Mental Health Parity: Exploring the Promising Potential of This Seemingly Intuitive but Exasperating to Implement Law

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Opening Keynote Address

Hall Center for Law and Health

Indiana Health Law Review Symposium

Mental Health and the Law

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Center for Health & Pharmaceutical Law
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Roadmap

1. Overview of ~~Mental~~ Behavioral Health Parity Laws
2. Some Challenges to Implementation
3. Promising Potential (?)
   a. *Wit v. United Behavioral Health*
   b. Rhetorical Value of Parity: Preventive Behavioral Health Case Study

Overview of Behavioral Health Parity Laws

What is behavioral health parity?

Overview of Behavioral Health Parity Laws

- “Parity” in the dictionary:
  - “the state or condition of being equal, especially regarding status or pay.”
    - "parity of incomes between rural workers and those in industrial occupations"
  - synonyms:equality, equivalence, uniformity, sameness, consistency, correspondence, congruity, congruence, levelness, unity, coequality, parallelism, evenness
- How apply to health coverage?

Overview of Behavioral Health Parity Laws

- **Americans face 50% chance of needing BH services over their lifetimes**
  - 1 in 5 adults experienced some form of mental illness in 2020; ~ 40 million Americans had SUD in 2020
- **Historically many plans did not provide equal (if any) coverage for MH and SUD services**
  - Plans did not include MH services until after WWII
  - Began offering limited hospital psychiatric care
  - burdensome restrictions on MH/SUD coverage
    - E.g., higher copayments, separate deductibles, lower annual visit limits, separate annual and lifetime caps on coverage, fewer covered services, and stricter medical management requirements (pre-authorizations or medical necessity reviews)
  - More restrictive than those placed on med/surg benefits

Overview of Behavioral Health Parity Laws

- **Primary goal** is to eliminate differences in insurance coverage for behavioral health
  - Increase fairness in insurance markets
  - **Patrick Kennedy** (D-RI, chief architect): "[A]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered from discriminatory treatment at all levels of society."
- **Primary objection**: concerns about costs
  - Long-term psychotherapy
  - Adverse selection

Overview of Behavioral Health Parity Laws

- **As of 2008 49* states had passed some version of MHP legislation**
  - Just over half required **full parity** for mental health coverage
  - 15 required **mandate offering parity**
  - 7 required **minimum mandated coverage**
  - Varied on key terms such as extent of coverage for MH/SUD, financial limitations, and populations covered
  - **do not apply** to employee-sponsored self-insured plans (majority of large employer plans)

Overview of Behavioral Health Parity Laws

- **Mental Health Parity Act of 1996** required parity of aggregate lifetime and annual dollar amounts for fully insured and self-insured group plan mental health benefits.
  - 1997 extended some provisions to Medicaid MCOs and CHIP benefits
- **1999: Clinton directed OPM to implement MH and SUD parity in FEHB program**
  - Cost-sharing, # of visits, length of tx limits; permitted study
- **Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008**:
  - extended parity requirements to SUDs and added new requirements regarding financial requirements and treatment limitations
  - did **not**:
    - apply to issuers who sold health insurance to individuals or sold health insurance policies to employers with 50 or fewer employees.
    - require plans to provide MH/SUD benefits.
- 2009 extended MHPAEA to CHIP plans

Overview of Behavioral Health Parity Laws

- MHPAEA **does not** require plans to cover BH
  - BUT "if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided." Self-Compliance Tool p. 3

- Parity **does not require coverage of specific MH/SUD conditions** (45 CFR 146.13(e)(3))
  - "A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition." 42 CFR 438.900
  - e.g., eating disorders – IF plan covers eating disorders, then parity applies in each classification; but doesn't have to cover eating disorders.
  - (But check state mandates, federal benchmark plans, etc.)

Overview of Behavioral Health Parity Laws

Affordable Care Act (ACA)

- **Essential Health Benefits** (EHB) provisions include **Mental Health and Substance Use Disorder services**, including Behavioral Health Treatment
- Insurance plans in the individual and small group markets **must comply** with federal MH parity requirements to satisfy EHB requirements
- **required Medicaid Alternative Benefit** Plans to include MH and SUD as basic service

All plans offered in the Marketplace cover these **10 essential health benefits**:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

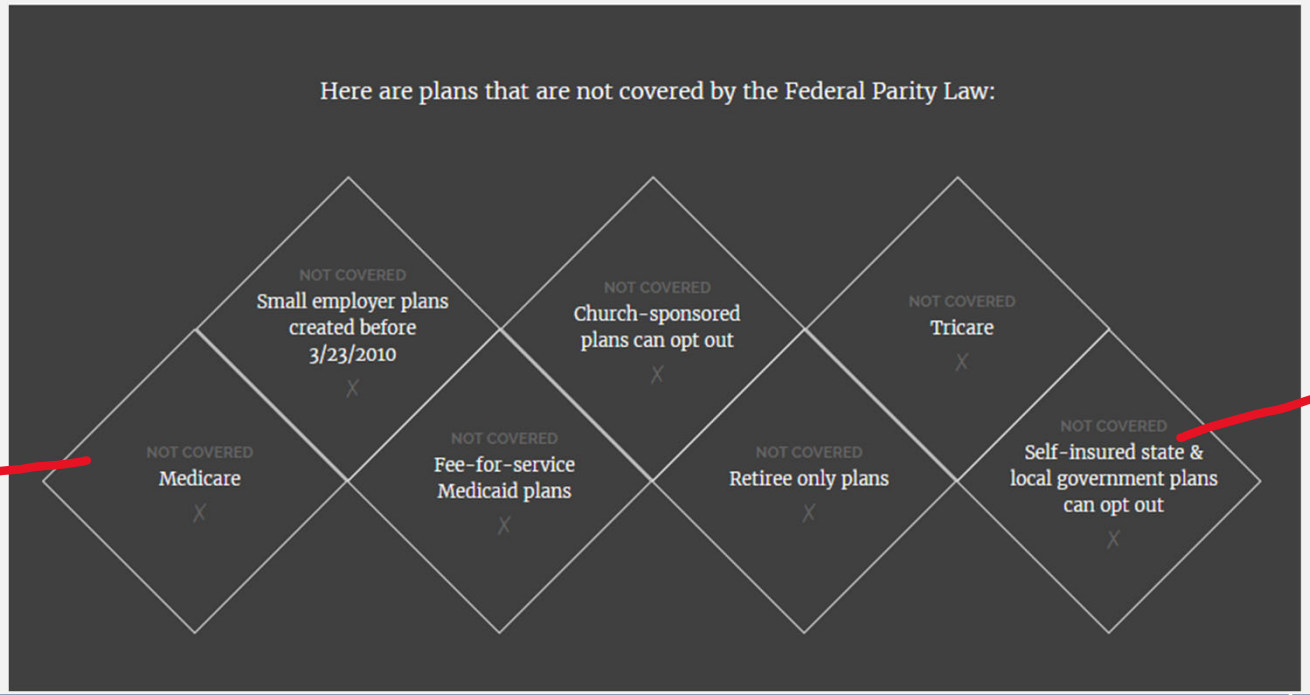
Overview of Behavioral Health Parity Laws

To what plans does federal parity law apply?

