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

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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.

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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]

GROOM INSIGHT: It is important for plans and issuers to clearly document decision-making processes so that they are able to demonstrate that they used the same "processes, strategies, evidentiary standards [and] other factors" when making coverage determinations. MHPAEA requires that the NQTL analyses be memorialized in writing with greater disclosure requirements having been recently added in statute, as discussed below. The DOL is requiring very detailed NQTL documentation in its current audits that goes beyond a basic checklist review of the NQTL rules.

II. The CAA and MHPAEA's Disclosure Requirements

The Consolidated Appropriations Act, 2021 ("CAA"), which we have discussed here [12] and here,[13] amended MHPAEA to require that subject plans and issuers "perform and document comparative analyses" of all NQTLs imposed on mental health and substance use disorder benefits and make these analyses available to the Departments, as well as state Departments of Insurance, upon request.[14]

Purpose of the CAA's Amendment to MHPAEA

The CAA's amendment to MHPAEA substantially increases the importance and complexity of compliance with the NQTL rule. Before the CAA's amendments to MHPAEA were adopted, the statute did not explicitly state how plans or issuers were to demonstrate and document that they were complying with the NQTL rule. According to the Departments, "this served as a major roadblock to obtaining compliance and ensuring that individuals received the [mental health and substance use disorder] benefits to which they were entitled."[15]

The CAA's new documentation requirement builds off of the NQTL requirements that were included in the final regulations implementing MHPAEA.

GROOM INSIGHT: To date, the audits conducted under the CAA by the DOL have been onerous, and the NQTL documentation requirements required by DOL have been extremely detailed and somewhat of a moving target. Hopefully, the Departments will

issue guidance under the CAA this year, as they are required to do, to make these expectations clear. Over the long run, clearer guidance under the CAA may *help* plans and issuers defend litigation regarding NQTLs that advances beyond the pleadings stage. The written parity analysis may be used to demonstrate that a disparate coverage decision for mental health and substance use disorder benefits and medical/surgical benefits was reached using the *same process* in compliance with MHPAEA.

Production of Medical Necessity Criteria and NQTL Analyses

The MHPAEA final regulations require the disclosure of medical necessity criteria used for medical/surgical and mental health and substance use disorder benefits, as well as the NQTL analyses noted above.[16] Complying with MHPAEA's disclosure obligations is a key component of defending a (filed or yet to be filed) lawsuit. Medical necessity criteria and NQTL analyses are considered to be instruments under which a plan is established or operated under ERISA Section 104.[17] The failure to produce such documents within 30 days of a participant request accordingly may subject the plan or issuer to statutory penalties under ERISA Section 502(c).[18]

Most plaintiffs asserting a MHPAEA claim will also bring a claim for statutory penalties if a defendant has not responded timely to the plaintiff's request for medical necessity criteria and/or an NQTL analysis. While a court has discretion as to whether to impose statutory penalties, the failure to produce the requested documents may impact the tenor of the litigation. For example, one court recently granted a plaintiff's motion for summary judgment on a MHPAEA claim, and at the same time, imposed more than $100,000 in statutory penalties against a defendant who failed to produce medical necessity criteria for services alleged to be medical analogs of the mental health treatment that was the subject of the lawsuit.[19]

The failure to produce medical necessity criteria and/or an NQTL analysis also may impact the pleading standard that is applied to MHPAEA claims. Some courts have applied relaxed pleading standards to MHPAEA claims where a plan administrator failed to comply with the plaintiff's request for such documents on the basis that the information necessary to plausibly allege a claim for relief is solely within the defendant's possession.[20]

