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Defending (and Defeating) Mental Health Parity and Addiction Equity Act Claims

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March 12, 2024

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Mental Health/Substance Abuse Crisis

- According to the 2022 HHS & SAMHSA National Survey on Drug Use and Health, in 2022:
  - 48.7 million Americans had a substance use disorder
  - 59.3 million suffered from mental illness
  - 4.8 million adolescents (19.5%) suffered from a episode of Major Depressive Disorder
  - 3.4 million adolescents (13.4%) had thoughts of suicide
- Numbers are growing

Principle Sources of Mental Health Parity Regulation

- 2008 Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) enacted (incorporated in ERISA, Public Health Act, and IRC), amended by Consolidated Appropriation Act of 2021 (“CAA”)
- 2013 Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “MHPAEA Regulations”)
- Technical Release 2023-01P
- Currently pending Proposed Revised MHPAEA Regulations
- Frequently Asked Questions (“FAQ’s”)
- MHPAEA Self-Compliance Tool
- State Mental Health Parity Acts

History of MHPAEA Regulation/Guidance

- 2008 MHPAEA enacted
- 2010 Affordable Care Act
- 2013 Tri-agencies issue the “MHPAEA Regulations” including the Nonquantitative (“NQTL”) regulations
- FAQ’s issued
- 2018 Self-Compliance tool
- 2021 Consolidated Appropriation Act added comparative analysis requirement
- Tri-agency reports to Congress
- Proposed regulations (still pending)

Text of MHPAEA

Covers mental health/substance use disorder benefits ("MA/SUD") offered by a group health plan. Does NOT mandate employers offer benefits (but subject to ACA mandates).

29 U.S.C. Section 1185a(a)(3):

> (A) In general: In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—
>
> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Text of MHPAEA (Continued)

(B) Definitions: In this paragraph:

(i) Financial requirement: The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses. . .

(ii) Predominant: A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation: The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

MHPAEA Regulations: "Quantitative" Limits

- Identify treatment classification (six different classifications: in-patient in-network, in-patient out-of-network, out-patient in-network, outpatient out-of-network, ER, drugs).
- Identify type of financial requirement/treatment limitation
  - Ask whether that same requirement/limitation is applied to "substantially all" M/S benefits in the classification
  - Ask what is the "predominant" version of that limit applicable to M/S benefits in the classification
- This is the "most restrictive" limit that can apply to MH/SUD benefits in that classification

29 C.F.R. § 2590.712(c)

MHPAEA Regulations: Nonquantitative Treatment Limits

- The 2013 MHPAEA Regulations also added a restriction on the use of Nonquantitative Treatment Limitations ("NQTL"):

"A group health plan (or health insurance coverage) may not impose a **nonquantitative treatment limitation** with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any **processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative** treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and **are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation** with respect to medical/surgical benefits in the classification."

29 C.F.R. § 2590.712(c)(4)(i)

2013 MHPAEA Regulations: Nonquantitative Treatment Limits

- What is an NQTL?
  - Medical necessity/experimental plan limits
  - Provider network admissions standards
  - “Step Therapy” or “First Fail”
  - Preauthorization/concurrent review requirements
  - Disparate reimbursement rates
  - Written treatment plan requirement
  - Licensure requirements

29 C.F.R. § 2590.712(c)(4)(ii)

2013 MHPAEA Regulations: Nonquantitative Treatment Limits

- The NQTL regulation does not require equal outcomes. Rather, it just requires that (*e.g.*,) the "evidentiary standards" used to determine what treatments are appropriate for MH/SUD benefits be applied equally and in parity with those used for M/S benefits.

- **"[P]rocesses, strategies, evidentiary standards, or other factors used in applying the nonquantitative** treatment limitation" to mental health benefits "are comparable to, and **are applied no more stringently than, the processes, strategies, evidentiary standards. . .** with respect to medical/surgical benefits."

- This can lead to significant variations in how MH/SUD benefits are administered as compared to M/S benefits
- *But see* Final Rules at 68,246-47 *("*[I]f a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit.")