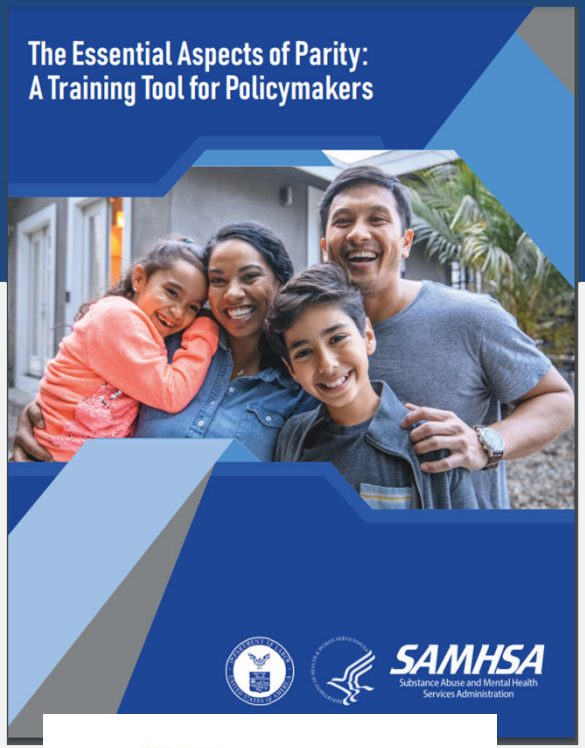
Source: ParityTrack.org

Overview of Behavioral Health Parity Laws

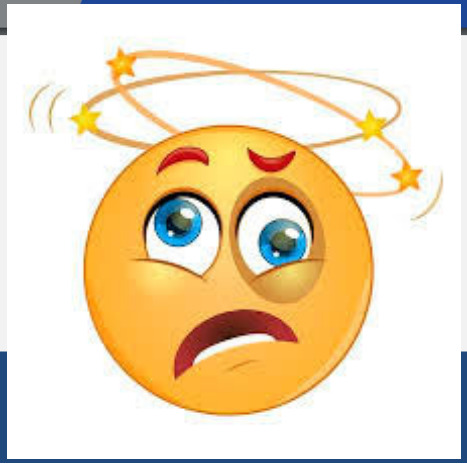
To what plans does federal parity law apply?



Source: ParityTrack.org



Overview of Behavioral Health Parity Laws



"Generally, MHPAEA requires that the **financial requirements** (such as deductibles, copayments, or coinsurance) and **treatment limitations** imposed on mental health and substance use disorder benefits **cannot be more restrictive** than the **predominant financial requirements and treatment limitations** that apply to **substantially all medical and surgical benefits**. Treatment limitations include **quantitative treatment limitations** (QTLs), such as annual or lifetime day or visit limits, which are numeric. Treatment limitations also may be **nonquantitative** (nonquantitative treatment limitations (NQTLs)); examples include preauthorization requirements and medical necessity reviews, which may restrict the scope and duration of benefits for treatment."

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/The%20Essential%20Aspects%20of%20Parity%20-%20A%20Training%20Tool%20for%20Policymakers_508.pdf (2021)

Overview of Behavioral Health Parity Laws

Parity comparisons are performed within each classification (or subclassification):

"Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately **for each type** of financial requirement or treatment limitation."

-45 C.F.R. § 146.136(c)(1)(ii)

Overview of Behavioral Health Parity Laws

6 Basic Classifications of Benefits (Commercial)

(1) Inpatient, in-network

(2) Inpatient, out-of-network

(3) Outpatient, in-network

(4) Outpatient, out-of-network

(5) Emergency care

(6) Prescription drugs

May **subdivide outpatient** services into two subclassifications:

- office visits, such as physician visits; and
- all other outpatient items and services, such as outpatient surgery, facility charges for day treatment centers, laboratory

Overview of Behavioral Health Parity Laws

Quantitative Parity Analysis: Mathematical test to analyze what the most restrictive **level** of **a type of financial requirement or QTL** can be applied to MH/SUD benefits **within each classification**

Step One: Substantially All Analysis

- **Type** of financial requirement or QTL will be considered to apply to **substantially all** med./surg. benefits in a classification if it applies to **at least 2/3 of all med./surg. benefits in that same classification.**
  - Plans must use a **"reasonable method"** to determine dollar amount of all plan payments for med./surg. benefits in a classification to be paid for the plan year (but can't be based on the overall book of the business).
- **If does not** apply to 2/3 of all med./surg. benefits in a classification, then **that type may not apply** to MH/SUD benefits in that same classification. -45 C.F.R. 146.136(c)(3)(A); 147.160(a)
- If applies to "substantially all," **-> Step Two**

Overview of Behavioral Health Parity Laws

Quantitative Parity Analysis (cont'd):

Step Two: Predominant analysis

- The plan may apply no more than the **predominant level** of that **type** of financial requirement or QTL that applies to med/surg benefits to MH or SUD treatment benefits in the **same classification**.

"Predominant level" is the level of the type that applies to **more than one-half** of medical/surgical benefits **in that classification** subject to the financial requirement or quantitative treatment limitation.

Overview of Behavioral Health Parity Laws

Quantitative Parity Analysis (cont'd):

Lessons Learned in California

- Common violation involved copayments or deductibles for outpatient items and services other than office visits, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.
- Regulators found that a **panoply of cost-sharing and deductibles applied** to outpatient med/surg non-office visit services or items.
  - A significant %, for example, were for **preventive or other services that do not have cost-sharing or deductibles**.
  - Remaining services or items **had a mix** of coinsurance and copayments.
- As a result, **fewer than two-thirds** of outpatient med/surg other than office visit services or items had copayments or deductibles applied to them in these plans. Thus, under the parity regulations, outpatient BH items and services other than office visits **could not be subject to copayments or deductibles** in these plans.

Overview of Behavioral Health Parity Laws

NQTL Analysis:

"[A plan] may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits **in any classification** unless, under the terms of the plan (or health insurance coverage) **as written and in operation**, any **processes, strategies, evidentiary standards, or other factors used in applying** the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are **comparable to**, and are **applied no more stringently** than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."

-45 C.F.R. §§ 146.136(c)(4)(i) (emphasis added); 147.160(a)

Overview of Behavioral Health Parity Laws

NQTL Analysis (cont'd)**:**

- Plans **do not have to use the same NQTLs** for med./surg. benefits and MH/SUD provided that "the processes, strategies, evidentiary standards, and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to a NQTL **are comparable and applied no more stringently** for MH/SUD than for med./surg. benefits." – 78 Fed. Reg. at 68, 241

Overview of Behavioral Health Parity Laws

Disclosure Requirements:

- MHPAEA requires health insurance issuers to disclose the **criteria for medical necessity** determinations of MH/SUD benefits upon request to "any current or potential participant, beneficiary, or contracting provider."

- MHPAEA also requires that plans provide a **detailed explanation for any denial** of reimbursement or payment of services for MH/SUD benefits upon request by the participant or beneficiary.

Overview of Behavioral Health Parity Laws

Highlighting Positives:

- Parity requirements apply to approximately **174 million** people
- Evidence of **increased access** – higher utilization, especially among children; fewer saying they are declining care because of costs
- **Milliman**, ***Impact of Mental Health Parity and Addiction Equity Act*** **(2017)**:
  - Based on analysis of healthcare utilization and cost patterns from 2008-2013, authors suggest that MHPAEA **drove increases in access to, and benefit richness** for, MH and SUD benefits
    - Greater change in benefit richness for BH than non-BH services, particularly for outpatient facility and professional services

> "The greatest changes in paid-to-allowed ratios for behavioral healthcare are observed in service categories that were typically subject to more restrictions prior to MHPAEA. This includes intermediate outpatient facility services, such as partial hospital and intensive outpatient care, as well as substance use services."

https://www.milliman.com/en/insight/2017/impact-of-mental-health-parity-and-addiction-equity-act/

Overview of Behavioral Health Parity Laws

Highlights

- ✓ Large did not drop BH coverage
  - ✓ 80% of large plans increased BH network post-MHPAEA
- ✓ Addressing easy to identify violations - FRs and QTLs
  - ✓ Almost all Optum plans dropped annual visit or annual day limits
  - ✓ *But remember CA findings*
- ✓ Some plans eliminating some NQTLs, like prior authorization
  - ✓ *But* not all!
- ✓ Evidence of **increased access** –
  - ✓ higher utilization, especially among children
  - ✓ fewer saying they are declining care because of costs

