Breakout Sessions – Series 5

EVEN MONEY

AVOIDING MENTAL HEALTH PARITY PITFALLS IN YOUR HEALTH PLAN

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It is a reasonable question to ask why employers, in-house attorneys, human resource professionals, plan fiduciaries, and plan sponsors should be interested in the federal mental health parity laws (“Parity Act”). The answer is found in the opioid addiction crisis in the United States and the increased need for mental health treatment. These both place one on notice that it is more important than ever to craft employee welfare benefit plans that comply with the Parity Act and that also remain financially stable and provide the coverage intended by the plan sponsor. This challenge is made more complex by the fact that district court opinions are expanding the application of the Parity Act and in doing so, have raised issues that must be addressed by plans. This paper first gives an overview of the history and basic application of the federal mental health party laws and then discusses the case law that plan administrators and sponsors must understand to navigate the Parity Act.

**Mental Health Parity Act of 1996**

Federal regulation of the mental health benefits in employer group health plans largely began with Congress’ enactment of the MHPA in 1996. Prior to the MHPA, most group health plans either excluded coverage of mental health benefits or covered them under far less generous terms and with substantially more restrictions than were applied to non-mental health benefits. To address this, the MHPA prohibited plans from establishing lower annual or lifetime benefit limits for mental health benefits and required large employer group health plans that covered mental health benefits to combine annual or lifetime limits so that they applied to both mental health and medical/surgical benefits.

**Mental Health Parity and Addiction Equity Act of 2008**

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA” or “Parity Act”) was signed into law on October 3, 2008, and expanded or superseded the parity provisions that were created under the MHPA. The MHPAEA also extended the MHPA’s parity provisions to substance use disorder benefits.

A. **Financial and Treatment Requirements.** Under the MHPAEA, plans may not impose more restrictive cost-sharing or treatment limitations on mental health and substance use disorder benefits (collectively referred to as “MH/SUD” benefits). Although plans are not required to provide MH/SUD benefits, if the plan chooses to, it may not impose more restrictive annual or lifetime benefit limits, financial requirements, or treatment limitations for MH/SUD benefits than those that apply to medical and surgical benefits (“Medical/Surgical”).

- **Annual or Lifetime Benefit Limits:** Plans may not impose annual or lifetime limits on benefits for MH/SUD that are more restrictive than those for Medical/Surgical.

- **Financial Requirements:** Plans cannot impose more restrictive financial requirements, including deductibles, co-pays, coinsurance, and out-of-pocket maximums on MH/SUD benefits than those that apply to “substantially all” Medical/Surgical benefits.

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1 According to the National Alliance of Mental Health website, approximately 1 in 5 adults in the United States experience mental illness in a given year; approximately 1 in 25 adults experience a serious mental illness in a given year that substantially interferes with or limits one or more major life activities; and approximately 1 in 5 youth ages 13 to 18 experience a severe mental disorder at some point during their life.
• **Treatment Limitations:** Plans cannot impose more restrictive treatment limitations on MH/SUD benefits than on Medical/Surgical benefits. Treatment limitations include those that can be expressed numerically, such as the number of covered visits, as well non-numerical limits, such as medical management standards, admission to provider networks, or “step therapy” requirements. Those that can be expressed numerically are referred to as “quantitative treatment limitations” and non-numerical limitations are referred to as “non-quantitative treatment limitations.”

**B. Network Parity.** The MHPAEA requires parity for access to out-of-network providers. If a plan covers Medical/Surgical benefits both in and out-of-network, and it also provides MH/SUD benefits, the plan must also provide MH/SUD benefits both in and out-of-network.

**Enforcement**

Self-funded private sector employer group health plans are subject to mental health parity enforcement by Department of Labor (DOL) and the Internal Revenue Service (IRS). The Department of Health and Human Services (“HHS”) has enforcement authority over self-funded non-federal governmental group health plans. The IRS has enforcement authority over self-funded non-ERISA church plans. Insured plans fall under the enforcement authority of state insurance departments; however, a handful of states, including Alabama, Missouri, Oklahoma, Texas, and Wyoming have determined that their insurance commissioners lack authority to enforce the MHPAEA, and therefore HHS has jurisdiction over insured plans in those states. For those states that have state laws imposing stricter MH/SUD parity requirements, the MHPAEA permits those state laws to be enforced.²

**General Discussion of the Parity Act by the Courts**

Although the Parity Act is complex in its application, the intent of the law is simple. According to the court in *Joseph F. v. Sinclair Servs. Co.*, 158 F. Supp. 3d 1239, 1262 (D. Utah 2016), if a plan provides MH/SUD benefits, it “must do so on a level that is on par with the benefits it provides for medical and surgical benefits. And once provided, the Parity Act prohibits imposing treatment limitations applicable only to mental health benefits.” “Essentially, the Parity Act requires ERISA plans to treat sicknesses of the mind in the same way that they would a broken bone.” *Munnelly v. Fordham Univ. Faculty*, 316 F.Supp.3d 714, 728 (S.D.N.Y. 2018).