2013 MHPAEA Regulations: Nonquantitative Treatment Limits

DOL FAQ Example 2:

(i) *Facts.* A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) *Conclusion.* In this *Example 2,* the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

2013 MHPAEA Regulations: Nonquantitative Treatment Limits

EXAMPLE 4.

(i) ***Facts.*** A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

(ii) ***Conclusion.*** In this *Example 4,* the plan complies with the rules of this paragraph (c)(4) because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. **This is the result even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.**

MHPAEA Regulations: Nonquantitative Treatment Limits

- Disclosure Requirements
  - "[C]riteria for medical necessity determinations"
  - "The reason for any denial . . . .of reimbursement or payment for services with respect to mental health or substance use disorder benefits."
  - "[T]he processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan."

MHPAEA: CAA Amendments

- CAA amended MHPAEA to require plans and insurers to perform and document a “comparative analysis” of the design and application of NQTL’s
- Rules for disclosure to regulators
- Provides for a correction process if it is found deficient
- FAQ, Part 45 (and the proposed new regulations) provides minimum standards for this analysis

MHPAEA: CAA Amendments

- The CAA's "comparative analysis" requires that plans and insurers:
  - Identify each NQTL and the MH/SUD and M/S benefit(s) to which the NQTL applies in each benefit classification
  - Identify the "factors" used in deciding that the NQTL will apply to MH/SUD and M/S benefits
  - Identify the "evidentiary standards" used to develop and apply the "factors" along with any other sources or evidence relied upon to design and apply the NQTL
  - Identify the comparative analysis showing parity between the processes and factors used for MH/SUD and M/S benefits
  - Identify the findings and conclusions reached by the plan or issuer regarding MHPAEA compliance
- CAA also required that the Tri-agencies submit a report to Congress analyzing plan/insurer comparative analyses
- Further details about the comparative analysis are found in FAQ 45
- DOL's position is that these documents must be provided to ERISA plan participants

2023 Proposed MHPAEA Rules

- August 3, 2023 Proposed Rules were released to (among other things) change NQTL standards
- Comment period closed in October
- No final rules have been issued

2023 Proposed MHPAEA Regulations

- Three new proposed NQTL rules (still retains the 2013 NQTL test):
  - **Substantially/Predominance Test**: NQTL cannot be "more restrictive" than the "predominant" NQTL applied to "substantially all" M/S benefits in the same classification
    - If the NQTL does not apply to 2/3 of M/S benefits in a class, it cannot be used for MH/SUB
    - Even if it does, it has to be the "predominant" NQTL variation applicable to M/S benefits in the classification
    - Based upon expected plan payments
  - Prohibition on "**discriminatory factors and evidentiary standards**" (*i.e.*, evidence that is "biased and non objective")
  - "**Mandated Use of Outcomes Data**" Requirement:
    - Must "collect and evaluate relevant data" to assess the impact of a NQTL on MH/SUD benefits
    - If there are "material differences" in "access" to MH/SUD benefits, this is a "strong indicator" of non-compliance
    - Must take "reasonable action" and document steps
    - Special Rule for network composition standards. Automatic violation of data shows "material differences in access to in-network" MH/SUD benefits as compared to M/S

2023 Proposed MHPAEA Rules

- Two Critical Exceptions:
  - **Independent Provisional Medical or Clinical Standards**: "Impartially applies independent professional medical or clinical standards" and does not deviate or modify them
  - **Fraud waste and abuse standards**: "reasonably designed to prevent fraud, waste and abuse. . . through objective and unbiased data." Also, "narrowly designed" to minimize the "negative impact" on access to MH/SUD benefits
- The "fraud, waste, and abuse" standard does not apply to "Mandated Use of Outcomes Data" rule
- Rigorous evidentiary standards
- How would these work in litigation?