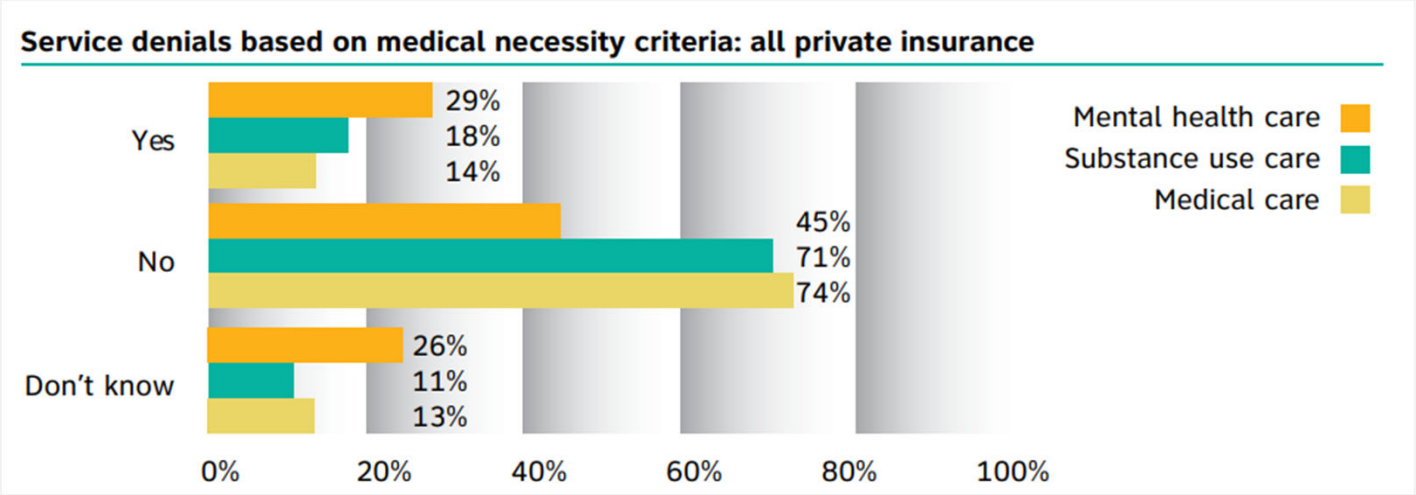
https://www.milliman.com/en/insight/2017/impact-of-mental-health-parity-and-addiction-equity-act/

Adapted photo by Katie Drazdauskaite on Unsplash

Some Challenges to Implementation

National Alliance on Mental Illness (NAMI), *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care* (2015)

However, nearly one third (29%) of respondents reported that they or their family member had been denied mental health care on the basis of medical necessity, more than twice the percentage who reported being denied general medical care. 18% of respondents reported being denied substance use care and 14% denied general medical care. For ACA plans, rates of reported denials based on medical necessity were lower, but denials for mental health care were still nearly twice the rate of denials for general medical care.[1]



https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf

Some Challenges to Implementation

Continued network adequacy and reimbursement rate disparities

- **Significantly higher rates of OON use** for BH v. med/sug
  - E.g., proportion of BH office visits OON was 4.8-5.1 x higher than for med/surg primary care office visits
  - Observed rapid increase in OON use for BH in inpatient and outpatient facility settings – network inadequacy?
- **Med/surg providers are paid at higher rates than BH, often for providing the same services**
  - primary care providers paid **20.7%-22% higher** rates for office visits than BH providers; med/surg specialty care providers paid **17.1%-19.1% higher** for office visits than BH
  - Primary care and med/surg specialists paid on average **15.2% and 11.3% higher** than Medicare-allowed amounts, respectively; **BH** paid on average **4.9% less**
  - True even for specific 99213 and 99124 codes (low and moderate complexity E&M visits): primary care and med/surg specialist physician paid **20.6% and 14.1% higher**, respectively, for low complexity than psychiatrists; **20.0% and 17.8% higher** for moderate complexity

Some Challenges to Implementation

Table A.59B Detailed Reasons for Not Receiving Mental Health Services in the Past Year: Among Adults Aged 18 or Older with a Perceived Unmet Need for Mental Health Services Who Did Not Receive Mental Health Services in the Past Year; by Past Year Level of Mental Illness, 2020

Reason for Not Receiving Services[1]	Any Mental Illness[2]		Serious Mental Illness[2]	
Could Not Afford Cost	44.9	(2.57)	49.5	(4.38)
Might Cause Neighbors/Community to Have Negative Opinion	13.7	(1.69)	18.4	(3.83)
Might Have Negative Effect on Job	10.3	(1.24)	12.8	(2.24)
Health Insurance Does Not Cover Any Mental Health Services	11.0	(1.59)	12.0	(2.62)
Health Insurance Does Not Pay Enough for Mental Health Services	19.4	(2.12)	18.1	(3.66)
Did Not Know Where to Go for Services	32.7	(2.47)	33.5	(4.04)
Concerned about Confidentiality	10.1	(1.33)	11.6	(2.15)
Concerned about Being Committed/Having to Take Medicine	16.2	(1.80)	25.9	(3.97)
Did Not Feel Need for Treatment at the Time	11.5	(2.37)	7.9	(3.27)
Thought Could Handle the Problem Without Treatment	29.7	(2.73)	25.0	(4.13)
Treatment Would Not Help	16.2	(2.49)	16.9	(3.75)
Did Not Have Time	17.5	(1.88)	15.0	(2.74)
Did Not Want Others to Find Out	10.0	(2.16)	10.0	(2.28)
No Transportation/Inconvenient	4.1	(0.95)	4.0	(1.64)
Related to COVID-19[3]	2.1	(1.14)	*	(*)
Some Other Reason[4]	9.5	(1.52)	8.5	(2.08)

https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Some Challenges to Implementation

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

dol.gov/agencies/ebsa

FACT SHEET

FY 2021 MHPAEA ENFORCEMENT

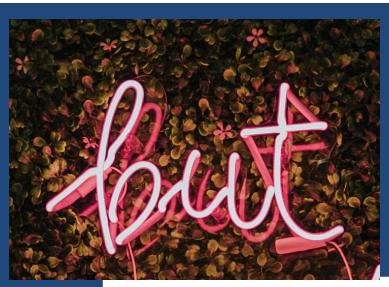
ENFORCEMENT OVERVIEW: ENSURING PARITY

EBSA cited **14 MHPAEA violations in 12 of the 74** closed investigations subject to MHPAEA. 8 of those investigations involved self-insured group health plans and 4 involved plans that offered both fully-insured and self-insured options. The cited violations involved **8 FRs, 3 QTLs, and 3 NQTLs**.

Benefits advisors obtain results.

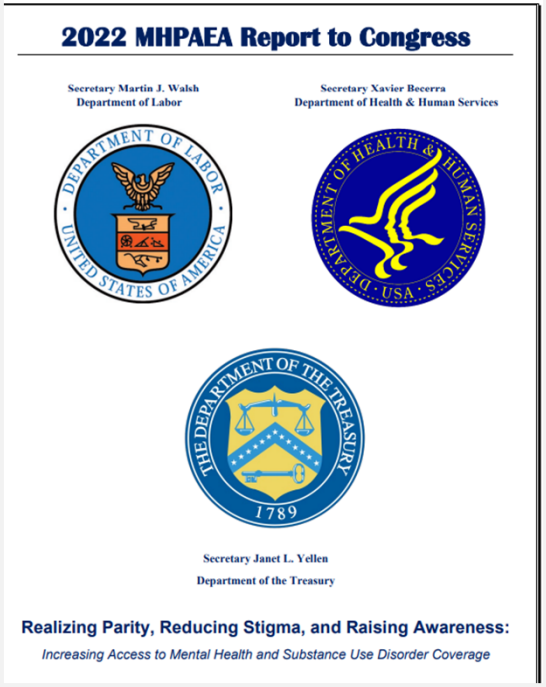
A benefits advisor in EBSA's Seattle District Office assisted a family that was having difficulty with claims for assessment and treatment of autism spectrum disorder. At issue was the "allowed amount" on the claims, which was a small fraction of the billed charges. The claimant's parents attempted multiple times to communicate with the health plan to resolve the problem but were unable to do so. The benefits advisor contacted the plan to inquire into the processing of claims for approximately 40 dates of service. The plan reprocessed the claims and paid approximately $20,000 more for the services.

https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2021.pdf



Some Challenges to Implementation

- EBSA has issued 80 insufficiency letters for over 170 NQTLs, requesting additional information and identifying specific deficiencies.
- CMS has issued 19 insufficiency letters identifying deficiencies in the comparative analyses and requested additional information to address these deficiencies.
- EBSA has so far issued 30 initial determination letters finding 48 NQTLs imposed on MH/SUD benefits lacking parity with medical/surgical benefits (36 unique NQTLs).
- CMS has so far issued 15 initial determination letters to plans and issuers finding 16 NQTLs out of parity with medical/surgical benefits. Two NQTLs were found to be impermissible separate treatment limitations in effect and 14 comparative analyses remained insufficient.
- EBSA received corrective action plans from 19 plans in response to initial determination letters. These corrective action plans address 36 NQTLs (30 unique NQTLs).
- CMS received corrective action plans from 6 plans and issuers in response to initial determination letters. These corrective action plans address 13 NQTLs.
- 26 plans and issuers so far have agreed to make prospective changes to their plans.