GROOM INSIGHT: Complying with MHPAEA's disclosure obligation paves the way for a court to require that a plaintiff affirmatively plead factual allegations supporting his/her claim of disparate treatment in order to survive a motion to dismiss. For example, plaintiffs frequently allege that defendants apply medical necessity criteria more stringently to the mental health and/or substance use disorder benefit at issue than to medical/surgical treatments in the same classification of benefits in violation of MHPAEA. When a defendant fails to produce the medical necessity criteria applicable to these mental health and/or substance use disorders and medical/surgical treatments, courts have allowed these claims to survive a motion to dismiss—even where they are based on rote allegations that merely parrot the language of the NQTL rule (*i.e.*, that the defendant failed to apply the

same "processes, strategies, evidentiary standards or other factors" to mental health and/or substance use disorder and medical/surgical treatments). By contrast, courts analyzing nearly identical allegations have dismissed these claims where the medical necessity criteria were produced or otherwise available to the plaintiff prior to the filing of the complaint.[21] In these cases, courts have held that speculative statements, legal conclusions, and recitals of the statutory language do not plausibly allege a MHPAEA violation.[22] Plans and issuers accordingly can materially aid their defense of these claims by complying with MHPAEA's disclosure obligations before the lawsuit is filed.

III. Typical MHPAEA Lawsuit

Many MHPAEA lawsuits are brought by a familiar set of plaintiffs' firms and follow a pattern. Here are key commonalities we have seen in these suits:

Claims for relief. Plaintiffs alleging a MHPAEA violation typically assert three claims for relief: (1) denial of benefits pursuant to ERISA Section 502(a)(1)(B); (2) injunctive relief pursuant to ERISA Section 502(a)(3); and (3) statutory penalties for failure to produce plan documents pursuant to ERISA Section 502(c)(1).

Because there is no specific private right of action created for asserting a MHPAEA claim, there has been some litigation regarding the proper vehicle for asserting a violation of the statute. Most courts have held that a MHPAEA claim may be asserted pursuant to ERISA Section 502(a)(3), and that is the statutory provision that plaintiffs most frequently invoke to allege a MHPAEA violation.[23] Some plaintiffs have alleged that a MHPAEA violation amounts to a breach of fiduciary duty that is actionable under ERISA Section 502(a)(2), but courts have routinely dismissed such claims on the basis that the plaintiffs have failed to allege plan-wide injuries and do not seek remedies that would inure to the benefit of the plan as a whole.[24] Some plaintiffs also have claimed that a MHPAEA violation gives rise to an ERISA Section 502(a)(1)(B) claim for the recovery of plan benefits on the basis that the terms of the plan include and are modified by MHPAEA's parity requirements. Courts are split on whether plaintiffs may proceed on such a theory.[25]

Relief Demanded. Regardless of which statutory provision a plaintiff invokes to assert a MHPAEA violation, the relief demanded is typically the same. Plaintiffs generally seek: (1) reformation of the plan to eliminate the allegedly discriminatory coverage limitation; (2) injunctive relief, including claims reprocessing; and (3) attorneys' fees and costs. In some cases, the size of the funds and the attorneys' fees awards have been significant, particularly where the litigation has advanced beyond the pleadings stage.

Example: In one of the few cases litigated past summary judgment, a court granted final approval of a class action settlement concerning a plan's coverage of ABA therapy that required the defendants to make a prospective change to the plan's terms and establish a $1.7 million settlement fund to pay participants' past claims (dating back ***ten*** years), as well as reimburse the cost of alternative health insurance participants obtained to mitigate their damages.[26] The court also awarded the plaintiffs' counsel $850,000 in attorneys' fees.[27] Most MHPAEA cases are resolved prior to or shortly after the

pleadings stage, so this case provides insight on the types of remedies available to plaintiffs in cases that proceed through discovery.

Defendants. Most MHPAEA lawsuits have been filed against plan sponsors of self-funded plans and issuers of fully-insured plans. A recent trend, however, has been the filing of MHPAEA suits solely against third-party administrators ("TPAs") of self-funded plans based on the TPA's application of plan terms that violate MHPAEA.[28] TPAs, accordingly, may be the target of MHPAEA lawsuits, even where the TPAs do not design the plan's terms or coverage criteria and only are administering the self-funded plan's terms.

