



OFFICE OF
INSURANCE COMMISSIONER

October 20, 2014

To Health Insurance Issuers in Washington State:

I am sending you this letter to clarify your obligations in complying with *O.S.T. v. Regence Blueshield*, 88940-6, 2014 WL 5088260, a decision issued by the Washington State Supreme Court on October 9, 2014.

In the *O.S.T. v. Regence* case decision, the Supreme Court clarified the Washington State Mental Health Parity Act. The Court held that under the Act, health plan issuers may not use blanket exclusions to deny services used to treat mental health conditions, if those treatments may be medically necessary.

In order to implement this clarification of the law, the Office of Insurance Commissioner (OIC) will review all blanket exclusions contained in filings for the 2015 plan year to ensure that medically necessary mental health services will not be inappropriately excluded. Issuers will be instructed to change provisions in their proposed plans that do not comply with Washington State's Mental Health Parity Act.

For plans currently in effect, issuers are instructed to administer their plans consistent with the law. Issuers may not deny claims for services that may be medically necessary based on blanket or categorical exclusions, regardless of the current contract language. If current coverage forms include a blanket exclusion, issuers must notify current enrollees of the correct coverage standard.

For claims previously denied based on a blanket or categorical exclusion, Issuers are instructed to do the following:

- Identify claims submitted since January 1, 2006 (for large group plans) or January 1, 2008 (for small group and individual plans) in which a mental health service was denied based on a blanket or categorical exclusion;
- Send a letter to current and prior enrollees who submitted the claims identified above, notifying them of the Court's determination that blanket exclusions cannot be the basis for denying services that may have been medically necessary. The letter should notify the consumer of the issuer's process for re-evaluating those claims on the basis of medical necessity. If those claims are subject to a class action settlement, the letter should notify the consumer of the issuer's process for processing settlement claims;
- By November 1, 2014, provide the OIC with a draft of the template for the notice letter described above, for the OIC to review before the notice is sent to consumers;

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- On or before March 1, 2015, provide to the OIC:
 - The number of notice letters sent to consumers;
 - The number of consumers that responded to the notice letters by appealing the denial, or requesting that their claim be reevaluated; and
 - For each claim submitted for reevaluation, a description of the outcome of each reevaluation.

The Office of Insurance Commissioner will independently inform consumers that each carrier must implement a process for allowing improperly denied claims to be reevaluated, and will encourage consumers to contact our Insurance Consumer Hotline should they have complaints, questions or concerns.

Questions about this letter related to 2014 or 2015 filings should be directed to Molly Nollette, deputy commissioner for the Rates and Forms Division. Questions about this letter related to the reevaluation of past claims should be directed to AnnaLisa Gellermann, deputy commissioner for the Legal Affairs and Investigations Division.

Sincerely,

A handwritten signature in black ink that reads "Mike Kreidler". The signature is written in a cursive, flowing style.

Mike Kreidler
Insurance Commissioner