https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

Some Challenges to Implementation

"The results described above suggest that implementation of MHPAEA has reduced barriers to care for behavioral health conditions. In fact, from our experience assisting health plans and employers with MHPAEA compliance testing, we have seen first-hand the **changes in benefit designs** that have been required to bring plans into compliance. However, although interim final rules implementing MHPAEA have been in effect since July 1, 2010, and final rules went into effect in July 1, 2014, we **continue to observe health plan issuers and employers offering benefits that are not fully compliant with the regulations regarding cost-sharing requirements**. And because the requirements of the law **affect both quantitative and non-quantitative** aspects of health plans, **determining compliance can both be highly technical and nuanced, and it may be difficult to assess compliance without performing an appropriately detailed analysis of each benefit plan**."

https://www.milliman.com/en/insight/2017/impact-of-mental-health-parity-and-addiction-equity-act/

Some Challenges to Implementation

Some Implementation Challenges

- **Understanding rights**
  - Lawyer's law
- **Assessing compliance**
  - Classifying benefits/making comparisons - e.g., intermediate services
  - FRs/QTLs
  - NQTLs (e.g., network adequacy, credentialing & reimbursement, etc.)
    - *as applied*
- **Monitoring for compliance**
  - Getting and analyzing disclosure
  - Resources
- **Jurisdictional confusion**

Some Challenges to Implementation

Promising Practices

- **Quality data**
  - Compliance filings
  - Standardized disclosure
- **Active regulators – granular analysis of data**
  - Evaluating plan practices in real time and on-site (market conduct studies/audits), especially for NQTLs, as applied; network adequacy reviews
- **Designated individuals at carrier and state**
  - **E.g., NY's Ombudsman program**
- **Ongoing stakeholder dialogue**
- **Transparency and Education**
  - FAQs, Self-Compliance Tool, Model Disclosure Form
  - Complaint tracking – e.g., Parity Complaint Registry and Appeal Resource, www.parityregistry.org

Some Challenges to Implementation

2022 MHPAEA Report to Congress

Secretary Martin J. Walsh
Department of Labor

Secretary Xavier Becerra
Department of Health & Human Services

- The Employee Benefits Security Administration (EBSA) has issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs across 86 investigations.[2]
- The Centers for Medicare & Medicaid Services (CMS) issued 15 letters between May and November 2021 to issuers in states where CMS has direct enforcement authority over MHPAEA (Texas, Missouri, and Wyoming) and to non-Federal governmental plan sponsors in those and other states.

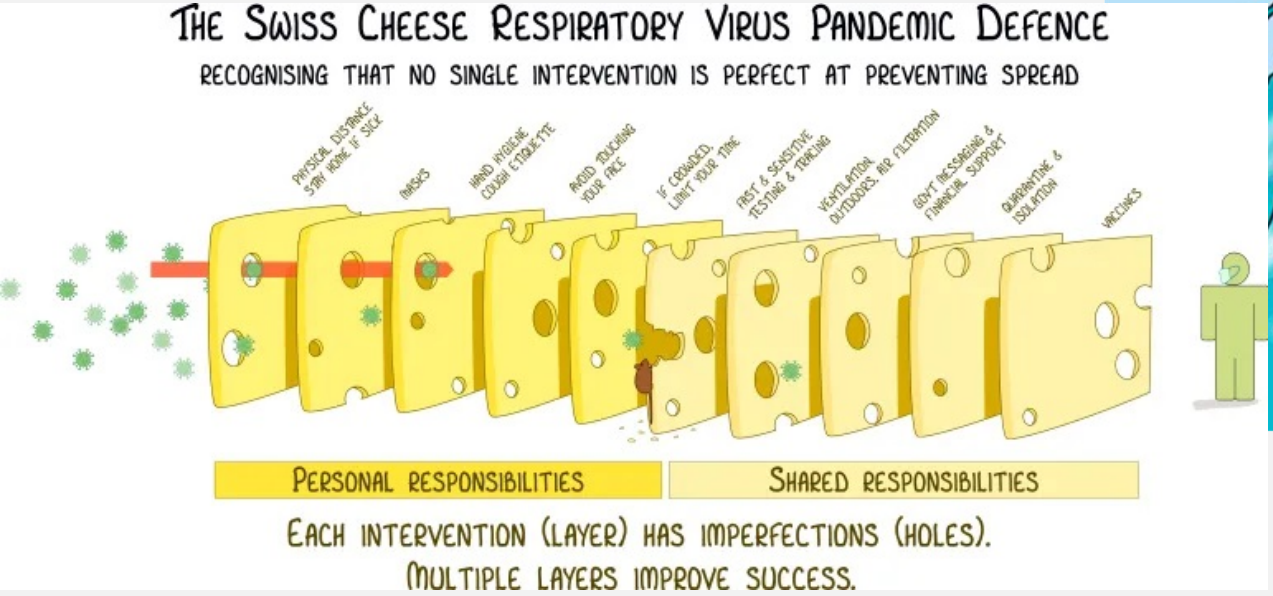
- None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt. EBSA observed several common themes in deficiencies:
  - Failure to document comparative analysis before designing and applying the NQTL;
  - Conclusory assertions lacking specific supporting evidence or detailed explanation;
  - Lack of meaningful comparison or meaningful analysis;
  - Non-responsive comparative analysis;
  - Documents provided without adequate explanation;
  - Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification/s affected by an NQTL;
  - Limiting scope of analysis to only a portion of the NQTL at issue;
  - Failure to identify all factors;
  - Lack of sufficient detail about identified factors;
  - Failure to demonstrate the application of identified factors in the design of an NQTL; and
  - Failure to demonstrate compliance of an NQTL as applied.

https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

Some Challenges to Implementation

- **Limited enforcement resources/power**
  - e.g., EBSA
    - <1 investigator for every 12,500 plans
    - May not directly enforce MHPAEA against insurance companies even if it obtains evidence of parity noncompliance
    - DOL can't assess **Civil Monetary Penalties**/currently limited to equitable relief
      - Efforts to change - Obama's Federal Mental Health and Substance Use Parity Task Force Report recommendations (2016) and Trump's 2017 Commission on Combating Drug Addiction and the Opioid Crisis Task Force agreed DOL should have CMP authority; legislation pending
  - States – takes political will

Promising Potential (?)



https://www.truman.edu/coronavirus/covid-video-updates-spring-2021/swiss-cheese-model/

Promising Potential (?)

Additional Tools to Consider/Encourage:

- **Civil Monetary Penalties**
- **Ending opt-outs**
- **Creative enforcement:** consumer fraud statutes, independent monitors – "cooperative federalism"
- **Legislating to:**
  - limit UM (e.g., no prior authorization for x)
  - Mandate coverage
  - define medical necessity criteria