Example: A court recently held that plaintiff could assert a MHPAEA claim against a self-funded plan's TPA, even though the TPA lacked the authority to re-write the plan's terms.[29] The court found that ERISA fiduciaries, including TPAs of self-funded plans, must "apply a plan's terms [] *only* if those terms do not violate ERISA." This approach is commonly taken by the DOL in the context of its own investigations.

Allegations. Most MHPAEA claims focus on the following three benefits: (1) ABA therapy to treat ASD; (2), residential treatment; and (3) wilderness therapy. Facial and as-applied challenges to plan terms and policies regarding these benefits have generally followed these fact patterns:

- *ABA therapy*: Plaintiffs have alleged that plans that provide coverage for ASD, but contain blanket exclusions of ABA therapy to treat this condition, violate MHPAEA. Multiple courts have held that such an exclusion is an impermissible separate treatment limitation.[30]

GROOM INSIGHT: ABA therapy exclusions are increasingly less common, but they remain the focus of both private litigation and DOL investigations.

- *Residential treatment and wilderness therapy:* In addition to alleging facial challenges to plan terms that limit coverage for residential treatment and wilderness therapy, plaintiffs have frequently challenged the application of NQTLs to these services. Plaintiffs in these cases commonly claim that: (1) the defendants apply medical necessity criteria more stringently to these mental health/substance use disorder services than they do to comparable medical/surgical services[31] and/or (2) the defendants require facilities providing these services to obtain licensure in excess of that which applies to comparable medical/surgical facilities.[32]

GROOM INSIGHT: Courts have held that, without a plausible comparison to a comparable medical treatment, there is no MHPAEA claim.[33] Plaintiffs typically identify inpatient skilled nursing, rehabilitation, and hospice care as medical analogs for residential treatment and wilderness therapy without closely reviewing the plan's terms to determine whether these benefits are in fact analogous to the mental health and/or substance use disorder facilities at issue. Plans and issuers should review plan terms for these intermediate levels of care to ensure consistency. Similarly, plans and issuers should be

prepared to challenge formulaic allegations that medical/surgical benefits other than skilled nursing are analogs for the mental health and/or substance use disorder treatment at issue — such defenses will be stronger where the plan terms support such an argument.

IV. Looking Forward

This is an incredibly dynamic area that will be at the forefront for policymakers and the courts. Recently, Congress has begun to consider new legislation that would create new MHPAEA-specific remedies that would address some of the litigation uncertainties noted above. One bill would add a MHPAEA-specific remedy for damages and equitable relief, and that same bill would "clarify" the right of participants and the DOL to obtain re-adjudication of benefits under ERISA Sections 502(a)(3) and 502(a)(5). While it is unclear if the legislation will ultimately be signed into law, the legislation evidences the importance of this issue for the DOL and policymakers.

In addition, it is clear to us that MHPAEA litigation and enforcement efforts, particularly regarding NQTLs, likely will continue to be active for the foreseeable future. Indeed, in a recently filed *amicus* brief, the DOL underscored its interest in using its enforcement authority to "protect[] the right[s]" of the 135 million Americans who are covered under plans subject to MHPAEA's requirements,[34] and the DOL's step forward into litigating these claims may be a harbinger of what is to come.

Based on commonalities we have seen among MHPAEA cases filed to date, there are three proactive steps plans and issuers can take now to set up a successful defense of these claims, should a lawsuit ultimately be filed: (1) a careful review of key plan terms and policies, (2) strong documentation of plan design decisions, and (3) compliance with MHPAEA's disclosure requirements.

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[1] 29 U.S.C. § 1185a.

[2] 2022 MHPAEA Report to Congress at 3.

[3] Complaint for ERISA Violations, *Walsh v. United Behav. Health*, No. 21-cv-4519 (E.D.N.Y. Aug. 11, 2021), ECF 1.

[4] *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010).

