MHPAEA

- Law requires MH and SUD benefits be offered in parity with med/surg benefits in six classifications
  - Financial requirements (e.g., copays) and QTLs (e.g., visit limits) must be no more restrictive than predominant financial requirements and QTLs that apply to substantially all med/surg benefits in the same classification
  - NQTLs cannot be applied to MH and SUD benefits in any classification unless comparable NQTLs are applied to med/surg benefits
- Limited increased-cost exemption available
- ACA extended the application of MHPAEA
Recent Guidance

- Financial requirements and QTLs
  - “Reasonable method” for substantially all and predominant analyses
- NQTLs
  - “NQTL analysis does not focus on whether the final result is the same; instead, [MHPAEA] compliance depends on parity in application of the underlying processes and strategies.”
- MAT for Opioid Use Disorder
- Disclosures
  - Is a plan’s NQTL criteria proprietary and/or does it have commercial value?

https://www.dol.gov/ebsa/mentalhealthparity/ See FAQs Parts 31 and 34
Disclosures

• MHPAEA provides that
  ▫ A plan must disclose the reason for any denial of reimbursement or payment for services for MH and SUD benefits to a participant or beneficiary (in accordance with ERISA claims procedure rules, if the plan is subject to ERISA).
  ▫ Criteria for medical necessity determinations must be made available to any current or potential plan participants, beneficiaries or contracting providers upon request.
  ▫ Other applicable Federal and State disclosure rules apply
Disclosure

- Participants, beneficiaries and their authorized representatives have a right to receive, upon request:
  - A SPD from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
  - The specific plan language regarding the imposition of a NQTL (such as a preauthorization requirement);
  - The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that a NQTL will apply to a particular MH or SUD benefit;
  - Information regarding the application of the NQTL to any med/surg benefits within the benefit classification at issue;
  - The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any med/surg benefits within the benefit classification at issue; and
  - Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

- Comments were due Jan. 2017 re model forms to request/report NQTL standards.
MHPAEA Plan Design

By: Lisa S. Kantor
Parity Plan Design Issues

• Exclusions For Residential Treatment

• Preauthorization And Pre-service Notification And Penalties
Exclusions For Residential Treatment

- Under 29 U.S.C.A. § 1185a (3) (A) (ii) (emphasis added):
  (3) Financial requirements and treatment limitations
  (A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—
  * * *
  (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
Exclusions For Residential Treatment

- Plans continue to have exclusions for residential treatment
- EBSA FACT SHEET FY 2016 MHPAEA ENFORCEMENT: Examples included investigation by the Dallas Regional Office of a plan that excluded coverage for residential treatment for substance use disorders. Enforcement involved Texas DOI and CMS and changes to all Texas insured products.

Exclusions For Residential Treatment


- *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 753 (N.D. Ill. 2015) (court held that exclusion for RTC in 2014 policy violated provision in MHPAEA precluding separate limitations for mental health)
Exclusions For Residential Treatment

- *S.S. v. Microsoft Corp. Welfare Plan*, 2015 WL 11251744 (W.D. Wash. 2015), (court held plan was subject to interim rules, which did not make clear that RTC exclusions violated MHPAEA, and therefore exclusion of coverage of residential treatment for psychiatric disorders, except eating disorders, was allowed; no discussion of statutory language)
- *Danny P. v. Catholic Health Initiatives*, 2016 WL 3551972 (W.D. Wash. 2016) (similar analysis with respect to exclusion for room and board charges at RTC facilities)
Exclusions For Residential Treatment

21st Century Cures Act

- SEC. 13007. CLARIFICATION OF EXISTING PARITY RULES.
- If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.
Example 1. (i) Facts. A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

45 C.F.R. § 146.136
(ii) Conclusion. In this Example 1, the plan violates the rules of this paragraph (c)(4) because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

45 C.F.R. § 146.136
Preauthorization And Preservice Notification And Penalties

- Final Regulations

Example 2. (i) Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects **60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.**

45 C.F.R. § 146.136
Preauthorization And Preservice Notification And Penalties

(ii) Conclusion. In this Example 2, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

45 C.F.R. § 146.136
Preauthorization And Preservice Notification And Penalties

- Final Regulations

Example 3. (i) Facts. A plan requires **prior approval** that a course of treatment is medically necessary for **outpatient, in-network medical/surgical, mental health, and substance use disorder benefits** and uses comparable criteria in determining whether a course of treatment is medically necessary. For mental health and substance use disorder treatments that do not have prior approval, **no benefits will be paid**; for medical/surgical treatments that do not have prior approval, there will only be a **25 percent reduction** in the benefits the plan would otherwise pay.