To achieve its statutory objective, the Parity Act “requires group health plans and health insurance issuers to ensure that the financial requirements (deductibles, copays, etc.) and treatment limitations applied to mental health benefits be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan or insurance.” *New York State Psychiatric Ass’n, Inc. v. UnitedHealth Grp.*, 798 F.3d 125, 128 (2d Cir. 2015)(citing 29 U.S.C. § 1185a(a)(3)(A)).

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² The 21st Century Cures Act (“Cures Act”) was signed into law on December 13, 2016 and resulted in increased focus on and enforcement of federal mental health parity requirements. Though the Cures Act does not expand on the MHPAEA’s requirements, it directed HHS, DOL, and IRS to issue compliance guidance, including illustrative examples, and called for increased coordination between federal and state authorities in enforcing mental health parity rules. The Cures Act also requires that, when a group health plan or insurer is found to have violated the mental health parity rules five times, the DOL, HHS, or IRS, as applicable, must audit the plan or insurer to help improve compliance with the rules. The Cures Act made one substantive “clarification” to the existing mental health parity rules. If coverage is offered for eating disorder treatment, then the treatment (including residential treatment) must be provided consistent with the mental health parity rules.
Plan must provide MH/SUD benefits in any classification of benefits in which Medical/Surgical benefits are provided. There are six classifications: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. For plan years beginning on or after July 1, 2014, office visits may be placed into a separate subclassification from all other outpatient items and services for benefits provided on an outpatient basis. So, if the plan provides MH/SUD benefits, it must provide those benefits in each category in which Medical/Surgical benefits are provided and, as noted above, there must not be any quantitative or non-quantitative differences.

Courts have consistently found that a plan cannot apply any treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant treatment limitation of that type applied to substantially all Medical/Surgical benefits in the same classification. See, Danny P. v. Catholic Health Initiatives, 891 F.3d 1155, 1158 (9th Cir. 2018) (“Nevertheless, as we read, interpret, and fill any gap in the language of the Parity Act, we are satisfied that [the Parity Act] precludes the Plan from deciding . . . that it will provide room and board reimbursement at licensed skilled nursing facilities for medical and surgical patients, but will not provide room and board reimbursement at residential treatment facilities for mental health patients.”); Munnelly v. Fordham Univ. Faculty, 316 F. Supp. 3d 714, 733 (S.D.N.Y. 2018) (“Here, the Plan’s exclusion regarding residential treatment services applies across the board, whether a provider is in-network or out-of-network. . . . Because (1) residential treatment services are only provided to treat mental health conditions, and (2) there is no corresponding limitation on analogous treatment for medical/surgical conditions, the Plan’s residential treatment services exclusion runs afoul of the Parity Act’s express requirements.”) These statements appear simple on their face but are complex in their application which has resulted in a number of interesting cases surrounding the attempts by plans to exclude or limit benefits for wilderness therapy.

The Expansion of the Application of the Parity Act

A. The Blanket Exclusion

Plans have attempted to excluded wilderness therapy altogether, taking the position that this is compliant with the Parity Act because wilderness therapy is excluded from Medical/Surgical as well as MH/SUD. The court in Welp v. Cigna Health & Life Ins. Co., 2017 WL 3263 *5 (S.D. Fla. July 20, 2017) dismissed a Parity Act claim because the exclusion applied equally to MH/SUD and Medical/Surgical. This appears to be a simple solution.

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3 26 C.F.R. § 54.9812-1(c)(iii)(C).
4 According to the court in Joseph F. v. Sinclair Servs. Co., supra, 158 F. Supp. 3d at 1260, the “rules also clarify that the term “treatment limitations” includes both “quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan.” The parity requirement governing nonquantitative treatment limitations provides: 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, except to the extent that recognized clinically appropriate standards of care may permit a difference.”
However, given the current state of the law as explained below, it is unlikely that a plan administrator or plan sponsor will succeed in complying with the Parity Act with a blanket exclusion. The plaintiffs’ bar has been successful in overcoming a blanket exclusion by arguing that the practical effect of a blanket exclusion results in a disproportionate impact on MH/SUD coverage because wilderness therapy is used only to treat MH/SUD.

