GROOM LAW GROUP

Publications

Three Key Strategies for Defending MHPAEA Claims: Preparing for the Lawsuit Before It Is Filed

PUBLISHED
09/16/2022

SOURCE
Groom Publication

SERVICES
Employers & Sponsors
- Health & Welfare Programs

Health Services
- Health Services Advocacy
- ERISA

Policy
- Federal Insurance Regulation

The *Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008* ("MHPAEA")[1] has increasingly been the focus of government enforcement activity and private plaintiff litigation. In its 2022 Report to Congress, the Departments of Labor ("DOL"), Health and Human Services ("HHS") and the Treasury (collectively, the "Departments") announced that MHPAEA enforcement is a "top priority."[2] That announcement came on the heels of the DOL's first complaint alleging a MHPAEA violation[3] and a wave of suits filed by private plaintiffs. In 2021 alone, private plaintiffs filed more than 100 lawsuits asserting a MHPAEA claim. MHPAEA litigation brought by private plaintiffs has been similarly active in 2022.

We have seen the same "cookie cutter" allegations in many recently-filed MHPAEA cases. Most MHPAEA cases have targeted the coverage of specific mental health benefits: applied behavioral analysis therapy ("ABA therapy") to treat Autism Spectrum Disorder ("ASD"), residential treatment, and wilderness therapy. Plaintiffs have challenged plan terms limiting coverage for these treatments in cases where the limitation is evident on the face of the plan document/summary plan description (a "facial" challenge) or results from the administration of the plan in a disparate manner (an "as-applied" challenge).

Plaintiffs have filed these cases on an individual basis and as putative class actions. Regardless of how the claim is pleaded, however, a successful lawsuit may ultimately result in plan-wide relief. That is because private plaintiffs typically demand an injunction seeking changes to the plan terms or policies that allegedly violate the statute. As a result, even a case filed by an individual plaintiff may have plan-wide implications.

Most MHPAEA cases rise and fall on the motion to dismiss. But, when confronted with these allegations, district courts have reached conflicting conclusions on the applicable pleading standard. There is little guidance from appellate courts on what is necessary to plausibly allege a MHPAEA violation. As a result, a motion to dismiss the very same allegations may be granted by one court and denied by another, and the outcome may even be different among courts within the same district.

So, what is the best way to defend a MHPAEA claim? The simple answer is: prepare your defense before the lawsuit is filed. Three key steps that plan sponsors and issuers should take before the DOL comes knocking or a lawsuit is filed are:

- Carefully review plan terms related to the benefits that are frequently the target of MHPAEA claims ***and*** the medical/surgical treatments that plaintiffs typically claim are analogs for these treatments.
- Confirm that the processes for designing and applying coverage limitations are well-documented and in compliance with MHPAEA's requirements.
- Confirm that processes are in place to comply with MHPAEA's disclosure requirements in response to participant document requests. Such requests are an "early warning" that a MHPAEA lawsuit may be coming.

I. MHPAEA Purpose and Requirements

MHPAEA is "designed to end discrimination in the provision of coverage for mental health and substance use disorders as compared to medical and surgical conditions in employer-sponsored group health plans and health insurance coverage offered in connection with group health plans."[4] To that end, MHPAEA requires that mental health and substance use disorder benefits be provided in parity with medical and surgical benefits.

Financial Requirements and Treatment Limitations

MHPAEA requires that the financial requirements and treatment limitations imposed by a plan or issuer on mental health and substance use disorder benefits be "no more restrictive" than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits.[5] MHPAEA also prohibits plans and issuers from imposing separate treatment limitations only with respect to mental health or substance use disorders.[6]

Financial requirements include participant cost shares such as deductibles, copays, and coinsurance. Treatment limitations may be quantitative or non-quantitative. Quantitative treatment limitations are expressed numerically and include caps on the number of office visits.[7] Non-quantitative treatment limitations ("NQTLs") are non-numerical requirements that limit the scope or duration of benefits and include medical necessity requirements and restrictions based on facility types.[8]

The NQTL Rule

Much of the recent government enforcement activity and private plaintiff litigation has been focused on NQTLs. The final regulations implementing MHPAEA require that the "processes, strategies, evidentiary standards or other factors" used in applying NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the "processes, strategies, evidentiary standards or other factors" used in applying the limitation with respect to medical or surgical benefits in the same benefits "classification" (*i.e.*, (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).[9]

The focus of the NQTL analysis is not on the outcome, but on the process used to determine and apply the NQTL. "[D]ipsarate results alone" do not mean that an NQTL does not comply with MHPAEA.[10] A plan may, for example, cover a treatment for a medical condition but not a mental health condition even where the benefits are in the same classification, as long as it applies the same process for making the coverage determinations.[11]