45 C.F.R. § 146.136
Preauthorization And Preservice Notification And Penalties

- Final Regulations

(ii) Conclusion. In this Example 3, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way. The penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

45 C.F.R. § 146.136
Q4: Prior to authorizing admission to an inpatient, in-network facility for a mental health condition, my group health plan requires that a plan representative examine the individual in person to determine whether inpatient care is medically necessary. For all medical and surgical inpatient, in-network admissions, my plan also requires prior authorization but it is conducted over the phone without an in-person examination. Is this in-person prior authorization requirement for mental health inpatient admissions permissible?

Preauthorization And Preservice Notification And Penalties

• **No.** The plan is imposing a prior authorization NQTL more stringently with respect to inpatient mental health benefits than to inpatient medical/surgical benefits. While some differences in prior authorization practices with respect to individual conditions or treatments might be permissible based on recognized clinically appropriate standards of care, the MHPAEA regulations do not permit a plan or issuer to apply stricter NQTLs to all benefits for mental health conditions in a classification than those applied to all medical/surgical benefits in the same classification. In this case, in order to receive prior authorization for any inpatient, in-network mental health benefits, a participant must undergo an in-person examination whereas prior authorization may be obtained more easily and quickly over the phone for any inpatient, in-network medical/surgical benefits. Accordingly, the plan’s in-person prior authorization requirement for these mental health benefits does not comply with MHPAEA.

Preauthorization And Preservice Notication And Penalties

- **Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Complaint**

- **Preauthorization and Pre-service Notification Requirements**
  - *Blanket Preauthorization Requirement*: Plan/insurer requirements preauthorization for all mental health and substance use disorders
  - *Treatment Facility Admission Preauthorization*: Plan/policy states that if insured is admitted to a mental health/substance abuse facility for non-emergency treatment without prior authorization insured will be responsible for costs of services OR reduces benefits 50%
  - *Extensive Pre-notification Requirements*: Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, IOP treatment and extended OP treatment visits beyond 45-50 minutes

The Mystery of the Missing MHPAEA Cases

By: Marc I. Machiz
A Dearth of Cases-DOL

- There are 2.2 million private health plans
- Interim regulations date to 2010, final regulations issued 2013
- DOL has yet to file a MHPAEA Lawsuit
- DOL opens and closes approx. 2000 benefit plan investigations a year
- Per DOL’s FY 2016 MHPAEA Enforcement Fact Sheet in 2016 DOL closed 191 MHPAEA investigations and issued cited 44 violations
- Because DOL seeks global correction when it finds a problem in an insured product, this is not quite as paltry as it sounds-but almost
A Dearth of Cases-Private Enforcement

- **Coleman v. Alcatel Lucent**, ND Ala. (Denial of ABA treatment)
- **Doe v. UFCW**, ND Ill (Exclusion of Residential Treatment)
- **Baily v. Anthem Blue Cross Life and Health**, ND Cal. (Denial of coverage for Residential Treatment for eating disorder-application of medical necessity)
- **Gallagher v. Empire Blue Cross** (SDNY) (exclusion of coverage of wilderness therapy)
Congressional Frustration—the Cure Act—We’re Watching You

- Overwhelming bipartisan passage included the cancer moonshot and research initiatives, but also a section on mental health
- No new resources
- Requires the Agencies to issue more guidance (beyond existing regulations and FAQs)—“a compliance program guidance document”
  - Examples (de-identified like the Fact Sheet discussed—but with NQTL details)
  - Agreements among agencies and IGS and states, recommendations, biannual updates, additional guidance (12 months to do it)—this from a Congress that abhors regulation—more guidance on disclosure—you can hear the frustration with how plans and participants are supposed to evaluate whether an NQTL is in parity—the plea for comparative information on “the processes, strategies, evidentiary standards and other factors” used both to develop and apply NQTLs
- Action Plan for Enhanced Enforcement
  - Coordination between and amongst Agencies and States includes strategic objectives, stakeholder input, timelines, examples of how to meet objectives—toll free number, parity website, recommendations for further Congressional action
- Report on investigations (after enactment)—similar to factsheet
- GAO study of compliance and enforcement—includes how HHS has used authority to audit (I’m unaware of HHS enforcement)—3 years
- Reaudits if plan or issuer has been found to violate 5 times [Nobody knows what this means—since and design violation by a carrier or large plan affects hundreds to tens of thousands—and few cases involve five discreet violations]
- Information on Eating Disorders—clarification that eating disorders are covered by MHPAEA
What’s Stopping Us? Substance

