No. 21-4110

In The United States Court of Appeals for
The Tenth Circuit

E.W., and I.W.
Plaintiffs-Appellees,

– v. –

HEALTH NET LIFE INSURANCE COMPANY, AND
HEALTH NET OF ARIZONA, INC.,
Defendants-Appellants.

On Appeal from the United States
District Court for Utah
No. 2:19-cv-00499-TC (Hon. Judge Campbell)

BRIEF OF *AMICI CURIAE* THE NATIONAL HEALTH LAW PROGRAM, AND THE KENNEDY FORUM, IN SUPPORT OF REVERSAL FILED WITH CONSENT OF ALL PARTIES (F.R.A.P. R. 29(a)(2))

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CORPORATE DISCLOSURE STATEMENT

The undersigned counsel certifies that the *amici curiae* The National Health Law Program and The Kennedy Forum are not subsidiaries of any other corporation and no publicly held corporation owns 10 percent or more of any *amici curiae* organization's stock.

Dated: June 28, 2022

/s/ Abigail K. Coursolle
Abigail K. Coursolle

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INTEREST OF *AMICI*

The National Health Law Program and The Kennedy Forum both represent the interests of people with behavioral health conditions and have come together to submit this *amicus curiae* brief in support of the Plaintiffs-Appellees in their appeal of the District Court's dismissal of their Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) claim.[1]

The National Health Law Program (NHeLP), founded in 1969, protects and advances health rights of low-income and underserved individuals and families. NHeLP advocates, educates, and litigates at the federal and state levels to advance health and civil rights in the United States. NHeLP works in depth with federal and state laws that are intended to ensure access to behavioral health services, including MHPAEA.

The Kennedy Forum, launched in celebration of the 50th anniversary of President Kennedy's signing of the landmark Community Mental Health Act, aims to achieve health equity by advancing evidence-based practices, policies and programming for the treatment of mental health and addiction. The Kennedy Forum is committed to providing leadership at all levels to unite the country around a

[1] All parties consented to the filing of this brief. (Consent attached as Exhibits A and B.) Counsel for *amici curiae* states that no counsel for a party authored the brief in whole or in part, and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

common vision to improve the lives of individuals living with mental illness and addiction, and to promote behavioral health for all. The Kennedy Forum works to ensure full implementation of the MHPAEA and to protect individuals' rights under the law.

INTRODUCTION

The worsening mental health and opioid crises have sharpened the focus on removing illegal barriers to treatment for mental health and substance use disorders (collectively "behavioral health"). The COVID-19 pandemic has exponentially increased the need for these services. For years, legislators and regulators have attempted to bridge the gap between need and treatment by ensuring fair and equitable access to these important services. Unfortunately, with each new bridge, insurers dig a new—but often illegal—trench, finding new ways to deny critically needed behavioral health services ostensibly covered under their plan. Appealing the denials is usually futile since the administrative appeals system largely reflects the insurers' flawed and conflict-ridden rationale for denying care. Moreover, fighting the denial on an individual basis through litigation demands resources for experts and advocacy typically far out of proportion with the specific coverage benefit at stake.

In the instant case, a young woman (I.W.) sought treatment for multiple serious mental health conditions including five suicide attempts. After initially paying for her treatment for about two months, her insurer, Health Net, then refused payment, against the recommendation of her treating providers and generally accepted standards of care, because it determined the care was no longer necessary using its own guidelines. *See* Order Granting Summary Judgment, pg. 3, n.1 (before I.W. was covered by Health Net on January 1, 2017, her care was covered by her prior

insurer for about four months in 2016). Health Net then refused to provide the guidelines, or the processes or analyses on which they were based, despite repeated attempts by E.W. to request Plan Documents, including skilled nursing and rehab guidelines in their external review. Complaint ¶ 30. Health Net eventually provided E.W. with its criteria for residential treatment coverage, but did not produce any of the other requested documents. *Id.* I.W. remained in treatment for 10 more months despite Health Net's refusal to pay for the care her providers determined was medically necessary. Nevertheless, the District Court in this case found that I.W. and her father E.W. failed to state a cause of action under MHPAEA and dismissed this claim. *Amici* urge this Court to reverse the District Court's decision so that access to covered and needed services will be preserved and information needed to identify parity issues and appeal service denials will be disclosed as required.

