
# Current Litigation Highlights Ongoing Need for Review of Plans for Mental Health Parity Compliance

*By Corrie Cripps*

Plan sponsors of self-insured group health plans have to balance the need for cost-containment strategies while ensuring compliance with federal health benefit mandates. Mental health parity compliance is particularly challenging to navigate as case law is still being developed in this area.

## Background

The Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the Affordable Care Act (ACA), generally requires that group health plans ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits.

MHPAEA generally applies to group health plans that provide coverage for mental health or substance use disorder benefits in addition to medical/surgical benefits. Some self-insured plans are exempt from MHPAEA, such as those with 50 or fewer employees.[1]

The Department of Labor (DOL) has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans.

## DOL Actions

In April 2018, the Departments of Labor, Health and Human Services and the Internal Revenue Service issued a package of guidance on MHPAEA. Among the items was the "FY 2017 MHPAEA Enforcement Fact Sheet", which states that in fiscal year (FY) 2017, the DOL conducted 187 MHPAEA-related investigations and cited 92 violations of MHPAEA noncompliance.[2]

The Employee Benefits Security Administration (EBSA) branch of the DOL authored publications and compliance assistance materials to assist plans with MHPAEA compliance. One of these publications, "Warning Signs" is an extremely useful tool to refer to when doing a quick review of a plan document/summary plan description.[3]

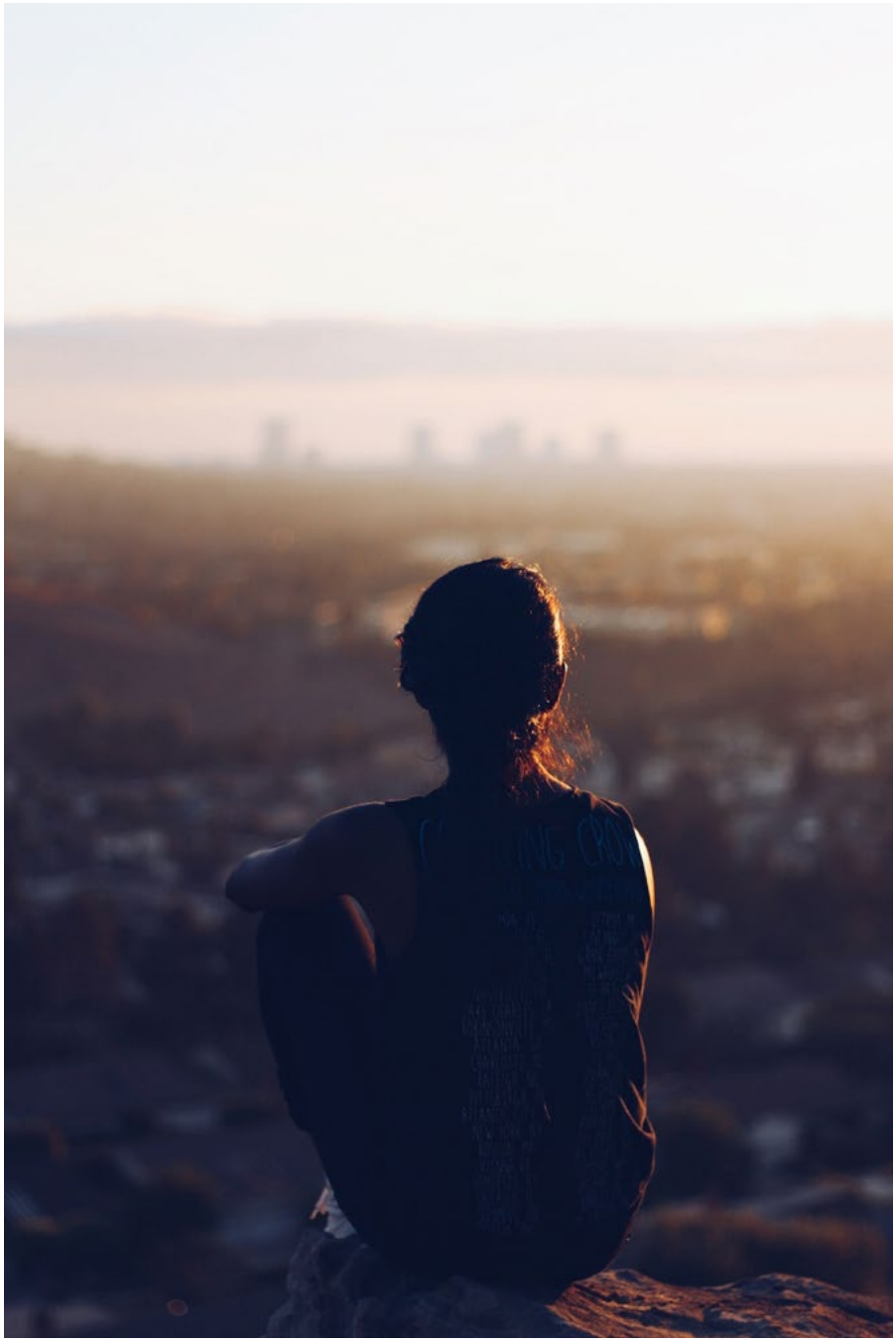
This document was published in May 2016, but the DOL is expected to publish a "Warning Signs 2.0" document in fiscal year 2018 to focus on non-quantitative treatment limitations (NQTLs), since this appears to be a problem compliance area for plans.

