American Academy of Pediatrics and the U.S. Surgeon General. CP 96 ("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..."); CP 84 ("The goal of treatment is to promote the child's social and language development and

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<sup>9</sup> Regence appears to take the position that neurodevelopmental therapies are *never* covered because they do not "treat" DSM-IV conditions. CP 176, ¶ 5. As Dr. Cowan opines, there is no medical basis for Dr. Gifford's statement that neurodevelopmental therapies are not "treatment" for developmental DSM-IV-TR conditions. See CP 924, ¶ 4. "Like insulin therapy for diabetics, neurodevelopmental therapies address the fundamental symptoms of the conditions and can dramatically improve those symptoms." CP 924-25, ¶ 5. Even Dr. Gifford admitted that his opinion regarding the word "treatment" was not based on any contract language, specific scientific study, medical literature, consensus statement, or even his own experience as a medical practitioner, but upon *an extra-contractual, historical understanding of the word related to insurance company efforts to limit their liability*. CP 905-06.

minimize behaviors that interfere with the child's functioning and learning"). Courts around the country have also concluded that neurodevelopmental therapy can be medically necessary for treating children with autism, overriding insurer exclusions and denials of the therapies. *See, e.g., Markiewicz v. State Health Benefits Comm'n*, 915 A.2d 553, 561 (App. Div. 2007) ("[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 [ ] mental illnesses subject to the parity statute"); *Micheletti v. State Health Benefits Comm'n*, 913 A.2d 842, 851 (App. Div. 2007) (same); *Bails v. Blue Cross/Blue Shield of Illinois*, 438 F.Supp.2d 914, 929 (N.D. Ill. 2006); *Wheeler v. Aetna Life Ins. Co.*, 2003 WL 21789029 (N.D. Ill. 2003).

O.S.T. offered extensive evidence that his specific neurodevelopmental therapies were medically necessary. CP 5-21; CP 503-505; CP 106-109 (coverage of O.S.T.'s speech therapy was needed to avoid hospitalization). Regence offered no evidence to dispute this. In fact, none of the claims records produced by Regence show that O.S.T.'s therapies were ever denied based upon medical necessity. CP 108; CP 111-13; CP 115.

L.H. also produced evidence that neurodevelopmental therapies were medically necessary to treat his DSM-IV-TR conditions. CP 689, ¶¶ 2-4; CP 696-98; CP 925, ¶ 8. Again, Regence offered nothing in return.

## 2. Regence'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 literal written words of a policy do not comply with the requirements of state law, the law will supersede the literal 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 by statute 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 the policies of O.S.T. and L.H. as a matter of contract law:

SECTION 5.14 STATE LAW. This Contract is entered into and delivered in the State of Washington. To the extent state law is applicable, *Washington law will cover the interpretation of this Contract.*

CP 51 (emphasis added). Here, as in *Z.D.*, “[t]he 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). Regence has not only violated the Parity Act, it has breached its contract of insurance.

**3. Regence Must Comply With Both the Mental Health Parity Act and the Neurodevelopmental Therapy Mandate.**

Regence 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 advances two arguments to support this non-sequitur. First, it claims that the Neurodevelopmental Therapy Mandate is more specific, and therefore takes precedence over the Parity Act. Regence Br., p. 20. Second, it argues that the trial court, by giving effect to the Parity Act, “implicitly repealed” the Neurodevelopmental Therapy Mandate statute. Regence Br., pp. 21-24. Both arguments ignore longstanding Washington law on statutory construction.

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 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”).<sup>10</sup>

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

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<sup>10</sup> 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”). 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.*

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. *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 Regence suggests, an expression of legislative intent with respect to coverage of neurodevelopmental therapy services above the established minimum. Regence Br., p. 19 (erroneously asserting that “[b]ecause the neurodevelopmental-therapy statute allows health carriers to exclude neurodevelopmental therapies in individual contracts and limit them to preschool-aged children in non-employer-sponsored group plans, any mandate of greater coverage would require amendment or partial repeal of that statute.”). 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.

Simply because an insurer was, in 1985, impliedly “permitted” to deny neurodevelopmental mental health services to children on individual plans and over age six on group plans did not foreclose the operation of another statutory mandate, such as the Parity Act, from later requiring coverage. That later requirement did not “repeal” any part of the earlier mandate – it simply imposed an additional requirement upon insurers with respect to coverage for mental health services.

After the Mental Health Parity Act took effect (and it was extended to individual plans), health carriers were required to reconsider 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 comporting 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.

*Id.*

Regence does not get to choose which state mandate it wants to follow while ignoring the other. It is required to follow both. *Id.* 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 Regence’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.