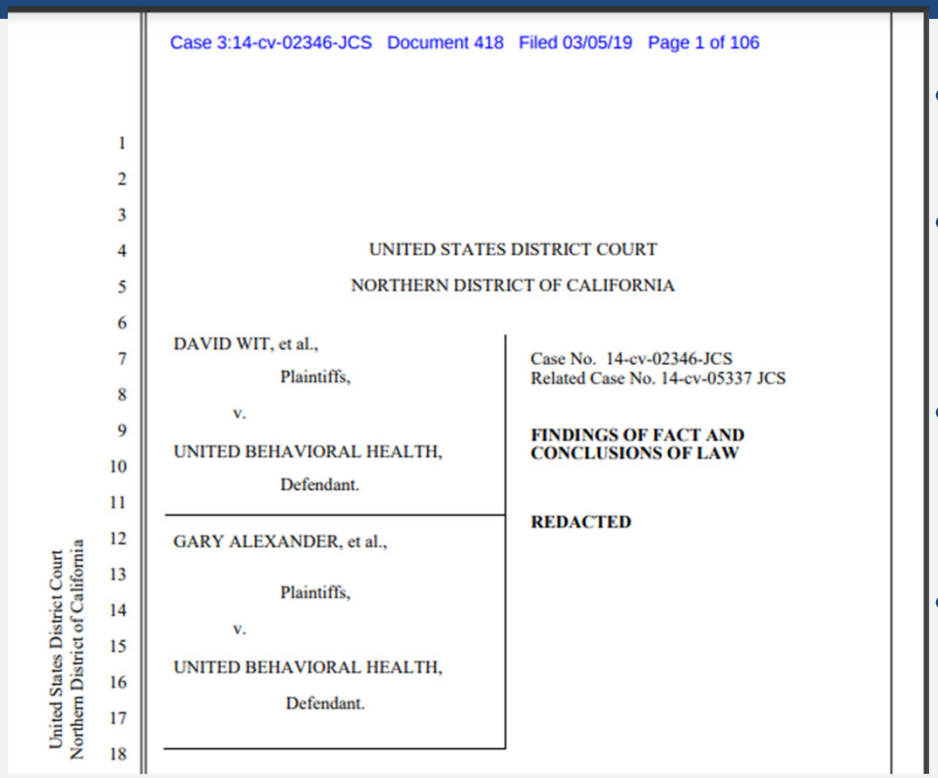
Wit v. United Behavioral Health

In the battle against the nation's mental health and addiction crises, this case is an inflection point and a bellwether. Former Congressman Patrick J. Kennedy, sponsor of the federal mental health parity act, hailed it as the "*Brown v. Board of Education* for the mental health movement," while a major news outlet dubbed it "one of the most important and most thorough rulings ever issued against an insurance company."[1] As reflected in the response of industry watchers—and the amicus briefs that have been (and will be) filed by the U.S. government, multiple states, the American Psychiatric Association, American Medical Association, and others—it is no exaggeration to call this one of the most significant ERISA cases of the 21st century.

The issue is simple: when an insurer denies coverage as not "medically necessary," may it use guidelines inconsistent with the plan's requirement to use the medical community's generally accepted standards of care? Here, the panel said "yes," even though Defendant United Behavioral Health's ("UBH") Guidelines were not plan terms, were infected by an egregious conflict of interest, and were shown, in unchallenged factual findings, to be far stricter than the medical community's standards.

https://www.zuckerman.com/sites/default/files/2022-05/Wit_Rehearing_Petition.pdf

Wit v. United Behavioral Health



Case 3:14-cv-02346-JCS Document 418 Filed 03/05/19 Page 1 of 106

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

DAVID WIT, et al.,

Plaintiffs,

v.

UNITED BEHAVIORAL HEALTH,

Defendant.

Case No. 14-cv-02346-JCS
Related Case No. 14-cv-05337 JCS

FINDINGS OF FACT AND CONCLUSIONS OF LAW

REDACTED

GARY ALEXANDER, et al.,

Plaintiffs,

v.

UNITED BEHAVIORAL HEALTH,

Defendant.

United States District Court
Northern District of California

- Theoretically, covered care, IF **medically necessary**
- plans provide for coverage of treatment that is consistent with generally accepted standards of care (**GASC**)
- **Denied** coverage based on UBH's Level of Care **Guidelines** and Coverage Determination Guidelines
- Alleged violations of terms of insurance **contracts or state law** (CT, IL, RI, TX) state mandates) – N.B. **not MHP**

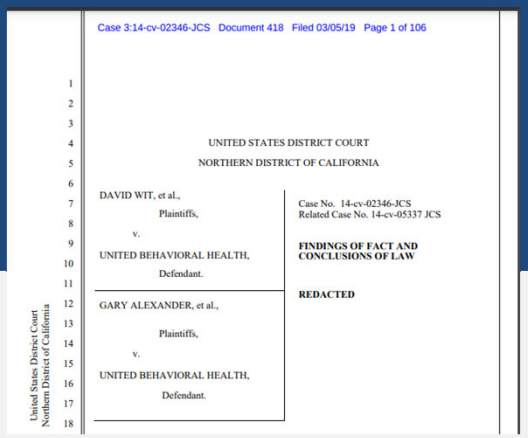
https://www.thekennedyforum.org/app/uploads/2022/06/Wit-v.-UBH-District-Court-Ruling.pdf

Wit v. United Behavioral Health

Medicare and Healthcare.gov define "**medically necessary**" as "Health care services or supplies **needed** to diagnose or treat an illness, injury, condition, disease or its symptoms and that **meet accepted standards of medicine**."

❖ **legislating medical necessity criteria – e.g.,**

- **CT:** requires insurers to use the **ASAM Criteria, or a set of criteria that UBH "demonstrates to the Insurance Department is consistent with"** the ASAM Criteria
- **IL**: all med nec determinations for SUDs shall be made in accordance with **ASAM** – "No additional"
- **RI:** requires payors such as UBH to **"rely upon" ASAM criteria** when developing SUD LOC coverage
- **TX:** requires insurance companies to apply **criteria issued by the Texas Department of Insurance** in making med nec determinations for SUD treatment when TX law governs plan and treatment from provider or facility in TX



Case 3:14-cv-02346-JCS Document 418 Filed 03/05/19 Page 1 of 106

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DAVID WIT, et al.,
Plaintiffs,
v.
UNITED BEHAVIORAL HEALTH,
Defendant.

Case No. 14-cv-02346-JCS
Related Case No. 14-cv-05337 JCS

FINDINGS OF FACT AND CONCLUSIONS OF LAW

REDACTED

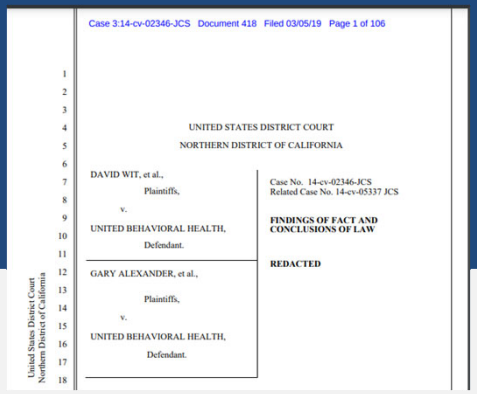
GARY ALEXANDER, et al.,
Plaintiffs,
v.
UNITED BEHAVIORAL HEALTH,
Defendant.

United States District Court
Northern District of California

Wit v. United Behavioral Health

- **District Court itemized** the specific ways in which, based on testimony/evidence, the UBH Guidelines **deviate from GASCs**
  - "the record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, 'mitigating' the impact of the 2008 Parity Act, and keeping 'benex' down"
- "the Court finds that during the class period UBH **violated the laws of Illinois, Connecticut, Rhode Island, and Texas** by failing to apply criteria that were in compliance with the laws of those states for making coverage determinations relating to substance use disorders treatment."

https://www.thekennedyforum.org/app/uploads/2022/06/Wit-v.-UBH-District-Court-Ruling.pdf



Case 3:14-cv-02346-JCS Document 418 Filed 03/05/19 Page 1 of 106

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DAVID WIT, et al.,
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FINDINGS OF FACT AND CONCLUSIONS OF LAW

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GARY ALEXANDER, et al.,
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v.
UNITED BEHAVIORAL HEALTH,
Defendant.