2023 Proposed MHPAEA Rules: Other Issues

- Provides rules regarding the “comparative analysis” that Plans/insurers need to do under the CAA
- Named fiduciary of a plan must certify the comparative analysis

DOL Enforcement Priorities: Report to Congress

- DOL, HHS, Treasury: "Top Priority"
- EBSA's six priority areas
  - Prior authorization requirements for inpatient care
  - Concurrent care review
  - Standards for provider admissions
  - Out-of-network reimbursement rates
  - Adequate network standards for providers (*e.g.*, lack of in-network options)
  - Exclusion of certain MH/SUD treatments (e.g., ABA therapy, nutritional counseling for eating disorders)
- CMS is focused on prior auth/concurrent review and prescription drug classifications
- Focus on service providers—but plans are not off the hook
- Examples of situations where "corrections" were required:
  - Excluded residential treatment/allowed for skilled nursing
  - Required phone call to access EAP to determine whether EAP or network provider was best
  - Excluded methadone w/o comparative analysis. OK for M/S

DOL Enforcement Policies: Report to Congress

- EBSA has issued hundreds of letters to plans and insurers seeking comparative analyses
- State regulators in NY, Pennsylvania, California, Illinois, Oregon (*e.g.*,) have assessed fines against multiple insurers/TPAs
- The agencies are almost certainly just ramping up

DOL Enforcement Priorities: Report to Congress

- Common deficiencies in CAA Comparative Analysis Report
  - No report prepared
  - Lack of meaningful analysis of NQTL design and application (e.g., no background of evidence and factors)
  - Lack of analysis of network adequacy
  - Lack of analysis of outcomes (*e.g.*, rate of prior authorization denials)
  - Failure to identify how NQTL was applied in operation
  - Failure to look at MS side of comparison

Litigation Background

- In 2021, over 100 private lawsuits asserting a MHPAEA claim
  - Residential treatment
  - ABA therapy
  - “Wilderness therapy”
  - Facial violation vs. as applied
- One source suggests 50-60% of claims results in a favorable decision, although many decisions are on a MTD
- Types of cases
  - Individual claims for benefits
  - Provider “mass actions”
  - Class actions
  - Government enforcement actions

Significant Settlements of Mental Health Parity Lawsuits

- A major California insurer paid $7 million to settle claims based upon medical necessity guidelines
  - Challenged in house Medical Necessity Criteria Guidelines
  - For example, they imposed (*e.g.,*) a “fail first” rule, which was allegedly inconsistent with prevailing medical standards
- The DOL worked with New York’s AG to obtain a $15+ million settlement
- California settled a state parity act claim for $200 million

Litigation Issues

- Litigation issues:
  - Standard for MHPAEA claim
  - Disclosure issues
  - Statuary basis for claim & remedy issues

Standard for Parity Act Claim: *E.W. v. Health Net Life Ins. Co.*, 86 F.4th 1265 (10th Cir. 2023)

- Standard for pleading MHPAEA Claim (stipulated)
  - Plausibly allege that the plan is subject to MHPAEA
  - Identify a specific treatment limitation on mental health or substance-use disorder benefits covered by the plan.
  - Identify medical or surgical care covered by the plan that is analogous to the mental health or substance abuse disorder care for which the Plaintiff seeks benefits
  - Plausibly allege a disparity between the treatment limitation on mental health or substance abuse disorder benefits as compared to the limitations that defendants would apply to the medical or surgical analog.
- "MHPAEA itself does not explicitly require a comparison between *analogous* forms of treatment, but such a requirement is implicit."
- "Plaintiffs plausibly alleged that care in inpatient skilled nursing facilities and residential treatment centers are analogues for purposes of MHPAEA."