ARGUMENT

I. Many Do Not Receive the Behavioral Health Services That They Need.

A. Despite Prevalent Need, People Often Go Without Needed Behavioral Health Care—Even Those with Insurance.

Millions of people in the U.S. need behavioral health care but do not get it. An estimated 40 million U.S. adolescents and adults have a substance use disorder ("SUD"). Substance Abuse & Mental Health Servs. Admin., *2020 National Survey on Drug Use and Health* 5 (2021), https://perma.cc/C5NX-Y7GD. Over 52 million (or one in five) U.S. adults live with a mental health condition. *Id.* at 5. The relationship between

mental health needs and substance use creates complex co-occurring behavioral health conditions for many in the U.S., with nearly half of people with a SUD also having a mental health diagnosis. *Id.* at 34. Meanwhile, related complications, including suicide and overdose, continue to drive down U.S. life expectancy, with 2010 marking the first time in six decades that life expectancy decreased. Anne Case & Angus Deaton, *Rising Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 49 Proc. Nat'l Acad. Sci. 15078 (2015), https://perma.cc/XY9Y-YYQ5. Since 2019 overdose deaths increased by nearly 50 percent, reaching a record high of nearly 108,000 in 2021. FB Ahmad et al., Ctrs. for Disease Control, *Provisional Drug Overdose Death Counts* (2021), https://perma.cc/G4GP-QV2R. The COVID-19 pandemic has had significant impacts on behavioral health, with sharp increases in the prevalence of conditions in specific populations, such as young adults, people of color, essential workers, and unpaid caregivers, experiencing a disproportionate impact. Mark E. Czeisler, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – US, June 24-30, 2020*, CDC Morbidity & Mortality Wkly. Rpt. (2020), https://perma.cc/7V2Q-4SLU; U.S. Dep't of Labor, *2022 MHPAEA Report to Congress* 6 (2022), https://perma.cc/4KHN-46U3.

Despite the ubiquity of behavioral health conditions, people often have trouble accessing the care they need. The majority of the U.S. population is covered by employer-sponsored coverage, Medicaid managed care, or other insurance coverage

required to comply with parity requirements. Kaiser Family Found., *Health Insurance Coverage of the Total Population* (2018), https://perma.cc/SY5D-T5HU. However, 56.2% of people with mental health conditions did not receive any mental health services in a year. Nat'l Inst. of Mental Health, *Mental Health Information: Statistics* (last updated Jan. 2021), https://perma.cc/Z5YC-Z4Z5. Additionally, roughly 11.8 million U.S. residents had an unmet need for mental health services in 2016, with 6.3 million (53%) reporting they received only a limited amount of care and the remaining 5.5 million (47%) reporting they received no care at all. Peggy Christidis et al., Am. Psych. Association, *An Unmet Need for Mental Health Services* (Apr. 2018), https://perma.cc/YZ43-R98Q. For those insured, high rates of denials of care, high out-of-pocket costs for mental health care, and problems finding providers within health insurance networks all create significant barriers to care. Nat'l Alliance for Mental Illness (NAMI), *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care* 2 (2017), https://perma.cc/3CA3-4RWG.

The unmet need for mental health services is particularly serious among groups that have historically experienced discrimination. For example, African Americans, American Indians, and Alaska Natives access mental health services at substantially lower rates than white Americans. Azza Altiraifi & Nicole Rapfogel, Ctr. Am. Prog., *Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis* (Sept. 10, 2020), https://perma.cc/SH9R-DBRM. Likewise, people with a range of disabilities

experience co-occurring mental distress at rates five times higher than people without disabilities, yet individuals with disabilities report twice as much difficulty in accessing appropriate mental health care. Ctrs. for Disease Control & Prevention (CDC), *The Mental Health of People with Disabilities* (2020), https://perma.cc/3QRV-874K; CDC, *Delayed or Forgone Medical Care Because of Cost Concerns Among Adults Aged 18-64 Years, by Disability and Health Insurance Coverage Status*, 59 Morbidity & Mortality Wkly. Rpt. 44, 44 (Nov. 12, 2010), https://perma.cc/2FUW-QCG5.