In *B.D. v. Blue Cross Blue Shield of Georgia* 2018 WL 671213, at *10 (D. Utah Jan. 31, 2018), the plan covered skilled nursing facilities, rehabilitation services and hospice care, and covered residential treatment centers if required by law. The administrator’s interpretation of this plan term was that the plan was not required by law to cover residential treatment centers. This violated the Parity Act because the practical effect of this interpretation was that plaintiffs received less coverage for mental health services than another participant would have received for medical/surgical benefits since residential treatment was used to treat MH/SUD. These statements appear simple on their face but are complex in their application which has resulted in a number of interesting cases surrounding the attempts by plans to exclude or limit benefits for wilderness therapy.

Similarly, in *Michael D. v. Anthem Health Plans of Kentucky, Inc.* No., 2019 WL 586673, at *8 (D. Utah Feb. 13, 2019), the court concluded that a violation of the Parity Act can arise when the effect of a limitation imposes a limit on mental health treatment that does not apply to medical or surgical treatment. In other words, the exclusion of wilderness therapy had an inordinate impact on mental health because wilderness therapy is only used in the treatment of mental health.” *Id.* at *9.

**B. The Analogue Coverage Theory**

The plaintiff’s bar, in challenging MH/SUD exclusions or limitations, also has focused on showing that there is an analogue coverage on the Medical/Surgical side that is treated differently than the MH/SUD coverage in question. In other words, if plaintiff is challenging an exclusion of residential treatment, the plaintiff must find an analogue coverage on the Medical/Surgical side that is the equivalent of residential treatment that is being covered by the plan. This violates the Parity Act because the coverage for Medical/Surgical is more expansive than the coverage for MH/SUD.

This approach was not successful in in *Roy C. v. Aetna Life Ins. Co.* 2018 WL 4511972, at *1 (D. Utah Sept. 20, 2018). There, the plan excluded coverage for wilderness therapy, defining “wilderness therapy” as “[w]ilderness treatment programs (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.” *Id.* at * 1. In addition, in the definition of Residential Treatment Facility (Mental Disorders), the plan expressly stated that one of the conditions was that the facility “[w]as not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.” *Id.*

The court determined that “[b]ecause the Parity Act targets limitations that discriminate against mental health and substance abuse treatments in comparison to medical or surgical treatments, to survive the dismissal of a Parity Act claim, a plaintiff must allege a medical or surgical analogue that the plan treats differently than the disputed mental health or substance abuse service.” *Id.* at 83. The court dismissed plaintiff’s complaint, determining that plaintiff had “failed to sufficiently identify a comparison or analogue to wilderness treatment in the medical
and surgical fields of treatment.” *Id.* at *3. The plan provided mental health services on both an inpatient and outpatient basis, including hospitalization, residential treatment, partial hospitalization, and intensive outpatient treatment as required by the Parity Act. It just did not provide coverage for wilderness treatment programs. *Id.*

This theory also was not successful in *A.H. by & through G.H. v. Microsoft Corp. Welfare Plan*, 2018 WL 2684387, at *4 (W.D. Wash. June 5, 2018). There, the plan excluded “educational or recreational therapy or programs; [including] wilderness programs.” *Id.* at *7. This exclusion applied to wilderness programs; the plan provided coverage for medically necessary treatment received in the wilderness if the treatment was provided by an eligible provider. Plaintiff alleged that this exclusion violated the Parity Act because wilderness programs were appropriately classified as intermediate services in the context of mental health treatment, and was analogous to skilled-nursing facilities and rehabilitation hospitals in the medical/surgical context which were services fully covered under the plan. The court held that the plaintiff had not alleged a violation of the Parity Act, concluding that plaintiff did not “point to anything in the Plan or the administrative record that show[ed] the wilderness program exclusion [was] only applied to mental health treatment.” *Id.* at *7. Defendants pointed out that wilderness programs and other recreational therapy were used to treat injuries and illnesses aside from mental health or substance abuse issues.

