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View From Proskauer: Developing Issues and Litigation Arising Under the Federal Mental Health Parity Act and the Affordable Care Act

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Introduction

The Employee Retirement Income Security Act of 1974 ("ERISA") historically distinguished between pension plans (see 29 U.S.C. § 1002(2)(A)(i)-(ii)) and welfare plans (see 29 U.S.C. § 1002(1)). Pension plans have long been subject to substantive statutory and regulatory requirements, which has resulted in substantial litigation on many of those technical requirements; for example, whether changes in benefits "cut back" "accrued benefits" in violation of ERISA § 204(g), 29 U.S.C. § 1054(g). Welfare plans, however, generally have not been subject to much substantive regulation. Historically, welfare plan litigation has been driven by the terms of the plans, procedural issues related to administrative exhaustion of claims for benefits, and court review of those benefit decisions, as opposed to the interaction between those plans and statutory requirements. [1]

[1] There have been, of course, exceptions. For example, enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") gave rise to a considerable amount of litigation. See Golub, Ira M.; Chevlowe, Roberta K: COBRA Handbook, 2014 Edition.

Health care reform, however—and, particularly, the Patient Protection and Affordable Care Act ("ACA")—may be shifting the paradigm. As more of the ACA's statutory requirements are rolled out and imposed on welfare plans, we expect the nature of litigation concerning welfare plans to expand. In fact, this is already starting to happen regarding substantive requirements imposed on welfare benefits by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Federal Parity Act").

The Federal Parity Act

The Federal Parity Act, which amended ERISA, the Public Health Service Act, and the Internal Revenue Code, was enacted to provide greater parity between mental health and substance-use-disorder benefits (collectively, "Mental Health Benefits") on the one hand, and medical and surgical benefits (collectively, "Medical Benefits"), on the other hand. See, e.g., Coalition for *Parity v. Sebelius,* 709 F. Supp. 2d 10, 12-13, 49 EBC 1519, (D.D.C. 2010). The Federal Parity Act applies to group health plans sponsored by private- and public-sector employers and the health-insurance issuers selling coverage in connection with group health plans. The Federal Parity Act does not by its terms require plans or issuers to cover Mental Health Benefits; instead, compliance is required only when a plan or issuer chooses to provide such benefits. However, state insurance law may require such coverage, and the vast majority of employer-provided plans cover Mental Health Benefits. [2]

[2] Further, the ACA requires that non-grandfathered health plans in the individual and small group markets offer Mental Health Benefits as one of the ten essential health benefits ("EHB"). In its regulations implementing EHB, the Department of Health and Human Services determined that EHB must meet the parity standards of the Federal Parity Act. See 78 FR 12834, 12844 (Feb. 25, 2013). The Federal Parity Act, however, exempts plans of employers with 50 or fewer employees from its requirements. See 29 U.S.C. § 1185a(c)(1). It is not clear how the EHB mandates fit with this small-employer exemption.

To achieve its goal, the Federal Parity Act mandates that financial requirements (e.g., copayments, coinsurance, or deductibles) and treatment limitations (e.g., limitations on the frequency of treatment, number of out-patient visits, or amount of days covered for in-patient stays) applicable to Mental Health Benefits generally can be no more restrictive than the requirements and limitations applied to substantially all of the Medical Benefits within a given classification. [3] The Federal Parity Act also prohibits financial requirements or treatment limitations that are applicable only to Mental Health Benefits.

[3] 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. See 29 C.F.R. § 2590.712(c)(2). Thus, by way of example, if a $10 copay applies to substantially all (i.e., at least two-thirds) inpatient in-network Medical Benefits, a $10 copay is the most restrictive copay that can apply to inpatient in-network Mental Health Benefits. See FAQs for Employees about the Mental Health Parity and Addiction Equity Act, issued by U.S. Department of Labor, May 18, 2012.

The Federal Parity Act also requires parity with regard to non-quantitative treatment limitations ("NQTLs"), which are non-numerically-expressed restrictions that affect the scope or duration of benefits under a group health plan. [4] Importantly, NQTLs are not limited to the terms of a plan; rather, NQTLs also involve the ways in which a plan operates. Under the Federal Parity Act, any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to Mental Health Benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Medical Benefits (the "NQTL Requirements").

[4] For example, NQTLs include: Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether treatment is experimental or investigative; formulary design for prescription drugs; standards for admission to plan provider networks, including reimbursement rates; plan methods used to determine usual, customary, and reasonable fee charges; "fail first" policies such as refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective; and exclusions based on failure to complete a course of treatment. See 29 C.F.R. § 2590.712(c)(4).