B. Insurers Fail to Cover Needed Behavioral Health Services.

A major reason that people with insurance forgo these important services is that their insurers fail to cover the care they are supposed to provide. Contractual obligations require insurers to cover the non-excluded services described in their plan terms. However, claim denials by insurers—like Health Net—create major barriers to behavioral health care, despite Congressional attempts to curtail such denials. *See infra* Section II. In one survey, 29% of respondents said they or their family member had been denied mental health care, and 18% of respondents had been denied SUD care by their insurer; comparatively only 14% had been denied general medical care. Nat'l Alliance for Mental Illness (NAMI), *A Long Road Ahead* 4 (2015), https://perma.cc/9VWC-S4UV (hereafter NAMI, *A Long Road Ahead*). Insurers are often impacted by market forces to "cherry-pick" the care they deem medically necessary out of covered plan services, to the detriment of the health and welfare of

their covered lives. *See* Neiloy Sircar, *Your Claim Has Been Denied: Mental Health and Medical Necessity*, 11 Health L. & Pol'y Brief 1, 10-11 (2017), https://perma.cc/68RS-6CW6.

Despite the high need for behavioral health services, health insurers still spend disproportionately few dollars on that care. For example, non-public insurers account for only a small portion of SUD treatment. *See* Steve Melek et al., Milliman, *Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* 6 (2019), https://perma.cc/ZB92-HF9J (hereafter Melek et al. 2019). A 2015 survey found that mental health claims were denied at double the rate of physical health claims. NAMI, *A Long Road Ahead* at 4. A 2019 analysis of claims data from over 37 million U.S. residents, found that only 1% of health care spending went to SUD treatment and only 4.3% to mental health treatment. Melek et al. 2019 at 17. These percentages remained fairly constant over a five-year period, despite a sharp increase in deaths from overdose and by suicide during that same period. *Id.*; Substance Abuse & Mental Health Servs. Admin., *2019 National Survey on Drug Use and Health* 25, 42-43 (2020), https://perma.cc/Y8SC-GEX2.

II. Despite Attempts by Congress and Regulators to Improve Access to Behavioral Health Care, Privately Insured Individuals Continue to Encounter Barriers to Care.

For nearly 30 years, Congress has repeatedly recognized the critical unmet need for behavioral health services in this country, amending ERISA on multiple occasions to address barriers to those services. Federal mental health parity laws are

intended to end long-standing discriminatory practices of health insurers that have limited access to behavioral health services and to "yield successful treatment for people with mental health or [SUD] problems." Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,258 (Nov. 13, 2013) (codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 CFR pts. 146 and 147); *see also Am Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 356 (2d Cir. 2016).

To that end, mental health parity requires that insurers cover behavioral health services comparably to medical and surgical services, including how treatment limitations are applied. 42 U.S.C. § 300gg-26(a)(3)(A)(ii). The law essentially "requires covered plans to treat sicknesses of the mind in the same way they would a broken bone." *Gallagher v. Empire Healthchoice Assurance, Inc.*, 339 F. Supp. 3d 248, 248 (S.D.N.Y. 2018) (citations omitted).

Straightforward in concept, ensuring compliance is extremely challenging in practice. Because behavioral health conditions and medical/surgical conditions typically differ in nature and treatment protocols, a thorough explication of the factors used by the insurer in developing and applying a provision limiting treatment is essential. The Kennedy Forum, *Filing An Appeal Based On a Parity Violation* 9 (2017), https://perma.cc/JSB3-LA2F. Without such information, it near impossible to evaluate whether a particular limitation is comparable and no more restrictively

applied to behavioral health conditions than medical/surgical conditions. Allowing insurers to evade disclosure of this information sharply inhibits peoples' ability to identify and file complaints about parity noncompliance. Limiting information serves to limit compliance and to restrict access to necessary behavioral health services. People cannot complain about what they do not know or do not understand.