However, other courts have found that the “analogue” theory was enough for a plaintiff to overcome a motion to dismiss the complaint. In *Vorpahl v. Harvard Pilgrim Health Ins. Co.*, 2018 WL 3518511, at *1 (D. Mass. July 20, 2018), the plan denied the claim based on plan language that excluded from coverage “[h]ealth Resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including services provided in conjunction with, or as part of, such programs.” The court succinctly defined the issue as “whether the exclusion for ‘wilderness programs’ is an exclusion that applies equally to medical/surgical benefits and mental health or substance use disorder benefits.” *Id.* at *3. Plaintiffs alleged that the plan violated the Parity Act by covering Medical/Surgical benefits provided in the category “inpatient treatment” (rehabilitation hospitals and skilled nursing facilities) and not covering wilderness programs which were the equivalent intermediate treatment. The court held that this allegation stated a claim for relief under the Parity Act. Allegedly, the wilderness programs were analogous to the inpatient treatment and the plan covered one, the inpatient treatment, and did not cover the other, the wilderness programs.

Similarly, in *A.Z. by & through E.Z. v. Regence Blueshield*, 333 F. Supp. 3d 1069, 1072 (W.D. Wash. 2018), patient A.Z. suffered from depression that got so acute that her treating physicians proscribed treatment at a licensed outdoor wilderness residential mental behavioral health program in Oregon called Evoke. A.Z.’s claim and appeal were denied because the plan did not cover a wilderness program. The plan excluded “[s]ervices for counseling in the absence of illness, not expressly described in this plan as a Covered Service.” *Id.* at 1076. The plan provided specific examples of non-covered services, including “educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program (EAP) services; [and] wilderness programs.” *Id.*

It is important to remember that in ruling on a motion to dismiss, the court assumes that the allegations in the complaint are true. The court’s role on a motion to dismiss is limited to determining if, based on the facts alleged, the plaintiff has stated a claim under the Parity Act.
Plaintiff contended that, since Evoke's wilderness program was an organized program licensed by the State of Oregon, it fell squarely within the definition of Residential Care provided by the Plan. Using the "analogue" argument, plaintiff alleged that the plan excluded coverage of outdoor/wilderness behavioral healthcare programs for mental illnesses, even though it covered medical treatment provided in other types of intermediate residential programs, such as skilled nursing care. The court concluded that plaintiff had stated a claim under the Parity Act because she alleged that the plan “categorically denied, in practice, coverage for medically necessary services at outdoor/wilderness behavioral healthcare programs” while covering medically necessary treatment in analogous medical/surgical services. *Id* at 1082. 6 The plan allegedly used “medical necessity” as a nonquantitative treatment limitation.

Again, in *Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248, 253 (S.D.N.Y. 2018), the court held that plaintiff had stated a claim for relief under the Parity Act based on the "analogue" theory. There, the plan took the position that wilderness therapy was not covered under the plan. Plaintiff sued, on behalf of himself and other similarly-situated plan participants, whose claims for wilderness therapy coverage have been denied. Plaintiff alleged that the plan's blanket exclusion of wilderness therapy violated the Parity Act. The court concluded that plaintiffs’ allegations survived a motion to dismiss, holding that “the relevant comparison is not whether benefits for wilderness therapy are available for medical/surgical patients, but rather whether the Plan has chosen to provide benefits for skilled nursing facilities and rehabilitation centers for medical/surgical patients, but chosen to deny benefits to those with mental health conditions who seek coverage for a residential treatment center offering wilderness therapy.” *Id* at 258.

**Analysis**

The courts are increasingly willing, at least at the pleading stage, to find analogue coverages that allow plaintiffs to state a claim for violation of the Parity Act. At this point, the most effective way for plan administrators and plan sponsors to navigate this difficult issue is to make sure the plan carefully defines the coverage grants and ensures that the coverage grants are the same for MH/SUD and Surgical/Medical. For example, the coverage grant could include medically necessary treatment provided by an eligible provider. Whatever coverage granted is crafted, it needs to apply across the board to all classifications of coverage. In addition, therapies that come within the coverage grant, including wilderness therapy, are covered. At the same time, a carefully worded plan provision can exclude from coverage “treatment” that does not meet the coverage grant such as educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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6 The court cited 29 C.F.R. § 2590.712(i) which states that “[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
If medically necessary treatment is provided equally across the plan, both MH/SUD and Medical/Surgical, it is more likely that a carefully crafted exclusion will be enforced. This type of approach will always be subject to the argument that the exclusion, as a practical matter, impacts MH/SUD coverage more adversely than Medical/Surgical. However, this argument can be addressed by showing that the standard for both MH/SUD and Medical/Surgical is to cover medically necessary treatment in each classification.
Even Money: Avoiding Mental Health Parity Pitfalls in Your Health Plan

Presenters
Sean P. Nalty (San Francisco) and Timothy J. Stanton (Chicago)

Moderator
Stephanie A. Smithey (Indianapolis)