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

***a. 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, Regence claims that subsequent legislative efforts to expand the age limit of Neurodevelopmental Therapy Mandate is proof that the Legislature never

intended to include neurodevelopmental therapies within the broad reach of the Parity Act. *Regence Br.*, p. 24-26. 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.”).

*Regence* 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 the DSM-IV-TR conditions of O.S.T. and L.H. The legislature expressed its intent in plain statutory language.

***b. 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 139.

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).

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

The failed efforts to expand the Neurodevelopmental Therapy Mandate and enact an autism coverage mandate cited by Regence show that the legislature recognized that the services sought in those bills *were already mandated* by the Parity Act, rendering the proposed legislation unnecessary.<sup>11</sup>

Starting in 2005, a task force worked on issues related to autism. In 2007, it issued a report recommending expanded coverage. After that report, in **2008** 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 Regence is a member – opposed the additional autism coverage mandates because it argued the Parity Act *already provided expanded coverage*:

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<sup>11</sup> For this reason, failed legislation is not evidence of legislative intent. Regence Br., pp. 24-25; *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”).

*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 487 (emphasis added); see <http://awhp-online.com/MemberProfiles/> (as of 3/18/12) (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 364-65. This case, and others like it, are providing the clarification that the DOH recognized was necessary.

*d. The Neurodevelopmental Therapy  
Mandate is Different Than the Parity Act.*

The Neurodevelopmental Therapy Mandate, unlike the Parity Act, is not restricted to children with 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 legislature 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. To the contrary, it merely suggests that Washington is considering raising the floor of required coverage even higher.

CP 461.

*e. 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 119-20 (emphasis added); *Spokane County Health Dist. v. Brockett*, 120 Wn.2d 140, 151, 839 P.2d 324 (1992) (“[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 139. *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).

**5. Neither the OIC Nor the DOH Has Adopted Regence’s Interpretation of the Parity Act.**

Regence 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 Act

trumps the Parity Act.<sup>12</sup> Regence Br., pp. 26-30. 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 364 (“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).

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<sup>12</sup> Regence also argues that the Court should defer to the “Caring for Individuals with Autism Task Force.” Regence Br., p. 27-28. Of course, a task force is not an agency entitled to deference, 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 ... the Task Force was convened primarily for the purpose of gathering information and providing recommendations.”).

*Fourth*, under RCW 48.18.510, Regence’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, as noted above, 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.” WSR 12-22-070 (Nov. 7, 2012). It also issued 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; *see* WSR 13-07-064 (March 19, 2013) (same proposed permanent rules).

**6. Regence’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 [http://seattletimes.com/html/localnews/2002196411\\_parity04m.html](http://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, such as Regence. Regence’s coverage approach – a construction which would results in the exclusion of *every* neurodevelopmental mental health service for insureds in the individual market, would gut the Parity Act and undermine its very purpose.

## V. CONCLUSION

The decision of the trial court should be affirmed. By its plain language, the Parity Act requires coverage of services which are “provided to treat mental disorders covered by [the DSM-IV-TR].” Regence’s exclusion of all neurodevelopmental therapies, even when medically necessary to treat a DSM-IV-TR condition, is illegal and a breach of contract.

The separate Neurodevelopmental Therapy Mandate does not change this result. Complying with the Parity Act does not create any conflict with the Neurodevelopmental Therapy Mandate. Regence can, and must, comply with both statutory requirements.

DATED: May 6, 2013.

SIRIANNI YOUTZ  
SPOONEMORE HAMBURGER

A handwritten signature in cursive script, appearing to read "Eleanor Hamburger", written over a horizontal line.

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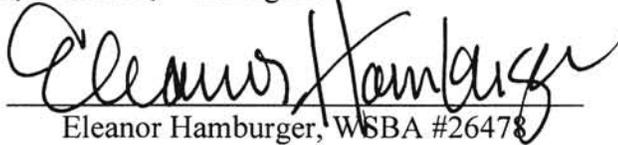
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**CERTIFICATE OF SERVICE**

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 OPPOSITION TO PETITIONERS' MOTION FOR DISCRETIONARY REVIEW was served upon counsel as indicated below:

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

  
Eleanor Hamburger, WSBA #26478



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CASE #: 69821-4-I  
Regence Blue Shield, Petitioner v. O.S.T et al, Respondents

Counsel:

The following notation ruling by Commissioner Mary Neel of the Court was entered on March 20, 2013, regarding petitioner's motion for discretionary review:

"This matter is one of several pending in state and federal trial courts and this court brought by plaintiffs, children who have been denied coverage for neurodevelopmental therapy (speech, occupational, behavioral and/or physical therapy), for the treatment of developmental delays and neurodevelopmental disabilities such as autism, based on a neurodevelopmental therapy exclusion in individual health plans purchased by their parents.