A. Congress Has Repeatedly Reformed Parity to Meet Insurers' Tactics to Deny Behavioral Health Care.

The history of mental health parity reform has been marked by ever more sophisticated attempts by Congress to level the playing field and equally sophisticated evasions by insurers to move the goalposts. Greater transparency, analysis, and accountability of plan determinations of medical necessity and coverage have consistently been a focus of these Congressional actions after the initial Mental Health Parity Act (MHPA).[2] 104 Pub. L. 204, 110 Stat. 2945 (1996).

Congress first addressed the disparities in coverage of behavioral health benefits perpetuated by health insurers in the 1996 MHPA. *Id.* While a significant step forward for parity in private insurance, the MHPA had numerous holes that allowed insurers to continue to make coverage for behavioral health benefits starkly narrower than that for services to treat physical health conditions. U.S. Gov't Accountability

[2] *See* Caroline V. Lawrence & Blake N. Shultz, *Divide and Conquer? Lessons on Cooperative Federalism from A Decade of Mental-Health Parity Enforcement*, 130 Yale L.J. 2216, 2219, 2224-25 (2021) (describing history of mental health parity law in Congress).

Office, GAO/HEHS-00-95, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* 5 (2000), https://perma.cc/P373-59Y9. This report found that, after enactment of the MHPA, about two-thirds of insurers adopted restrictive mental health benefit design features to offset the impact of the reforms they made to comply with MHPA, while about 14% remained non-compliant. *Id.* at 5. The GAO also found that most insurers maintained design features that were more restrictive for mental health benefits than for medical/surgical benefits, only patchwork compliance with MHPA, and problems with relying on complaints for compliance. *Id.* at 12. Thereafter, Congress repeatedly stepped in to improve mental health parity

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), which was intended to address the range of discriminatory treatment limitations that persisted after enactment of MHPA, to apply protections to the treatment of substance use disorders, and focus on the need for transparency and disclosure of criteria used to make decisions. MHPAEA, 122 Stat. at 3881-93. After MHPAEA, discrimination increasingly shifted from fairly obvious quantitative limits, to other, nonquantitative limits on treatment, which can easily have the same discriminatory effect but typically require more analysis and information that is within the exclusive control of the insurer to prove. *See, e.g.*, Steve Ross Johnson, *Mental Health Parity Remains a Challenge 10 Years After Landmark Law*, Mod. Healthcare (Oct. 5, 2018), https://perma.cc/D6JV-9GYT; Parity Implementation Coalition, *Response to*

Departments Joint Request for Comments on "[Proposed] FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX at 5 (2018), https://perma.cc/2VZJ-XE7D ("The most significant problem area of MHPAEA and ERISA compliance . . . remains the unwillingness of plans to provide . . . a detailed summary of the key steps taken to analyze a [treatment limitation] when requested to do so.").

The 21st Century Cures Act attempted to close loopholes found by insurers and address noncompliance. Pub. L. 114-255, 130 Stat. 1033 (2016) (codified at 42 U.S.C. § 300gg-26(a)). This act included requirements that the Secretary of Health and Human Services develop a parity action plan, the Department of Labor (DOL) issue a report on parity investigations in ERISA plans, and the GAO produce a study on parity that would detail how covered insurers were complying with certain parity requirements, including medical necessity transparency requirements. *Id.* §§ 13002-13007. The law also required the federal agencies to provide guidance to plans on parity compliance, including plans' obligations to disclose documents that demonstrate parity compliance or noncompliance. *Id.* §§ 13001-13002. Yet, a 2019 GAO report found that employer-sponsored plans continued to not meet parity requirements and greater oversight was needed. Gov't Accountability Office (GAO), *Mental Health and Substance Abuse: State and Federal Oversight of Compliance with Parity Requirements Varies* (2019), https://perma.cc/32NS-K3QC ("GAO 2019 Report").