Our Agenda

- MHP Compliance – Nuts and Bolts
- Recent Federal MHP Developments
- What Are Courts Actually Doing?
  - Wilderness Therapy
  - ABA Therapy
  - Other
- Key Takeaways for Plan Sponsors
Mental Health Parity Law – Nuts & Bolts
MHPAEA – Nuts & Bolts

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Generally requires parity in medical/surgical benefit and health/substance use disorder benefits:
  - **Annual or lifetime limits** (not as relevant post-ACA)
  - **Financial requirements and quantitative treatment limitations** (e.g., deductibles, copays, limits on frequency or number of visits, limits on periods of coverage, waiting periods)
  - **Nonquantitative treatment limitations** (e.g., processes, strategies, evidentiary standards, other factors in connection with mental health and substance use disorder benefits)
- General Rule: No permissible separate treatment limitations for mental health/substance use disorder benefits

Financial Requirements and Quantitative Treatment Limitations
Financial Requirements & QTLs – Basics

- A financial requirement or quantitative treatment limitation can be applied to MH/SUD only if the limit also applies to “substantially all” of the medical/surgical benefits in that classification.
- And then the FR or QTL can only be applied at a level that is no more restrictive than the “predominant” level used for medical/surgical.

What???

Financial Requirements & QTLs – Key Terms

- Financial Requirements
- Quantitative Treatment Limitations
- Substantially all (two-thirds)
- Predominant level
How Would This Apply to Your Plan?

- Deductible or copayment (FR)
- Limitations on number of visits (QTL)
- Exclusion of all treatment for certain condition
- Exclusion of all MH/SUD benefits within one of the six classifications

Nonquantitative Treatment Limitations
NQTL – Our General Rule

- Plans (in terms and in practice) can’t have separate treatment limitations only for MH/SUD
- Plans can only use processes, strategies, evidence standards, or other factors to apply a NQTL to MH/SUD if those factors are similar to and applied no more strictly than they are to medical and surgical benefits in a classification
- *What???

NQTLs – Key Terms

- Nonquantitative Treatment Limitations
- Process, strategies, evidentiary standards, and other factors
How Would This Apply to Your Plan?

- Medical Necessity
- Experimental or Investigational Exclusions
- Scope of Services

Other Recent MHP Developments

- Eating disorders (21st Century Cures Act)
- DOL model disclosure letter
Blanket Exclusions

- Successful if applied equally across all plan benefits
- Unsuccessful if there is a disproportionate impact on MH/SUD coverage

The Analogue Coverage Theory

- The argument is that there is an analogue coverage on the medical/surgical side that is treated differently than the MH/SUD coverage
- So far most courts have addressed this argument at the pleading stage
- This argument will expand the reach of mental health parity if the allegations can be proven
Analogue Coverage Theory Not Successful

- The court dismissed plaintiff’s complaint, determining that he had “failed to sufficiently identify a comparison or analogue to wilderness treatment in the medical and surgical fields of treatment.” *Id.* at *3

- The court rejected plaintiff’s claim, holding that plaintiff did not “point to anything in the Plan or the administrative record that show[ed] the wilderness program exclusion [was] only applied to mental health treatment.” *Id.* at *7.
Analogue Coverage Theory Successful

  - Plaintiffs alleged that the plan violated the Parity Act by covering medical/surgical benefits provided in the category “inpatient treatment” (rehabilitation hospitals and skilled nursing facilities) and not covering wilderness programs which were the equivalent intermediate treatment.

  - Plaintiff alleged that the plan excluded coverage of outdoor/wilderness behavioral healthcare programs for mental illnesses, even though it covered medical treatment provided in other types of intermediate residential programs, such as skilled nursing care.
Analogue Coverage Theory Successful

- The court found that the relevant comparison is not whether benefits for wilderness therapy are available for medical/surgical patients, but rather whether the Plan has chosen to provide benefits for skilled nursing facilities for medical/surgical patients and chosen to deny benefits for residential treatment centers offering wilderness therapy.

- Generally accepted standards of care for the treatment of patients suffering from a mental health or substance abuse disorders.
Key Takeaways for Plan Sponsors

- Clear plan and SPD language
- Ask questions of your claims administrators
- Be alert to participant complaints and challenges in this area – causes?
- How would your plan respond to a DOL-style disclosure request?
- Does the plan have any special treatment rules or limitations for MH/SUD?

Key Takeaways for Plan Sponsors

- How were our standards of care developed?
- Will blanket exclusions work?
- How to confront the analogue coverage theory?
- How to respond to *Wit v. United Behavioral Health*?
- Has claims administrator told us anything about its conflict of interest/ERISA fiduciary protections?
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