United States District Court
Northern District of California

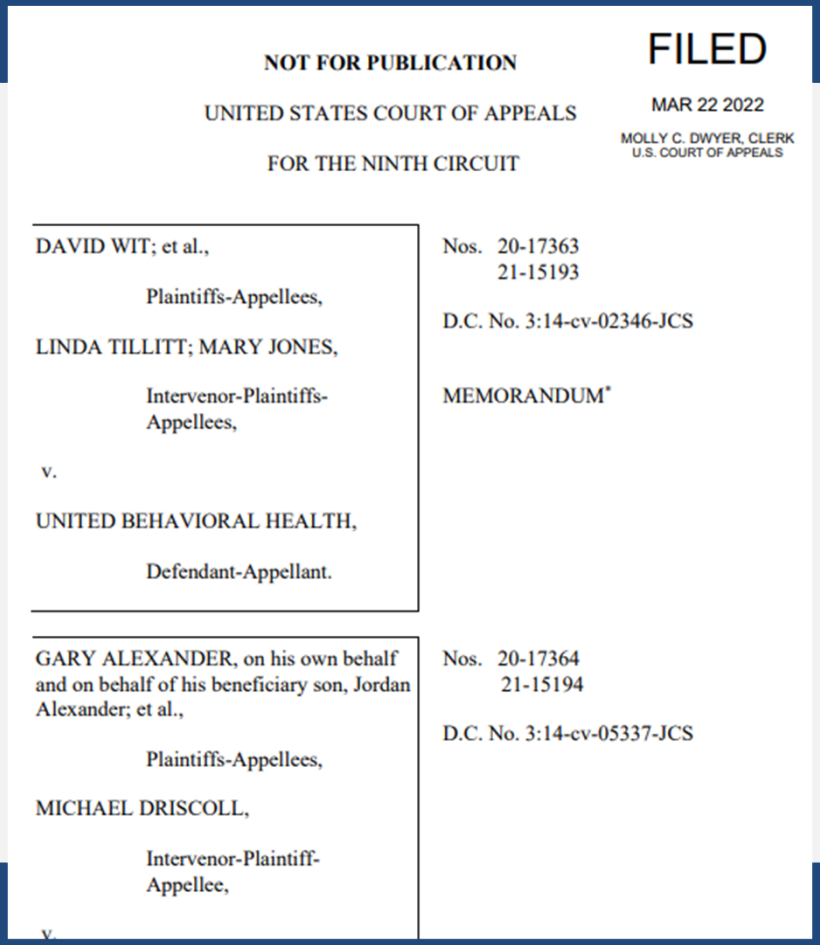
Wit v. United Behavioral Health

Conclusions of Law:

- **Breach of Fiduciary Duty:** "Thus, when it **adopts and applies its Guidelines** to coverage determinations, UBH is required to act in a manner that is **consistent with the fiduciary duties** set forth above, that is, the duty of **loyalty**, the duty of **due care** and the duty to **comply with plan terms.**"
  - "the Court finds, by a preponderance of the evidence, that UBH **has breached its fiduciary duty** by violating its duty of **loyalty**, its duty of **due care**, and its duty to **comply with plan terms** by adopting Guidelines that are **unreasonable and do not reflect generally accepted standards of care**."
- **Denial of Benefit**: "the Court finds, by a **preponderance** of the evidence, that UBH's **Guidelines were unreasonable and an abuse of discretion** because they were **more restrictive than generally accepted standards of care**."
  - "In addition to **plan terms requiring UBH to use generally accepted standards of care**, UBH was specifically required, pursuant to the laws of **Illinois, Connecticut, Rhode Island, and Texas**, to administer requests for benefits pursuant to Plans governed by those states' laws in accordance with those laws. For the reasons stated above, the Court finds that UBH **did not adhere to these state law requirements**."

https://www.thekennedyforum.org/app/uploads/2022/06/Wit-v.-UBH-District-Court-Ruling.pdf

Wit v. United Behavioral Health



NOT FOR PUBLICATION

FILED

MAR 22 2022

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID WIT; et al.,

Plaintiffs-Appellees,

LINDA TILLITT; MARY JONES,

Intervenor-Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

Nos. 20-17363
21-15193

D.C. No. 3:14-cv-02346-JCS

MEMORANDUM*

GARY ALEXANDER, on his own behalf and on behalf of his beneficiary son, Jordan Alexander; et al.,

Plaintiffs-Appellees,

MICHAEL DRISCOLL,

Intervenor-Plaintiff-Appellee,

v.

Nos. 20-17364
21-15194

D.C. No. 3:14-cv-05337-JCS

"UBH's interpretation—that the **Plans do not require consistency with the GASC [generally accepted standards of care] —was not unreasonable**. . . . The Plans exclude coverage for treatment inconsistent with the GASC; Plaintiffs did not show that the Plans mandate coverage for all treatment that is consistent with the GASC. . . . We therefore reverse."

-No mention of **state mandates** class

https://cases.justia.com/federal/appellate-courts/ca9/20-17363/20-17363-2022-03-22.pdf?ts=1647979262

Wit v. United Behavioral Health

"For every one of th[e] plans, a precondition of coverage is that the treatment must be consistent with generally accepted standards of care. **This is not the same thing as saying that the plans provide coverage for all services that are consistent with generally accepted standards. That's not plaintiffs' argument**." 3-ER-464-65 (emphasis added)." 3-ER-464-65 (Pl's opening statement at trial).

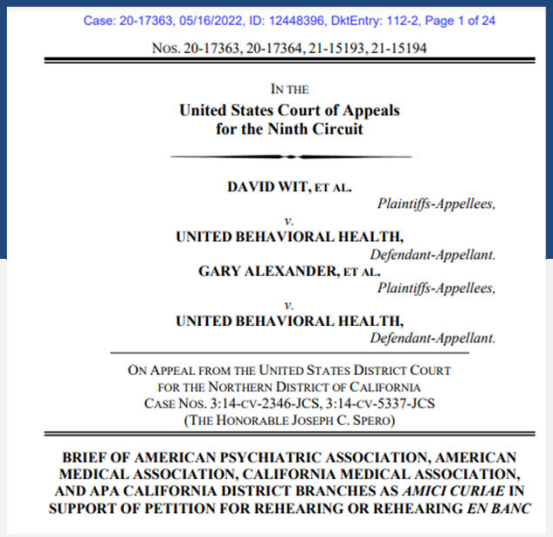
"Every class member's health benefit plan includes, as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care. . . . On the other hand, Plaintiffs do not dispute that a service that is consistent with generally accepted standards of care may, nonetheless, be excluded from coverage under a particular class member's plan." D Ct's factual findings 2-ER-253 (citations omitted)

"UBH's interpretation—that the **Plans do not require consistency with the GASC [generally accepted standards of care] —was not unreasonable**. . . . The Plans exclude coverage for treatment inconsistent with the GASC; Plaintiffs did not show that the Plans mandate coverage for all treatment that is consistent with the GASC.
. . . We therefore reverse."

-No mention of **state mandates** class

https://cases.justia.com/federal/appellate-courts/ca9/20-17363/20-17363-2022-03-22.pdf?ts=1647979262

Wit v. United Behavioral Health



Case: 20-17363, 05/16/2022, ID: 12448396, DktEntry: 112-2, Page 1 of 24

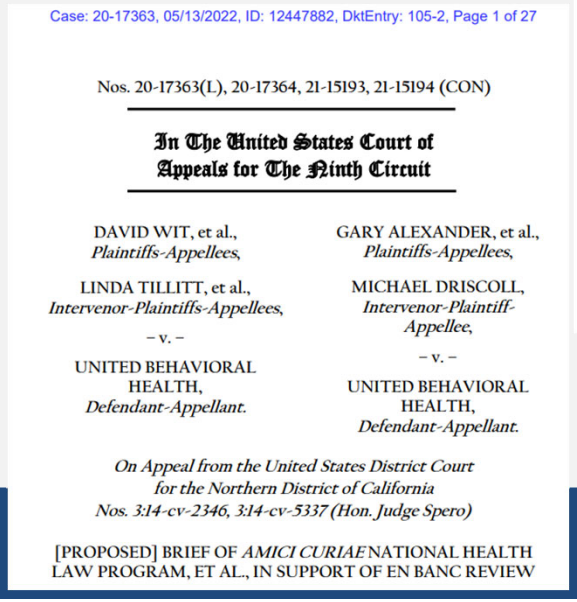
Nos. 20-17363, 20-17364, 21-15193, 21-15194

IN THE
United States Court of Appeals for the Ninth Circuit

DAVID WIT, ET AL.
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.
GARY ALEXANDER, ET AL.
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
CASE NOS. 3:14-CV-2346-JCS, 3:14-CV-5337-JCS
(THE HONORABLE JOSEPH C. SPERO)

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, CALIFORNIA MEDICAL ASSOCIATION, AND APA CALIFORNIA DISTRICT BRANCHES AS *AMICI CURIAE* IN SUPPORT OF PETITION FOR REHEARING OR REHEARING *EN BANC*



Case: 20-17363, 05/13/2022, ID: 12447882, DktEntry: 105-2, Page 1 of 27

Nos. 20-17363(L), 20-17364, 21-15193, 21-15194 (CON)

In The United States Court of Appeals for The Ninth Circuit

DAVID WIT, et al.,
Plaintiffs-Appellees,

LINDA TILLITT, et al.,
Intervenor-Plaintiffs-Appellees,

– v. –

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, et al.,
Plaintiffs-Appellees,