Congress again amended ERISA in the Consolidated Appropriations Act to improve access to care by forcing greater transparency and regulation of insurers' criteria and methods, both written and unwritten. Pub. L. 116-260, 134 Stat. 2900, § 203 (2020); *see also* Substance Abuse & Mental Health Servs. Admin, *The Essential Aspects of Parity: A Training Tool for Policymakers* 2-3 (2022), https://perma.cc/9HV5-TALN (listing the evolution of parity enforcement). Many states have also passed laws requiring insurers in their states to provide covered behavioral health benefits consistent with generally accepted standards of care. *See, e.g.*, Ellen Weber, Legal Action Ctr., *Spotlight on Medical Necessity Criteria for Substance Use Disorders* 9-10 (2020), https://perma.cc/V4PE-GZNN. As Congress and other regulators have scrutinized insurance coverage of behavioral health benefits more closely, insurers have responded by finding ways to hide and obscure their illegal actions to avoid the consequences of their illegal denials.

B. Despite Congressional and Regulatory Action, Insurers Evade Parity Compliance.

Even as the need for behavioral health services grows, compliance with parity requirements continues to be a problem. *See, e.g.*, *2022 MHPAEA Report to Congress* at 6. Recent studies have found that disparities have actually increased in several key areas of parity. *See id.* at 16-18; *see also* Steve Melek et al., 2019 at 7-8, https://perma.cc/ZB92-HF9J (concluding parity issues remain with respect to network adequacy and

provider reimbursement); *see also* NAMI, *The Doctor is Out* (finding network adequacy and costs for mental health care remain a significant parity issue).

Although insurers are required to comply with parity, including disclosure requirements, compliance is not closely enforced. *See, e.g.*, 29 C.F.R. § 2560.503-1. The existing legal scheme does not ensure that regulators scrutinize the quality and empirical underpinnings of insurers' internal medical necessity guidelines. *See* Am. Health Lawyers Assoc., *Medical Necessity: Current Concerns and Future Challenges* 28-29 (2005), https://www.yumpu.com/en/document/read/21768262/medical-necessity-american-health-lawyers-association. Under ERISA the insurer has a duty to disclose the "internal rule, guideline, protocol, or other similar criterion" that was used in making the denial of care and provide "an explanation of the scientific or clinical judgement for the determination, applying the terms of the plan to the (patient's) medical circumstances." 29 C.F.R. § 2560.503-1(g)(1)(v). Regulations also require basic "process" measures, including standards for who oversees medical necessity decisions and who can make a denial of care. *See, e.g.*, *id.* § 2560.503-1(b). But there are few guardrails that meaningfully prescribe how insurers use clinical guidelines to ensure that they follow generally accepted standards of care. Am. Health Lawyers Assoc. at 43. Insurers often rely on internally developed guidelines that restrict coverage, the terms and criteria for which are purposefully ambiguous and not consistent with generally accepted standards of care. Internal guidelines for

behavioral health frequently serve as gatekeeping mechanisms that limit coverage through overly restrictive medical necessity, admission, or level of care criteria. *See id.* at 37-45; *see also* Chloe Reichel, *Obstacles Prevent Access to Mental Health Care, Even Among Insured*, The Journalist's Resource (July 10, 2019), https://perma.cc/R7JT-7GD2.

This lack of regulatory scrutiny too often allows insurers to manipulate the guidelines illegally to deny reimbursement for needed behavioral health services by deeming the care not "medically necessary." *See* Am. Health Lawyers Assoc., at 29. Such denials frustrate Individuals, family members, and clinicians because they shed no light on the criteria used to make a decision or how those criteria were applied in the particular case. *Id.* at 3; NAMI, *A Long Road Ahead* at 4-5. An individual is often confused by the conflict between the insurer's standard and the generally accepted standards of care used by their clinician, but has few clear avenues to access the services their clinician says they need or dispute the standard used by the insurer. All too often, people simply accept the insurers' denials and forego the care they need. *See, e.g.*, Consumer Reports Nat'l Research. Ctr., *Surprise Medical Bills Survey* 3 (2015), https://perma.cc/7Q3B-QUHS.

