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Publications

Influential Circuit Court Establishes Pleading Standards in Residential Treatment Center Cases

ATTORNEYS & PROFESSIONALS

Mark C. Nielsen
mnielsen@groom.com
202-861-5429

Paul Rinefierd
prinefierd@groom.com
202-861-9383

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In the past several years, the U.S. District Court for the District of Utah has been a hotbed for litigation involving claims for mental health treatment at residential treatment centers. Dozens of lawsuits have been filed in the District of Utah (due to the number of Utah residential treatment centers, as well as active plaintiffs' counsel in the area) that allege improperly denied benefits under ERISA Section 502(a)(1)(B), and/or violations of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). For a time, these cases proliferated at the district court level, with courts developing varying pleading standards for MHPAEA claims, as well as summary judgment decisions.

These cases have begun bubbling up to the Tenth Circuit, which has recently issued multiple detailed opinions in cases involving residential treatment centers. *See D.K. v. United Behavioral Health*, 67 F.4th 1224 (10th Cir. 2023) (affirming a summary judgment decision in favor of a plan participant); *David P. v. United Healthcare Ins. Co.*, 77 F.4th 1293 (10th Cir. 2023) (affirming summary judgment to the plan participant); *Tracy O. v. Anthem Blue Cross Life & Health Ins.*, 807 F. App'x 845, 847 (10th Cir. 2020) (affirming summary judgment to defendants).

The Court has continued to focus on residential treatment center claims, having recently issued two additional precedential opinions in cases involving residential treatment centers—*E.W. v. Health Net Life Insurance Co.*, 86 F.4th 1265, issued on November 21, 2023, and *Ian C. v. UnitedHealthcare Insurance Co.*, 87 F.4th 1207, issued on December 5, 2023. Both of these cases drew amicus briefs (a brief by the National Health Law Program and the Kennedy Forum in *E.W.*, and a brief by the U.S. Chamber of Commerce in *Ian C.*), and show that the Tenth Circuit is responding to the large numbers of residential treatment cases with lengthy opinions and detailed analysis and guidance.

1. In *E.W.*, the Tenth Circuit Resolves the Pleading Standard for MHPAEA Claims

In *E.W.*, a complaint was filed by a plan participant (E.W.) on behalf of a dependent (I.W.) who from September 2016 through December 2017 received treatment at Uinta Academy, a Utah residential treatment center, for mental health services and an eating disorder. I.W.'s treatment was covered through February 23, 2017, after which the plaintiffs' claims were denied as not medically necessary.

After exhausting their administrative remedies, the plaintiffs filed a complaint alleging two claims—one for improperly denied benefits under ERISA Section 502(a)(1)(B), and another for violation of MHPAEA. The district court granted the defendants' motion to dismiss the MHPAEA claim and later granted summary judgment to the defendants with respect to the benefit denial claim. On appeal, the Tenth Circuit affirmed the district court's summary judgment decision, but reversed with respect to the MHPAEA claim after concluding that the plaintiffs had satisfied their pleading requirements.

To start its analysis of the plaintiffs' MHPAEA claim, the Tenth Circuit observed that the Court has not as a matter of precedent decided "whether MHPAEA provides a separate cause of action." The Court noted that the First Circuit has recognized a right of action for alleged MHPAEA violations under ERISA Section 502(a)(3). But the Tenth Circuit ultimately declined to resolve the issue in this case because it found that defendants did not directly challenge the plaintiffs' right to bring a MHPAEA claim.

Next, the Tenth Circuit acknowledged that no appellate court has "defined the elements of a MHPAEA claim." After recognizing different pleading tests that various district courts have applied, the Tenth Circuit adopted a four-part pleading test that the Court had addressed with the parties at oral argument. The Court stated that, to adequately plead a MHPAEA violation, a plaintiff must:

(1) [p]lausibly allege that the relevant group health plan is subject to MHPAEA;

(2) identify a specific treatment limitation on mental health or substance-use disorder benefits covered by the plan;

(3) identify medical or surgical care covered by the plan that is analogous to the mental health or substance-use disorder care for which the plaintiffs seek benefits; and

(4) plausibly allege a disparity between the treatment limitation on mental health or substance-use disorder benefits as compared to the limitations that defendants would apply to the medical or surgical analog.