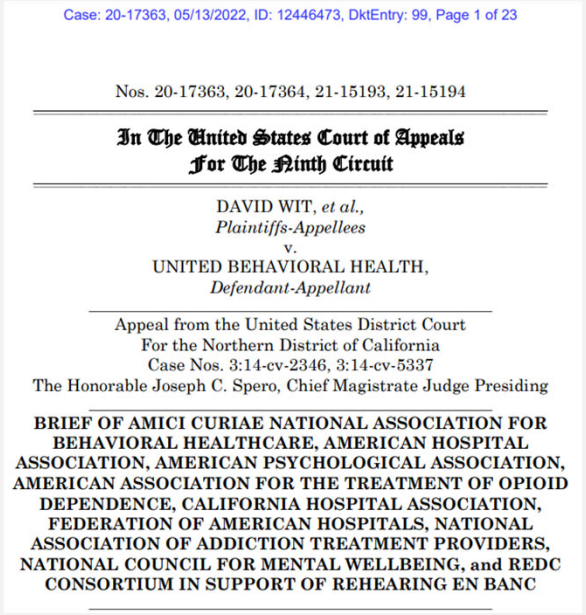
MICHAEL DRISCOLL,
Intervenor-Plaintiff-Appellee,

– v. –

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

On Appeal from the United States District Court for the Northern District of California
Nos. 3:14-cv-2346, 3:14-cv-5337 (Hon. Judge Spero)

[PROPOSED] BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, ET AL., IN SUPPORT OF EN BANC REVIEW



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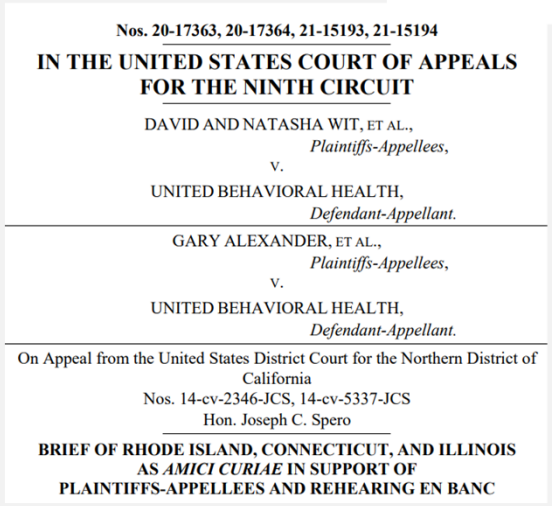
Nos. 20-17363, 20-17364, 21-15193, 21-15194

In The United States Court of Appeals For The Ninth Circuit

DAVID WIT, *et al.*,
Plaintiffs-Appellees
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant

Appeal from the United States District Court
For the Northern District of California
Case Nos. 3:14-cv-2346, 3:14-cv-5337
The Honorable Joseph C. Spero, Chief Magistrate Judge Presiding

BRIEF OF AMICI CURIAE NATIONAL ASSOCIATION FOR BEHAVIORAL HEALTHCARE, AMERICAN HOSPITAL ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE, CALIFORNIA HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS, NATIONAL COUNCIL FOR MENTAL WELLBEING, and REDC CONSORTIUM IN SUPPORT OF REHEARING EN BANC



Nos. 20-17363, 20-17364, 21-15193, 21-15194

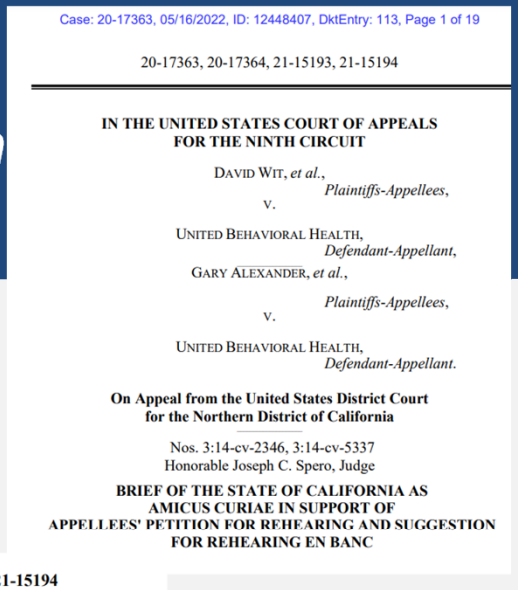
IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DAVID AND NATASHA WIT, ET AL.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, ET AL.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

On Appeal from the United States District Court for the Northern District of California
Nos. 14-cv-2346-JCS, 14-cv-5337-JCS
Hon. Joseph C. Spero

BRIEF OF RHODE ISLAND, CONNECTICUT, AND ILLINOIS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND REHEARING EN BANC



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20-17363, 20-17364, 21-15193, 21-15194

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DAVID WIT, *et al.*,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant,
GARY ALEXANDER, *et al.*,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

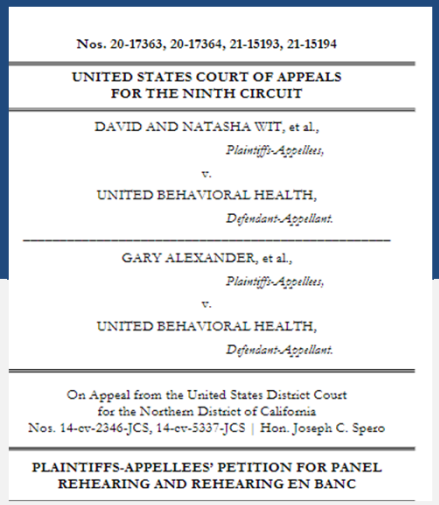
On Appeal from the United States District Court for the Northern District of California

Nos. 3:14-cv-2346, 3:14-cv-5337
Honorable Joseph C. Spero, Judge

BRIEF OF THE STATE OF CALIFORNIA AS AMICUS CURIAE IN SUPPORT OF APPELLEES' PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

https://www.thekennedyforum.org/wit/

Center for Health & Pharmaceutical Law & Policy
SETON HALL | LAW



Nos. 20-17363, 20-17364, 21-15193, 21-15194

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID AND NATASHA WIT, et al.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, et al.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

On Appeal from the United States District Court
for the Northern District of California
Nos. 14-cv-2346-JCS, 14-cv-5337-JCS | Hon. Joseph C. Spero

PLAINTIFFS-APPELLEES' PETITION FOR PANEL
REHEARING AND REHEARING EN BANC

Wit v. United Behavioral Health

"**Virtually every ERISA plan** in the country, often as a condition of state law, **requires medical necessity decisions to follow the medical community's generally accepted standards of care**. And **virtually every insurer relies on guidelines separate** from the plans to evaluate that question. See Assoc. for Behavioral Health and Wellness ('ABHW') Br. 1–2 (ECF No. 41) (amicus supporting UBH explaining that 'guidelines are essential tools' for its member insurers, who collectively 'provide coverage to over 200 million people'). By allowing the mental health subsidiary of the nation's largest insurer to use guidelines that are much stricter than the medical community's views, the panel's resolution of this test case will **affect the coverage of mental health and addiction patients nationwide**."

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

Preventive PH Well-Visits routinely are covered with no co-pay	Preventive BH Well-Visits are NOT routinely covered at all (cannot bill)

Does this violate the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)?

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

Non-Quantitative Treatment Limitations (NQTLs): not expressed numerically but otherwise limit scope or duration of benefits for treatment under a plan or coverage.

Examples from Non-Exhaustive List of NQTLs

- **Medical management standards** limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Restrictions based on geographic location, facility type, provider specialty, **and other criteria that limit the scope or duration of benefits for services provided** under the plan or coverage

-45 C.F.R. 146.136(c)(4)(ii); 147.160(a)

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

NQTL Analysis:

"[A plan] may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits **in any classification** unless, under the terms of the plan (or health insurance coverage) **as written and in operation**, any **processes, strategies, evidentiary standards, or other factors used in applying** the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are **comparable to**, and are **applied no more stringently** than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."

-45 C.F.R. §§ 146.136(c)(4)(i) (emphasis added); 147.160(a)

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

Can plan satisfy NQTL analysis?