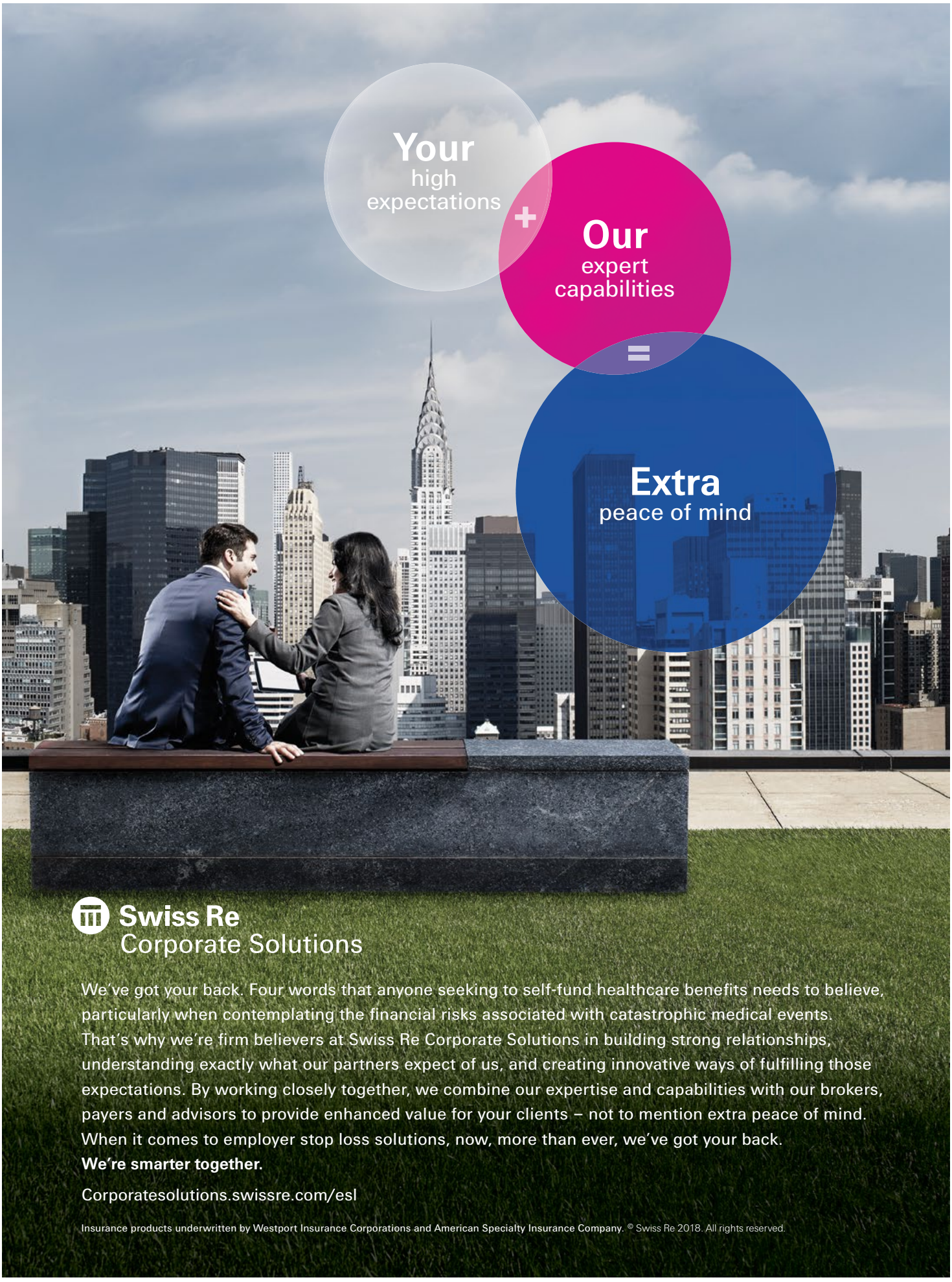
NQTLs are generally limits on the scope or duration of benefits for treatment that are not expressed numerically, such as medical management techniques, provider network admission criteria, or fail-first policies. In terms of MHPAEA compliance, plans should ensure that any NQTLs with respect to MH/SUD benefits are comparable to the limitations that apply to the medical/surgical benefits in the same classification.

## Current Mental Health Parity Cases

MHPAEA does not require that self-insured group health plans cover MH/SUD benefits; it only requires that if a plan does cover MH/SUD benefits that the benefits are in parity with the medical/surgical benefits.

One of the challenges for plans is determining the scope of benefit types that are compared for parity purposes. Since case law is still being developed in this area, these matters continue to be unsettled.