[5] 29 U.S.C. §§ 1185a(a)(3)(A)(i)-(ii); *see also* 29 C.F.R. §§ 2590.712(a), (c)(2)(i).

[6] 29 U.S.C. § 1185a(a)(3)(A)(ii).

[7] 29 C.F.R. § 2590.712(a).

[8] 29 C.F.R. §§ 2590.712(a), (c)(4)(ii).

[9] *Id.* §§ 2590.712(c)(4)(i)-(ii).

[10] Preamble, Final Rules, 78 Fed. Reg. 68,240, 68,245-46 (Nov. 13, 2013).

[11] *See Bushell v. United Health Group, Inc.*, No. 17-cv-2021, 2018 WL 1578167, at *5 (S.D.N.Y. Mar. 27, 2018) ("[T]he regulations do not prohibit health plans from saying 'treatment *x* is covered for medical condition *y* but not for mental-health condition *z*.' … [A]s long as the insurer applies the same *process*, it is not a problem if the resulting coverage decision differs for medical and mental-health treatments.").

[12]https://www.groom.com/resources/end-of-year-omnibus-bill-adds-mental-health-parity-and-addiction-equity-act-disclosure-requirements/.

[13]https://www.groom.com/resources/mental-health-parity-remains-a-priority-for-tri-agency-mhpaea-compliance-in-response-to-the-caa/.

[14] 29 U.S.C. § 1185a(a)(8)(A). Parallel provisions are in the Public Health Service Act and the Internal Revenue Code.

[15] 2022 MHPAEA Report to Congress at 7-8.

[16] 29 C.F.R. §§ 2590.712(d)(1) & (d)(3).

[17] *Id.*

[18] *Id.*

[19] *See, e.g., M.S. v. Premera Blue Cross*, No. 553 F. Supp. 3d 1000 (D. Utah Aug. 10, 2021).

[20] *See, e.g., David P. v. United Healthcare Ins. Co.*, No. 2:19-cv-00225, 2020 WL 607620 (D. Utah Feb. 7, 2020).

[21] *See, e.g., Laurel R. v. United Healthcare Ins. Co.*, No. 2:19-cv-00473, 2020 WL 570257 (D. Utah Feb. 5, 2020).

[22] *See, e.g., id.*

[23] *See, e.g., Christine S. v. Blue Cross Blue Shield of N.M.*, 428 F. Supp 3d 1209, 1229 (D. Utah 2019).

[24] *See, e.g., N.R. v. Raytheon*, 24 F.4th 740, 751 (1st Cir. 2022).

[25] *Compare N.R., supra, with Raygoza v. ConAgra Foods, Inc. Welfare Benefit Wrap Plan*, No. 15-03741, 2016 WL 9454419, at *5 (C.D. Cal. Nov. 4, 2016).

[26] *D.T. v. NECA/IBEW Fam. Med. Care Plan*, No. 2:17-cv-00004, 2021 WL 4709805 (W.D. Wash. Oct. 8, 2021).

[27] *Id.* at *3.

[28] *See, e.g., Deighton v. Aetna Life Ins. Co.*, No. 2:21-cv-7558 (C.D. Cal. Sept. 21, 2021).

[29] *See Doe v. United Behav. Health*, 523 F. Supp. 3d 1119 (N.D. Cal. 2021)

[30] *See, e.g., id.*.

[31] *See, e.g., M.S., supra.*

[32] *See, e.g., H.H. v. Aetna Ins. Co.*, 342 F. Supp. 3d 1311 (S.D. Fla. 2018).

[33] *See M.N. v. UnitedHealthcare Ins. Co.*, No. 2:18-cv-00710, 2020 WL 1644199, at *6 (D. Utah April 2, 2020) ("Without some facts about actual as-applied, analogous medical treatment coverage, other than labels and conclusions, there can be no comparison and hence no claim.").

[34] DOL Amicus Brief, *N.R. v. Raytheon*, No. 20-1639, 2020 WL 6131046, at *3 (1st Cir. Oct. 7, 2020).