- No one understands how to evaluate NQTLs that are used similarly (but not necessarily in parity) for both medical surg and mental health—e.g. preauthorization for residential treatment is required for both med surg conditions and addiction and seems too stringently applied for addiction (notorious for the absence of clear standards of care)—but how to go about proving that across the board different “methods, processes, strategies, evidentiary standards, or other factors” are being used to deny or shorten admissions, or used to develop the particular limitation (e.g. default x days for a particular treatment)—proof of disparate impact will not do.
  - Requests for information, at least absent a subpoena, will generally yield self-serving, often post hoc, explanations of why the NQTL is being imposed “uniformly”
- Network (in)adequacy (effectively rationing) is an overarching NQTL with daunting proof problems (payment problems that psychiatrists complain of may be mirrored, e.g. among dermatologists)—consider the irony of a defense based on proof that the medical network is inadequate as well.
- In the addiction area, clear standards of care don’t seem to exist, though evidence based work suggests that drug assisted treatments are woefully underutilized. Seemingly neutral application of medical necessity standards
- “Behavioral Health” claims are largely administered separately by different organizations from med/surg claims using distinct medical management techniques; plans and carriers outsource behavioral health management—until it is clarified that post hoc rationalizations for separate and distinct sets of NQTLs will be unacceptable parity will be an illusion—where in fact NQTLs are developed separately, by separate organizations
What’s Stopping Us? Substance - Are Exclusions NQTLs?

- Marc’s Hobby Horse—Both sides have wrongly assumed that exclusions and age limits that function as exclusions of treatments are NQTLs. Courts have likewise assumed rather than decided the issue.
- If exclusions are NQTLs, plaintiffs must prove that the plan or carrier used more stringent “methods, processes, strategies, evidentiary standards, or other factors” to develop exclusions on medical side than it used to develop exclusions on the mental health/substance abuse side. While a plan cannot use exclusions on the mental health side unless they are employed on the medical side, a single treatment exclusion (or age limited treatment) forces use of the difficult NQTL analysis.
- QTLs are numeric limits on days, hours or visits for identified treatments.
- They may not separately accumulate on the mental health side; they are also subject to a stringent test requiring them to be applied to a similar or smaller dollar volume of benefits on the mental health/subst. abuse side than on the med/surg side. Exclusions applied to specific treatments (if they are QTLs) cannot pass these tests.
- Exclusions (and age limits) on specific treatments for otherwise covered conditions such as autism are the equivalent of zero day, hour or visit limits. 0 is a number. Saying a treatment is excluded is no less a numeric limit than saying that the plan offers 0 hours, days or visits.
- Plans commonly exclude certain treatments, notably applied behavioral analysis or some component therapy for autism, either entirely or before or after a certain age; allowing treatments between the ages of 2 and 6 is common. If these treatment exclusions are understood to be QTLs they are per se unlawful and easy targets for litigation.
- A plan can deny coverage for a treatment as not medically necessary—an NQTL. So, application of an age 2-6 guideline (to interpret medical necessity) would be sustainable if backed by a medical consensus similar to that used on the medical surgical side to defend medical necessity guidelines.
- But plans and carriers are writing categorical exclusions rather than relying on medical necessity. Note: limitations on setting (think Residential Treatment for drugs and eating disorders) have been defined by the regulation as an NQTL. Generally, if application of an exclusion requires the evaluation of some qualitative aspect of the treatment—is the treatment medically necessary, more costly than another effective treatment, dangerous, subject to a black box warning, provided in a particular setting, provided by qualified personnel, or administered involuntarily—the examples in the regulation teach that the regulations drafters intended the treatment limitations to be treated as an NQTL—though their application could lead a plan to deny treatment altogether.
What’s Stopping Us? (Process)