Regulatory Guidance

The Departments of Labor, Treasury, and Health and Human Services (collectively, the "Departments") jointly issued on February 2, 2010 interim final regulations that control the rules applicable to health plans until July 1, 2014. The Departments have now issued final regulations (effective after July 1st for calendar year plans after January 1, 2015), which have expanded the scope of the parity obligation, and is leading to litigation.

The interim final regulations contained an exception to the NQTL Requirements, which provided that "recognized clinically appropriate standards of care" may permit differences between NQTLs applied to Mental Health Benefits and NQTLs applied to Medical Benefits. See 75 FR 5410, 5416 (Feb. 2, 2010). After determining that this exception was "confusing, unnecessary, and subject to potential abuse," the Departments removed it from the final regulations (see 78 FR 68240, 68245 (Nov. 13, 2013)). Id. at 68240. The final regulations recognize, however, that using clinically appropriate standards of care can result in disparate results, as long as the evidentiary standards applied to the Mental Health Benefits are comparable to, and not applied more stringently than, those used for Medical Benefits. Id. at 68245.

The final regulations also changed the rules on the "scope of services"/"continuum of care" issue, which relates to whether and how the parity rules apply to coverage for intermediate services, such as residential treatment, partial hospitalization, and intensive-outpatient treatment. Cf. *Brazil v. OPM*, (N.D. Cal. Mar. 28, 2014) (noting residential-treatment requirement in the final regulations did not apply to treatment in 2011). Despite the Departments' recognition that not all treatment or treatment settings for Mental Health Benefits correspond to those for Medical Benefits, they did not resolve this "scope of services" issue in the interim final regulations. See 75 FR 5410, 5416 (Feb. 2, 2010). Instead, the Departments asked for comments on whether the NQTL Requirements needed to address specifically this or other NQTL-related issues, such as prior authorizations and concurrent review, service coding, and provider-network criteria. [5] Ultimately, the Departments did address these issues in the final regulations, which require that plans and issuers provide intermediate services, such as residential treatment, under the same conditions applied to Medical Benefits. See 78 FR 68240, 68246-47 (Nov. 13, 2013) & 2590.712(c)(4)(ii)(H) & Ex. 9.

[5] Of note, the report prepared for the Departments found that only 18% of the employer-based plans had claims for residential treatment. See *http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml*

Litigation Involving State and Federal Parity Acts

The final Federal Parity Act regulations appear to be leading to a rise in litigation. Several lawsuits also have been brought under state parity laws (ERISA does not preempt state insurance laws that provide the same or more benefits than federal law), [6] and these cases offer a preview of issues that may arise in Federal Parity Act litigation.

[6] In this area, ERISA only preempts state insurance law if it "prevents the application of a requirement of [the Federal Parity Act]." 29 U.S.C. § 1191(a)(1).

State Parity Act Litigation

While most state litigation has related to parity issues revolving around whether plans provided comparable Mental Health Benefits, at least one case enforced state requirements that, per the court, go beyond parity to enforce minimum benefit mandates. In *Harlick v. Blue Shield of California,*686 F.3d 699, 710-11, 53 EBC 2203, 2012 BL 136420 (9th Cir. 2012) plaintiff had a covered condition (anorexia nervosa) under California's parity act, which required insurers to provide coverage for "medically necessary treatment of [certain specified] severe mental illnesses." The Ninth Circuit held that this means a plan must cover all forms of health-care treatment found medically necessary for the mental illness regardless of whether the benefit is provided for Medical Benefits. Thus, the plan had to pay for nine months of residential care for the plaintiff, despite the plan language specifically excluding coverage for residential treatment.

Several cases address Washington's mental health parity act, which has been implemented in phases, with the final phase including a parity requirement. For example, in *Z.D. v. Group Health Coop.,* , 53 EBC 2190, 2012 BL 135588 (June 1, 2012) the court found that an insurer's policy of denying coverage for medically necessary neurodevelopmental therapy for those over the age of six was a violation of Washington's parity act, since the insurer did not impose those age-based limits on its coverage of physical therapy. In a subsequent decision, the court held that the insurer could enforce a sixty-visit yearly cap on outpatient visits for neurodevelopmental therapy for treatment of a mental illness, since the same limitations are imposed on therapies provided for physical injury or illness. *Z.D. v. Group Health Coop.,* , 56 EBC 1721, 2013 BL 94708 (W.D. Wash. Apr. 8, 2013).

In *K.M. v. Regence BlueShield,*, 57 EBC 2391, 2014 BL 19045 (W.D. Wash. Feb. 27, 2014) the insurer excluded neurodevelopmental services for anyone over six years of age. Although the insurer argued it applied this age-based exclusion to both physical and mental conditions, the court found this blanket exclusion to be a coverage exclusion (not just a treatment limitation) that likely violated the act. The court seemed to be implicitly accepting plaintiff's argument that the Washington state act went beyond parity to impose coverage mandates. In any event, because the loss of this coverage could cause irreparable harm, the court granted a preliminary injunction and certified a class of plans seeking to bar enforcement of the age limit by the insurer.