III. Requirements Prohibiting Discrimination and Disclosure of Those Requirements are a Crucial Component of Parity.

Eliminating discriminatory treatment limitations is at the heart of federal parity law. Thus, MHPAEA broadly prohibits not only discriminatory quantitative

coverage limits but also discriminatory nonquantitative limitations, such as limits on the scope or duration of behavioral health treatment relative to medical and surgical services, including medical management criteria and other conditions on whether and when a therapy can be accessed. 42 U.S.C. § 300gg-26(a)(3)(A)(ii); 29 C.F.R. § 2590.712(c)(4)(ii). In practice, these limitations often take the form of utilization review criteria or differing criteria for providers that limit the provider network.

Hand in hand with these obligations is the need for disclosure. Disclosure of information by insurers is particularly important if enrollees and regulators are to be able to enforce parity. As the preamble to the 2013 MHPAEA Final Rule acknowledged, "it is difficult to understand whether a plan complies with the provisions without information showing that the processes, strategies, evidentiary standards, and other factors used in applying a [limitation] to mental health or [SUD]benefits and medical/surgical benefits are comparable, impairing plan participants' means of ensuring compliance with MHPAEA." 78 Fed. Reg. at 68,247.

The lack of adequate disclosures contributes to a lack of parity enforcement. The GAO 2019 Report detailed continuing compliance issues, including that the general lack of parity requirement knowledge meant that the relatively low numbers of parity complaints were a poor indicator of the extent of noncompliance. *See* GAO 2019 Report. It also noted that insurers may be incentivized by the lack of complaints, and subsequent enforcement, not to comply because the risk is not significant. *Id.* at

28. The GAO also pointed to state officials and others reporting difficulty assessing noncompliance based on issuer documentation and as applied to beneficiaries because a lack of information provided by the plans. *Id.* at 16-17; 37.

Insurers' failure to adhere to disclosure requirements not only affect individual efforts to vindicate rights but also hinder regulators' ability to enforce the law. Numerous studies have found problems with identifying parity compliance. In one study, a team of parity experts concluded that they could not conduct a complete assessment of parity compliance because the available documents from insurers did not include the necessary information and additional searches did not provide the needed information, particularly on nonquantitative treatment limitations. Legal Action Ctr. et al., *Parity Tracking Project: Making Parity a Reality* 6-8, 11-12 (2017), https://perma.cc/HK5R-B8QL ("Parity Tracking Report"); *see also* U.S. Dep't of Labor, *2022 MHPAEA Report to Congress*, at 19-20 (describing issues with insurers failing to properly disclose information pursuant to parity investigations); U.S. Dep't of Labor, *Factsheet: FY 2019 MHPAEA Enforcement* (2019), https://perma.cc/4J3U-VTSK (finding noncompliance where insurer could not establish that comparable processes, strategies, evidentiary standards, and other factors were used to apply the limitation to a behavioral health service as compared to medical and surgical benefits).

The resistance by insurers to disclosing the factors underlying their design and implementation of treatment limits as required is not surprising. Indeed, it is

precisely the insurers who are engaging in discrimination that are using "processes, strategies, evidentiary standards and other factors specifically designed to restrict access to mental health or substance use disorder benefits" that have the greatest incentive to evade disclosure. 78 Fed. Reg. at 68,246. And because the incentives are so great, detailed disclosures are especially essential to uncover discrimination that has been buried under what appear to be facially neutral procedures.

To ensure that this kind of discrimination comes to light, the regulations require that for any treatment limits they use, insurers must ensure that

> 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.