- If a plan establishes **evidentiary standards to use in determining whether a treatment is medically appropriate based on recommendations "by panels of experts** with appropriate training and experience in the fields of medicine involved," and "[t]he evidentiary standards are **applied in a manner that is based on clinically appropriate standards of care for a condition**," then the plan complies with parity "because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits **are comparable to and are applied no more stringently** than for medical/surgical benefits."
  - This is true **even if** application of these standards results in **different benefits coverage** for MH or SUDs than for a particular med/surg condition

45 CFR 146.36(c)(4)(iii) Example 4

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

Can plan satisfy NQTL analysis?

"**ILLUSTRATION 1**: A Plan **covers neuropsychological testing but excludes such testing for certain conditions**. In such situations, look to see whether the exclusion is based on **evidence addressing, for example, clinical efficacy** of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on **criteria and evidence from comparable sources** with respect to medical/surgical and mental health conditions? Does the plan have **documentation indicating the criteria used and evidence supporting the plan's determination** of the diagnoses for which the plan will cover this service and the **rationale for excluding** certain diagnoses? The result **may be that the plan permissibly** covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome **may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions** for which testing is covered and those for which it is excluded."

Self-Compliance Tool at 35.

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

Can plan satisfy NQTL analysis?

"ILLUSTRATION 5: A patient with chronic depression has not responded to five different antidepressant medications and therefore was referred for **outpatient treatment with repetitive transcranial magnetic stimulation (TMS)**. This **specific treatment has been approved by the FDA** and has been the subject of more than **six randomized controlled trials published in peer reviewed** journals. The plan **denies** the treatment as **experimental**. The plan states that it used the **same criteria** to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its **standard for both** medical/surgical benefits and MH/SUD benefits as requiring that **at least two randomized controlled trials showing efficacy** of a treatment be published **in peer reviewed journals for any new treatment**. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a **committee of medical experts** involved in plan utilization management reviews reviewed the journals and **determined that only one of the articles provided sufficient evidence of efficacy**. The plan **did not identify what specific standards** were used to assess whether a peer review had adequately evidenced efficacy and what the **qualifications** of the plan's experts are. Lastly, the plan **does not impose this additional level** of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

Conclusion: The plan's **exclusion fails to comply** with MHPAEA's NQTL requirements because, **in practice**, **the plan applies an additional level of scrutiny** with respect to MH/SUD benefits and therefore applies the NQTL **more stringently** to mental health benefits than to medical/surgical benefits **without additional justification**. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by **establishing standards for when a peer review has adequately evidenced efficacy**, and that the **qualifications of the plan's experts are similar** for both MH/SUD and medical/surgical benefits."

Self-Compliance Tool at 36.

Rhetorical Power of Parity: Preventive Behavioral Health Case Study

CO enacted HB 21-1068 (July 6, 2021):

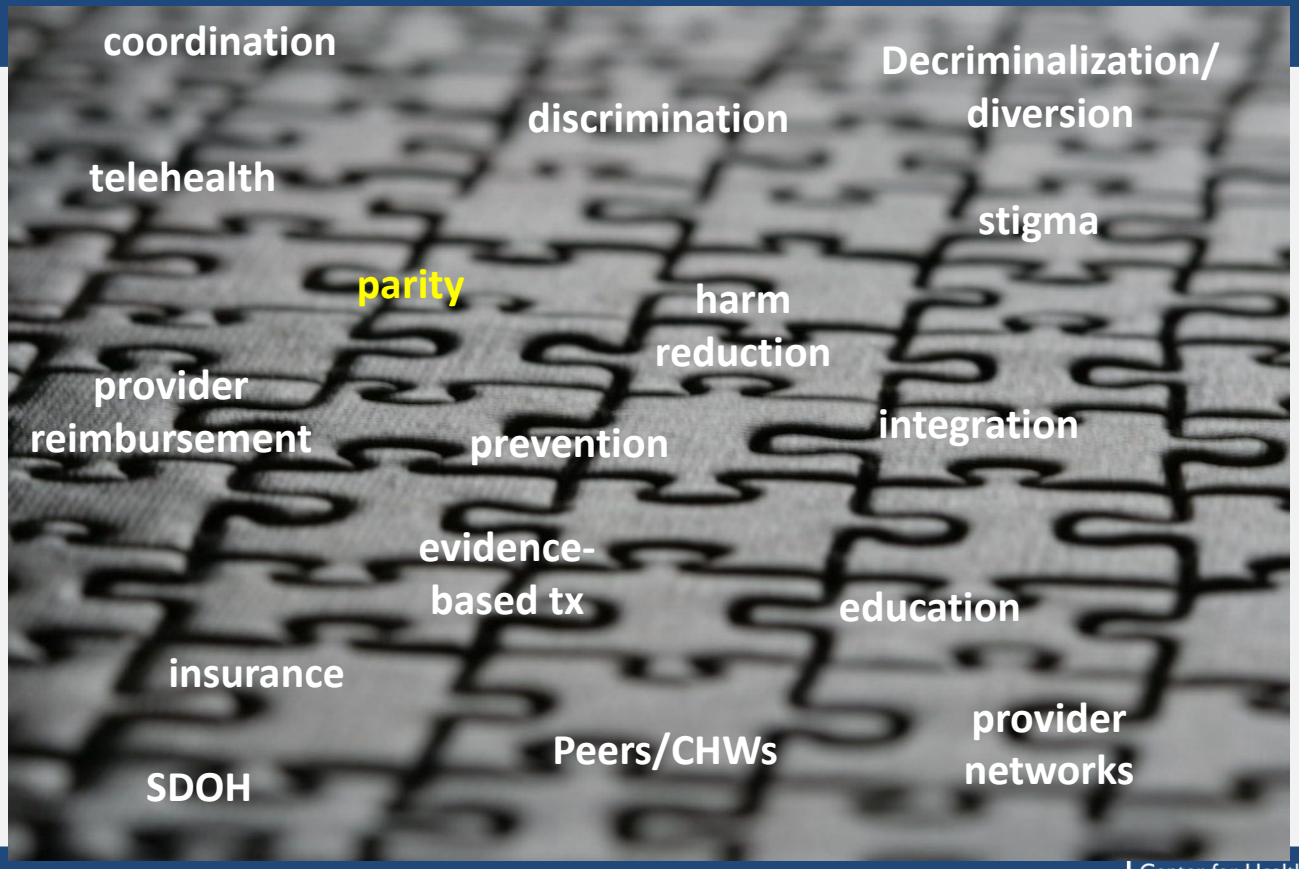
- Requires coverage for total cost for **preventive annual MH wellness exam** of up to 60 minutes by **qualified mental health care provider**
- Must be no less extensive than the coverage provided for a physical examination and must comply with the requirements of the Mental Health Parity and Addiction Equity Act **(MHPAEA)**

Delaware HB 303 (enacted 8/2/2022):

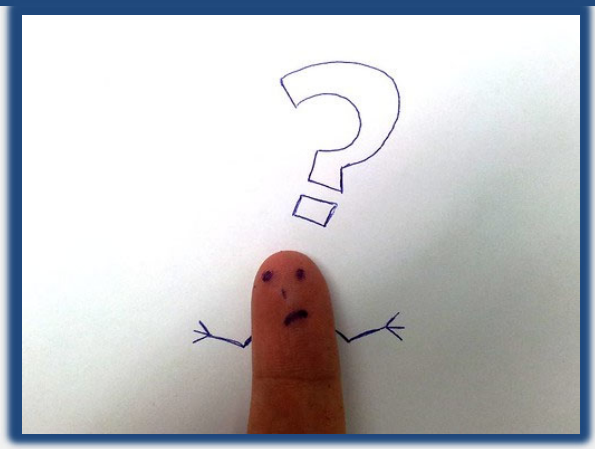
- Requires coverage of pre-deductible, **annual Behavioral Health Well Check** with a **licensed mental health clinician** for commercial and Medicaid plans
- Reimbursement must be **no less than what similarly qualified medical professional** would receive for annual physical

Preventive BH bills pending in a number of states, e.g.: Connecticut A 217 (2021); **Hawaii SB 2585 / HB 1946; Kentucky HB 55; Massachusetts S.2572; New Jersey A1141**

Promising Potential (?)



Questions? Suggestions?



Tara.Ragone@shu.edu