Plaintiffs take the position that the exclusion violates the Mental Health Parity Act, RCW 49.44.341, which requires that "all health service contracts providing health benefit plans that provide coverage for medical and surgical services" shall also provide "mental health services." The statute, enacted in 2005, did not apply to individual health plans until 2008.

The insurers argue that the exclusion is permitted by the earlier Neurodevelopmental Therapy Mandate, enacted in 1989, which provides that an "employer-sponsored *group* health contract for comprehensive health care service . . . shall include coverage for neurodevelopmental therapies for covered individuals under the age of six." (Italics mine) RCW 48.44.450. The insurers note that since 1989, they have offered *individual* health plans that exclude neurodevelopmental therapy benefits and that the policies are priced accordingly, i.e. the insureds pay a lower premium than they would absent the exclusion.

This fundamental issue is pending in this court in two cases that are in line to be heard by a panel of judges in the July 2013 term: O.S.T. v. Regence Blue Shield, No. 69724-2-I (review under RAP 2.2(d) based on trial court's CR 54(b) findings); and A.G. v. Premera Blue Cross and Lifewise of Washington, No. 68726-3-I (discretionary review granted under RAP 2.3(b)).

In the present matter, in December 2012 the trial court certified a class under CR 23(b)(3) of all individuals, who are covered or have been covered under a non-ERISA health plan, and have required or require neurodevelopmental therapy for treatment of a qualified mental health condition. Also in December 2012, the trial court granted in part and denied in part Regence's motion to dismiss plaintiffs' claims for lack of standing. The court granted the motion with respect to plaintiff O.S.T.'s claim for injunctive relief because he is no longer an insured, denied the motion with respect to O.S.T.'s claim for damages, and denied the motion with respect to L.H.'s standing for declaratory and injunctive relief.

Regence now seeks discretionary review of the class certification order, arguing that the predominance and superiority requirements for class certification are not met. Regence argues that individual issues will predominate over common ones and that the statutory independent review process (IRO) in chapter 48.43 RCW is superior to class action litigation. Plaintiffs respond that class claims predominate and that the IRO process is unavailable/unhelpful because reviewers' statutory authority is limited to determining medical necessity or appropriateness of treatment consistent with the scope of covered benefits in the medical plan, i.e. it does not include determining whether a plan meets state law. RCW 48.43.535. See Z.D. v. Group Health Cooperative, No. C11-1119RSL (W.D. Wash. June 1, 2011), 2012 WL 1977962.

Regence also seeks review of that part of the order denying its motion to dismiss standing as to L.H. Regence argues that L.H. has not been diagnosed with a DSM-IV condition by a properly licensed professional, i.e. a medical doctor, and that Regence paid L.H.'s claims under the rehabilitation benefit in his policy. L.H. responds that he has been diagnosed by his therapists with a DSM-IV mental health condition, expressive language disorder. He also argues that although some claims were paid under the rehabilitation benefit, they no longer are because it has a limit on the number of visits that would not apply if his claims were processed as a mental health benefit.

Regence has raised debatable issues, but it has not demonstrated probable error that substantially alters the status quo or substantially limits its freedom to act. Even if Regence demonstrated probable error, it does not make practical sense for this court to take review of these issues now. As noted above, the fundamental mental health parity issue is pending in two cases which are expected to be heard by a panel of judges in July 2012. If the insurers prevail, it appears that the litigation will terminate. If the insureds prevail, the litigation presumably will go forward, although the possibility of settlement may increase. Moreover, the issue before the court on appeal is a discrete, legal issue. Even if the parties were able to comply with the expedited briefing schedule and also address the issues of class certification and standing, allowing review of these issues would unnecessarily complicate the appeal and make a timely decision on the fundamental statutory/parity issue more difficult.

Alternatively, Regence asks that this court stay the trial court proceedings pending the appeals in O.S.T. v. Regence Blue Shield, No. 69724-2-I, and A.G. v. Premera Blue Cross and Lifewise of Washington, No. 68726-3-I. The trial court is in a better position to determine whether a stay is appropriate.

Therefore, it is

ORDERED that discretionary review is denied."

Sincerely,

A handwritten signature in black ink, appearing to read 'R.D. Johnson', with a long horizontal flourish extending to the right.

Richard D. Johnson  
Court Administrator/Clerk

c: Honorable John Erlick

ssd