• To gain standing where a treatment is not outright excluded, the patient will likely have to exhaust.
  ◦ Most health claims are never exhausted but resolved through informal give and take between carriers/tpas and health care providers who are themselves conflicted because they have long term relationships with the payers – As a DOL official, I’ve asked hospitals to tell us what problems they have getting claims paid—almost invariably, the answer I got was we have no problems
• Mental Health and Addiction Patients are not ideal class representatives—putting the burden on the agencies to do more
• Real Participant access to internal plan analysis of NQTL design and application is limited—rationales post-hoc
• Lack of clarity about when the analysis is plan wide and when the carrier can look to all or a portion of its book of business
• The triagency process slows and stymies government enforcement—the fact sheet doesn’t say what’s pending
• The States have invariably approved or acquiesced in the very plan design features we might challenge—carriers will raise state approval as a “defense” claiming that they cannot unilaterally change approved insurance provisions; at the same time they will disclaim responsibility for parallel provisions in the self-funded plans that they draft and administer—impeding global correction
• While HHS has been active interpretively, it’s not clear that they’ve devoted enforcement resources.
• DOL has never been given enforcement resources for Mental Health or Health - even the Cure Act added nothing.
What’s Stopping Us? (Remedies)

• A number of settled class actions have been brought challenging exclusions and dollar limits on Autism treatments—under state or federal parity laws. These settlements, carrier wide in the State of Washington, have provided for funds in the single digit millions, available to participants who have been denied coverage in whole or part who can show that they have paid for treatment that should have been covered. These modest sums, I’m told, are more than sufficient to cover out of pocket expenditures—but claims are modest because parents who couldn’t get coverage were simply unable to pay for treatment, and so had no bills to submit.

• Without large potential awards and larger settlement funds, MHPAEA cases will not be attractive to the class action bar, and we will wait for the now frozen and overtaxed agencies to ride to the rescue—what are our chances if only Trump can fix it?
Rethinking Remedies—A Game Changer?

- If a plan improperly excludes a mental health treatment participants may seek:
  - Injunctive relief—sin no more
  - Reformation—which can look backward-allowing claims to be belatedly filed-approach would be limited to costs incurred
  - Benefits for a claim filed and denied (is that 502(a)(1)(B) or (a)(3)?)
  - Out of pocket treatment costs incurred for which no claim was filed (because it was understood that plan didn’t cover it) –cousin of reformation or surcharge
  - Claims for amounts that would have been incurred had the plan design been lawful with proof—
    - Person by person
    - In the aggregate—what would it have cost to provide benefits using a lawful design

- **A.F. v. Providence Health Plan**, 2016 Lexis U.S. Dist. LEXIS 1503 (D. Ore. 2016), has an extended discussion of remedies and relies on **Cigna v. Amara** and **New York State Psychiatric Association, Inc. v. Unitedhealth Group**, 798 F.3d 125 (2d 2015) to clearly reject arguments that plaintiffs were limited to (a)(1)(B) claims for amounts actually submitted as claims or even amounts actually incurred, instead allowing make-whole relief, including for the cost of treatment they would have incurred had their been coverage. Such relief is necessary to prevent unjust enrichment by the carrier and is available equitable relief that also serves to make plaintiffs whole. The Court does not reach whether these amounts can be proven by class wide proof of what the coverage would have been expected to pay if properly designed and administered, or whether each patient’s likely costs would have to be individually proven. See also, **O’Dowd v. Anthem Health Plans Inc. Inc.** 2015 WL 5728814 (D. Co. Sept. 30, 2015)
A Call to Action – Plan Design

• Plan Design is Largely a matter of Public Record—some products can be obtained online, others from the state insurance commissioners-
• Can the plaintiff’s bar and or the APA work together to catalog all the problematic plan design features and which carriers employ them? Too utopian? Then do it separately.
A Call to Action – Network Adequacy

- Work with the APA to develop a methodology for showing that mental health networks are inadequate, even shams and to document the payment practices that discourage mental health professionals from joining networks while better compensating med/surg providers to join a more robust network.

- Note that the defense will blame the psychiatrists—arguing that because they are in shortage, they prefer to opt out of insurance and treat wealthy neurotics.
A Call to Action-Substance

• Argue that treatment exclusions are QTLs and virtually per se unlawful
• Argue that State approvals of plan design provisions are irrelevant
• Argue that State definitions of what is mental health must comport with professional and scientific consensus (is it in the DSM?)
• Argue that post-hoc rationalizations for NQTLs are inadmissible
• Argue that book of business evaluation of QTLs are almost always improper
• Argue for an unjust enrichment remedy based on class wide proof
• But Can we Certify classes that provide meaningful relief? [Segue]
Mental Health Parity Class Certification Cases