86 F.4th at 1283. The Court then recognized that a MHPAEA claim can be either a "facial" challenge that "focuses on the terms of a plan," or an "as-applied" challenge that "focus[es] on treatment limitations that a plan applies 'in operation.'" *Id.* at 1284-85.

After adopting the applicable pleading standard, the Tenth Circuit held that the plaintiffs had pled a plausible "as-applied" MHPAEA violation. Specifically, the Tenth Circuit accepted the plaintiffs' allegations that the defendant denied coverage for I.W.'s residential treatment based on an acute-level treatment guideline, but that residential treatment was classified as a sub-acute level of treatment under the applicable plan. Further, the Tenth Circuit agreed with the plaintiffs that inpatient skilled nursing was a "relevant analog" to residential treatment (although the Court did not reach the plaintiffs' other claim that inpatient hospice care and rehabilitation facilities were also relevant analogs), and the Court held that the plaintiffs plausibly pled that the defendants did not apply acute guidelines to skilled nursing treatment. The Tenth Circuit remanded to the district court to proceed with considering the plaintiffs' MHPAEA claim.

2. In *Ian C.*, the Tenth Circuit Declined the Plaintiffs' Invitation to Disturb *Firestone* Standards of Review for Denied Benefit Claims

The *Ian C.* case involved claims for one of the plaintiffs' treatment at Catalyst Residential Treatment, a Utah facility, for mental health and substance abuse issues. Treatment was covered for an initial two-week period, but denied thereafter as not medically necessary. The plaintiffs exhausted their administrative claims process and filed a complaint raising a claim for denied benefits under ERISA Section 502(a)(1)(B), alleging that the defendant failed to give the plaintiffs' claims a "full and fair review" as required under ERISA Section 503(2) and ERISA claims regulations.

The parties filed cross-motions for summary judgment, and the district court entered summary judgment in favor of the defendant. On appeal, the Tenth Circuit reversed.

As a threshold matter, the Tenth Circuit addressed the applicable standard of review for ERISA denied benefit claims. The Court recognized that, as the Supreme Court first held in *Firestone Tire & Rubber Co.*, 489 U.S. 101 (1989), courts "proceed de novo *unless* the plan authorizes the administrator to determine benefits on a discretionary basis, in which case we apply the more deferential arbitrary-and-capricious review standard." In *Ian C.*, although the applicable plan delegated discretion to the defendant, which would "suggest arbitrary-and-capricious review," the plaintiffs contended that the Court "should review [their] appeal de novo because [the defendant] failed to 'substantially comply' with ERISA's procedural requirements." Similarly, the plaintiffs asserted—based on the U.S. Department of Labor's amendments to ERISA claims regulations issued in 2002 and 2011—that the Court should "adopt de novo review for all cases in which administrators fail to 'strictly adhere[]' to ERISA regulations."

The Tenth Circuit declined the plaintiffs' invitation noting that "[n]othing in Ian C.'s brief convinces us to stir the pot." In particular, the Court rejected as a "flawed premise" the plaintiffs' argument that "the Department of Labor's ERISA regulations can, or should, dictate our judicial standards of review."

The Court then went on to describe ERISA's procedural requirements, and what it means for administrators to provide a "full and fair review" of benefit claims under ERISA Section 503 and its implementing regulations. Among other things, the Court stated that a "full and fair review" requires "a 'meaningful dialogue' between the claimant and the administrator," as well as "'an ongoing good faith exchange of information.'"

In addition, the Court emphasized that an administrative appeal must "reevaluate the claim on a clean slate," meaning after an initial claim denial a subsequent reviewer cannot "show[] any deference to the first reviewer—a rare case when the appealing party gets a true second bite at the apple." The Court then stated that this means a subsequent reviewer "must 'take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim,' even if those materials were unavailable to the first reviewer."

GROOM INSIGHT: Over the past several years, dozens of motions to dismiss and summary judgment decisions have been issued by district courts on residential treatment benefit claims, which resulted in varying standards and uncertainty for claims administrators. It is clear that the Tenth Circuit—in which these cases are often filed—is focusing on the proliferation of mental health parity cases and the need for clear pleading and summary judgment standards. The fact that multiple Tenth Circuit panels have waded into dense administrative records and issued lengthy precedential opinions signals that the Court is focused on this important area implicating mental health parity. And the standards that the Tenth Circuit has provided should lend clarity and consistency to district court proceedings.

Please reach out to the authors or your regular Groom attorney if you have questions.