Federal Parity Act Litigation

Plaintiffs have brought two class action system-wide lawsuits against UnitedHealth. In *New York State Psychiatric Ass'n v. UnitedHealth Group,* (S.D.N.Y. Oct. 31, 2013) a group of participants, providers with assignments, and the New York State Psychiatric Association sued UnitedHealth in its capacity as claims administrator for a class of plans. The lawsuit alleged that various claims-practices by UnitedHealth violated the Federal Parity Act and the ACA, including by allegedly: (i) implementing more restrictive prospective and concurrent review of claims for mental health benefits in violation of the Federal Parity Act; and (ii) failing to provide continuing coverage during claims appeal and external review of the claims in violation of the ACA. The court stated that, if proven, the claims demonstrated violations of the acts, but held UnitedHealth was not a proper defendant. The court noted that the Federal Parity Act and the ACA apply to "group health plans" and "health insurance issuers." Because UnitedHealth was neither the insurer nor the plan administrator (it was the claims administrator), the court held it was not a party to which the acts applied. The decision is currently on appeal to the Second Circuit.

More recently, in *Wit v. UnitedHealthcare Ins. Co.,* No. 14-cv-2346 (N.D. Cal.), *complaint filed* May 21, 2014, plaintiffs commenced a putative class action against UnitedHealth for allegedly violating the Federal Parity Act by, for example, denying coverage for residential treatment by using more restrictive standards that fail to take into account the effectiveness of the treatment. UnitedHealth was sued both as claims administrator for self-insured plans, and as insurer for fully-insured plans.

Federal Parity Act claims are also being brought against employers and their plans. In *C.M. v. Fletcher Allen Health Care, Inc.,* (D. Vt. Apr. 30, 2013) the medical plan was administered by the employer, Fletcher Allen. Plaintiff alleged that Fletcher Allen violated the Federal Parity Act by conducting both prospective and concurrent medical-necessity reviews for certain mental-health office visits, and by limiting the number of outpatient visits a participant may schedule without the need to first obtain pre-approval—both of which were limitations allegedly not applied to Medical Benefits.

Fletcher Allen argued that, to survive a motion to dismiss, plaintiff had to show that the plan's terms create disparities between Mental Health Benefits and Medical Benefits. The court disagreed. First, the court noted that engaging in an analysis of the plan's terms to determine whether they do or do not create disparities is more appropriate for summary judgment. Second, the court explained that plaintiff's claims were not necessarily tied to the plan's terms—plaintiffs also alleged that Fletcher Allen violated the NQTL Requirements, which include the ways in which a plan operates. With regard to NQTLs, the court found that it was defendant's burden to prove that clinical or other appropriate standards justify any alleged differences between the ways in which Mental Health Benefits and Medical Benefits are covered.

Boeing and Microsoft have also recently been sued under the Federal Parity Act. On March 11, 2014, a complaint was filed in *S.S. v. Microsoft Corp.* No. 14-cv-351 (W.D. Wash.), Welfare Plan, alleging that Microsoft violated the Federal Parity Act by excluding coverage for psychiatric treatment in residential centers, even when such treatment is medically necessary. According to plaintiffs, this exclusion is not "at parity" with Microsoft's coverage

of Medical Benefits. Microsoft has moved to dismiss, arguing, inter alia, that plaintiff's allegations rest on guidance and obligations imposed in the final regulations, which do not become applicable until July 1, 2014.

In *C.S. v. Boeing Company Master Welfare Plan,* No. 14-cv-574 (W.D. Wash.), complaint filed April 17, 2014, plaintiffs commenced a putative class action against Boeing for allegedly applying an NQTL to Applied Behavior Analysis ("ABA") therapy for certain participants and beneficiaries diagnosed with Autism Spectrum Disorders ("ASD"). According to plaintiffs, the alleged limitation is effectuated by Boeing's failure to provide access to licensed entities offering ABA therapy in the State of Washington, which results in a "de facto exclusion of services that are otherwise covered under the terms of the Boeing Plan." The parties have stipulated to an extension of time for Boeing to respond to the complaint until July 17, 2014.

Proskauer's Perspective

There is an advocacy infrastructure aggressively pursuing claims under the state and federal mental health parity acts, with several of the plaintiffs' counsel appearing in multiple lawsuits. Medical providers also may use these acts to seek to enforce expansion of coverages.

These parity act lawsuits will bear close watching, both for their effect on obligations imposed by the various parity acts, and as possible roadmaps for future litigation seeking to enforce the broader range of benefit obligations imposed by the ACA.

Indeed, as the New York State Psychiatric Association lawsuit illustrates, some linkage between the acts and claims is already occurring.

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