By: Molly Moriarty Lane
Mental Health Parity Class Certification Cases

- Eight class certification cases involving mental health parity claims
  - 2 granted class certification
  - 2 granted class certification in part and denied in part
  - 4 denied class certification
- Blanket exclusion v. medical necessity
- Claims for injunctive/declaratory relief v. claims for damages
Class Certification Granted


- Claims for violations of California’s MHPA and breach of contract for categorically denying coverage for behavioral therapy and speech therapy to members with autism spectrum disorders.
- Denial based on ground that services constitute custodial care and non-health care services.
- Resolution of claims would require court to decide whether services were “health care services” or “custodial care.”
- Would not require medical necessity determination.
Class Certification Granted


- ERISA claims based on United’s denial of claims for mental health or substance use disorder treatment.
- Alleged that United used overly restrictive medical necessity guidelines that were inconsistent with generally accepted standards of care.
- Requested only injunctive relief. Dropped claims for out-of-pocket expenses.
Class Certification Granted


- Commonality established because court not required to determine medical necessity.
  - “Of particular significance is the fact that Plaintiffs do not ask the Court to make determinations as to whether class members were actually entitled to benefits (which would require the Court to consider a multitude of individualized circumstances relating to the medical necessity for coverage and the specific terms of the member’s plan).”
- Defendant required to re-process claims according to new guidelines.
- Court rejected ascertainability arguments.
Class Certification Granted In Part and Denied In Part


- ERISA claims alleging that Defendants’ denial of neurodevelopmental therapy coverage for members over the age of six violated Washington’s MHPA.
- Plaintiffs requested certification of two classes:
  - First class seeking declaratory and injunctive relief under 23(b)(1)(A) or (b)(1)(B) was certified.
  - Court denied class certification for second class seeking monetary relief under 23(b)(e) on the ground that “individual questions of ‘medical necessity’ are not susceptible to common resolution.”
Class Certification Granted In Part and Denied In Part


- Plaintiff filed second motion for class certification seeking to certify two subclasses, one for “incurred” claims and the other for “surcharge” claims.
- Incurred claims class seeking declaratory and injunctive relief certified under 23(b)2.
- Class certification denied for surcharge class because class members required to establish medical necessity.
Plaintiff alleged that treatment limitations for autism services violated ERISA and state and federal parity acts.

Class certification granted under 23(b)(3) but denied under 23(b)(2).

Common issue existed as to whether treatment limitations applied equally to mental health and med/surg services.
Class Certification Denied

Graddy v. Blue Cross Blue Shield of Tennessee, 2010 WL 670081 (E.D. Tenn. 2010)

- ERISA claims for Defendant’s denial of coverage for ABA autism treatment utilizing policies intended to hamper claims processing.
- Class certification denied under 23(b)(2) because claims required “individualized assessment as to ultimate propriety of the benefits decisions affecting each and every class member.”
Class Certification Denied

*J.T. v. Regence Blue Shield, 291 F.R.D. 601 (W.D. Wash. 2013)*

- ERISA claims alleging violations of MHPA based on Regence’s denial of allegedly medically necessary neurodevelopmental therapy.
- Class certification denied because plaintiff’s claims were not typical and she was not an adequate class representative.
Class Certification Denied

Daniel F. V. Blue Shield of California, 305 F.R.D. 115 (N.D. Cal. 2014).

- ERISA claims alleging Defendants breached the plan terms and violated MHPA by denying claims for residential treatment based on exclusion in plan.
- Class certification under Rule 23(b)(3) denied
  - Common issues of law and fact do not predominate:
    - Class members would need to establish medical necessity.
    - Calculating damages would require “more than simply re-processing denied claims.”
  - Class not ascertainable or superior
Class Certification Denied


- Claims for violations of California’s Unfair Competition Law, MHPA, and Unruh Civil Rights Act based on Defendants’ practice of concurrent review and prospective limitation of long-term treatment.  
- Plaintiff dropped breach of contract claim and request for compensatory and non-economic damages.  
- Class certification denied because class members required to establish medical necessity:  
  - “Each member will be required to litigate the necessity of their individual treatment in light of their diagnosis and unique clinical circumstances.”
Key Takeaways

• Claims requiring individualized proof of medical necessity are more difficult to certify.
• Claims for monetary relief are more difficult to certify.
• Claims based on categorical exclusions fare better on class certification.
• Claims for injunctive and declaratory relief fare better on class certification.
Questions?