Standard for Parity Act Claim: *K.K. v. Premera Blue Cross*, 2023 U.S. Dist. LEXIS 101944 (W.D.W.A. June 12, 2023)

- Granted summary judgment against the MHPAEA claim
- Treated as a stand alone claim under ERISA Section 502(a)(3)
- Comparison between "residential mental health" and "inpatient skilled nursing"
- The court granted summary judgment because the MHPAEA "does not require that the . . . treatment criteria be the same....All that the Parity Act requires is that the process in determining how best to treat behavioral verses medical disorders be based on a similar level of evidence and support."
- Noted issues with remedy under ERISA Section 502(a)(3)

Disclosure Issues

- MHPAEA includes its own disclosure requirements
- ERISA Section 104(b)
  - Requires a plan to disclose to participants "instruments under which the plan is established or operated."
  - $100/day penalty for failing to do so (at the discretion of the Court)
  - DOL believes that MHPAEA documents should be disclosed under this provision
  - *M.S. v. Premera Blue Cross,* 553 F. Supp. 3d 1000 (D. Utah 2021) (imposing $123,100 fine for failure to produce medical necessity criteria under ERISA Section 104(b))
- ERISA claims procedures separately require that a fiduciary provide documents "relevant" to the claim. *E.g.,* 29 CFR § 2560.503-1(h)(2)(iii)
- Potential litigation consequences
  - Administrative record issues
  - Establish M/S comparison and reason for imposing NQTL on MH/SUD benefit
  - Failure to produce "plan documents" creates separate claim under ERISA Section 104(b)
  - Disclosure failures can affect Rule 12 motion. *See E.W. v. Health Net Life Ins. Co.,* 86 F.4th 1265 (10th Cir. 2023)

Statutory Basis for Claim, Procedural Rules & Remedy Issues

- What is the statutory basis for a MHPAEA claim? ERISA Section 502(a)(1)(B) or Section 502(a)(3)
- ERISA Section 502(a)(1)(B):
  - "Claim for benefits" under the Plan
  - Statutory law arguably is a implied term of the Plan (and might be incorporated in its written terms)
  - Decided on the administrative record under a discretionary standard
  - *Kathleen T. v. Cigna Health & Life Ins. Co.,* 2021 U.S. Dist. LEXIS 191269 (N.D. Ill. June 15, 2021)
- Growing number of Courts hold that the claim under ERISA 502(a)(3):
  - Restrictions on discovery?
  - Discretion? *K.K. v. Premera Blue Cross,* 2023 U.S. Dist. LEXIS 101944 (W.D.W.A. June 12, 2023)
  - But what remedy is available?

Statutory Basis for Claim, Procedural Rules & Remedy Issues

- Proceeding under Section 502(a)(3) may well benefit defendants
  - Administrative record is often deficient—Defendant might need additional production
  - Less important to address during administrative process
  - Remedy issues (see next slide)
  - Can still argue discretion (but that is challenging)
  - But risk that a court could hold that this is improper

Statutory Basis for Claim, Procedural Rules & Remedy Issues

- If the Parity Act claim is raised under ERISA Section 502(a)(3), what is the appropriate remedy? That section of ERISA is limited to "equitable relief"
- *M. S. v. Premera Blue Cross*, 553 F. Supp. 3d 1000 (D. Utah 2021)
  - Supplemental briefing about the remedy
- Remand? Reprocessing? Surcharge? Unjust enrichment?
- One reason why Defendants might agree that (a)(3) is the appropriate vehicle for pursuing a Parity Act claim.

State Analog Parity Statutes

- Many states have enacted mental health parity statutes
- NY: Timothy's law
  - Mandates certain minimum coverage terms for group health plans
  - Premiums and cost sharing services must be consistent with M/S benefits
- CA: Mental Health Parity Act
  - Broad mandates for coverage for MH/SUD benefits
- Very likely preempted by ERISA with respect to self-funded plans

Strategies for Winning MHPAEA Claims

- As is often the case in ERISA claims, success in litigation often depends on prelitigation preparation
- Draft plan documents/disclosure documents in light of litigation, and for use on Rule 12/Rule 56 motions
- Create internal process for disclosing documents under ERISA
- Decide how to address MHPAEA claims at administrative level and create an appropriate process to resolve same
- In litigation
  - Use (and prepare) disclosure documents on a Rule 12 motion
  - Evaluate and
  - Consider arguments for abuse of discretion review
  - Create template responses to common allegations
  - Consider in house experts

Questions?

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