**Swiss Re**
Corporate Solutions

We've got your back. Four words that anyone seeking to self-fund healthcare benefits needs to believe, particularly when contemplating the financial risks associated with catastrophic medical events. That's why we're firm believers at Swiss Re Corporate Solutions in building strong relationships, understanding exactly what our partners expect of us, and creating innovative ways of fulfilling those expectations. By working closely together, we combine our expertise and capabilities with our brokers, payers and advisors to provide enhanced value for your clients – not to mention extra peace of mind. When it comes to employer stop loss solutions, now, more than ever, we've got your back.
**We're smarter together.**

Corporatesolutions.swissre.com/esl

Insurance products underwritten by Westport Insurance Corporations and American Specialty Insurance Company. © Swiss Re 2018. All rights reserved.

The following are some recent cases that highlight this area of concern.

***Vorpahl v. Harvard Pilgrim Health Care Ins. Co. (D. Mass. July 20, 2018)[4]***

This focus of this case is on coverage of a "wilderness treatment program". The plan at issue is a fully-insured plan that denied coverage for an employee's dependent children who received treatment at a state-licensed outdoor youth treatment program that was authorized to provide mental health services.

The children's parents claim the plan's exclusion for "health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, and services provided in conjunction with (or as part of) those programs" violates the MHPAEA and the ACA. The US District Court for the District of Massachusetts dismissed the ACA claim but denied the insurer's motion to dismiss the MHPAEA claim, so this portion of the lawsuit will proceed.

What is interesting about this case is how the plan participants determined the medical/surgical equivalent of the wilderness treatment program, which is different than how the plan viewed the benefits and exclusions.

The plan argued that its exclusion is a categorical exclusion that applies to both medical/surgical benefits and MH/SUD benefits provided at this type of facility. The example the plan gave for the medical/surgical equivalent is a "diabetes camp", which the plan would also exclude.

The plan participants argued that because the plan covers medical/surgical benefits provided at other inpatient treatment settings it should cover this wilderness treatment program setting as well since it is an equivalent type of treatment setting. In support of their position, they cited the Joseph F. v. Sinclair Servs. Co. case from 2016, in which the court ruled that the plan violated MHPAEA by covering skilled nursing facilities but not covering residential treatment facilities.

So which comparison is correct—the more specific setting comparison, or the broader category comparison? There is currently no direct guidance on this issue.

While this case is still at its early stages procedurally, we will be watching to see how it develops.

***Bushell v. Unitedhealth Group Inc., 2018 WL 1578167 (S.D.N.Y. 2018)[5]***

The question in this case is how to determine the MH/SUD equivalent of the plan's "nutritional counseling" benefit.

In this case, the plan participant who has anorexia nervosa sued the insurer after it denied her claim for nutritional counseling to treat her condition. The insurer asserted that nutritional counseling was not covered under the plan.

The plan participant argued that the plan covered such counseling for non-mental health conditions, such as diabetes, and therefore was in violation of MHPAEA. The insurer asked the court to dismiss the claim, arguing that the counseling services that were requested were not in the same classification as the counseling services that were covered under the plan. The court refused to dismiss the claim, therefore allowing the case to proceed.

The parity rules under MHPAEA are applied on a classification basis. Therefore, if a plan provides mental health or substance use disorder benefits in any "classification", then mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. Those classification requirements apply to the following:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care; and
- Prescription drugs

In this particular case, the medical/surgical benefit of diabetes nutritional counseling was covered within the "outpatient, out-of-network" classification (as noted by the court in this case), but the mental health benefit for anorexia nutritional counseling, which may also fall into that classification, was not. Therefore, if mental health is covered under the plan, and the medical/surgical benefit of nutritional counseling for diabetes is covered in any of the classifications listed above, then the mental health benefit of nutritional counseling must be provided in parity in that same classification(s).

The plan participant makes a good argument for parity here. Plans that cover both (1) mental health benefits and (2) the medical/surgical benefit of diabetes nutritional counseling should take the conservative approach and cover mental health nutritional counseling as an additional benefit. Another option would be for the plan to provide a "Nutritional Counseling" benefit that is more general, and not specific to just diabetes.

The results are pending in this case but we will be tracking the outcome. Plans should be aware that eating disorder treatments are considered mental health benefits. Congress addressed this in section 13007 of the 21st Century Cures Act and this subject was also addressed in the FAQs that the Departments issued on June 16, 2017.6,7 Plans should be cautious when reviewing plan exclusions to ensure they cannot be interpreted as applying a limit on an eating disorder treatment.

## Conclusion

The DOL's published enforcement reports suggest that the DOL is continuing to investigate compliance with MHPAEA. In addition, based on current litigation, it appears there is a fairly low burden to state a claim under MHPAEA that survives a motion to dismiss. Plan sponsors should review cost-containment techniques with counsel to ensure they are designed to mitigate risk in this area while ensuring compliance. ■

*Corrie Cripps is a plan drafter/compliance consultant with The Phia Group. She specializes in plan document drafting and review, as well as a myriad of compliance matters, notably including those related to the Affordable Care Act.*