29 C.F.R. § 2590.712(c)(4)(i). These same criteria, etc. treatment limitations for medical necessity determinations and denials of care must also be disclosed to enrollees, providers, and others. 29 C.F.R. § 2590.712(d)(1)-(3). These provisions are necessary to ensure that "individuals have the necessary information to compare [treatment limitations] of medical/surgical benefits and mental health or [SUD] benefits under the plan to effectively ensure compliance with MHPAEA." 78 Fed. Reg. at 68,248; *see also* U.S. Depts. Labor, Health & Human Servs., and Treasury, *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act*

Part 38 at 1 (2017), https://perma.cc/Y2WK-XL36 (emphasizing that a MHPAEA analysis requires information about both behavioral health and medical/surgical benefits). This information is also critical to a meaningful appeal process because without it a person cannot fully explain why they qualify for services or why the standards used by the plan are inappropriate under parity requirements.

As indicated by the examples set forth in the regulations and the case law, where a treatment limit is facially applied to some extent on medical/surgical coverage, the details of the insurer's parity analysis are critical to evaluating the issuers' compliance with the MHPAEA. 29 C.F.R. § 2590.712(c)(4)(iii); *see Gallagher*, 339 F. Supp. 3d at 257 (discussing cases). Research on parity compliance also confirms that the existence of disparate results warrants further, more careful examination of treatment limits in operation. Steve Melek & Stoddard Davenport, Milliman, *Nonquantitative Treatment Limitation Analyses to Assess MHPAEA Compliance: A Uniform Approach Emerges* 2 (2019), https://perma.cc/7GLM-UYGH (finding the greater the disparity of outcomes between medical/surgical and behavioral health, the more likely an audit will show parity noncompliance).

A. Parity Requires Comprehensive and Expansive Disclosure.

In issuing the final MHPAEA regulations, three federal agencies jointly emphasized that transparency regarding treatment limitations is important because both the limitations and the tests for compliance can be complicated. *See* 78 Fed. Reg.

at 68,262. To ensure that information required to be disclosed is sufficient, the federal agencies required information that tracked the key components of the insurers' duties to ensure parity. They made clear that insurers must disclose within 30 days of a request "information on medical necessity criteria for both medical/surgical benefits and mental health and [SUD] benefits as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limit with respect to medical/surgical benefits and mental health or [SUD] benefits under the plan" as part of the instruments under which the plan is operated. *Id.* § 2590.712(d)(3); *see also* 29 U.S.C. § 1024(b)(4); 29 C.F.R. § 2590.712(d)(3); 29 C.F.R. § 2520.104b-1; 29 C.F.R. § 2575.502c-1. Insurers must also produce this information upon request when a beneficiary appeals an adverse benefit determination that applied that treatment limitation. *See id.* § 2590.712(d). In other words, the requirement on insurers is to provide the full range of information needed to understand the coverage criteria and evaluate compliance with parity.

In 2016, Congress affirmed the importance of meaningful disclosures in the 21st Century Cures Act. The Act requires the relevant federal agencies to issue a compliance guidance document that includes specific examples illustrating a finding of compliance and noncompliance with "sufficient detail to fully explain such a finding, including a full description of the criteria involved." 42 U.S.C. § 300gg-26(a)(6). The Act also directed the agencies to issue guidance to implement the

disclosure requirements, which were to include "examples of methods of determining appropriate types of nonquantitative treatment limitations" and the sources of information, the evidentiary standards, the methods processes, strategies, and other factors used by insurers. *Id.* § 300gg-26(a)(6)(C)(i).

In 2019, the Departments released a Frequently Asked Questions document with a model disclosure request form. *See* U.S. Depts. of Labor, Health & Human Servs., and Treasury, *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39* (2019), https://perma.cc/5SWX-HNW7. The disclosure form sets clear expectations about the information an individual should receive about limitations including plan language; the factors used to develop them; the processes, strategies, or evidentiary standards used to identify such factors; the methods and analysis used to develop them; and any evidence and document to establish parity as written, an *in operation*, with behavioral health and medical/surgical benefits. *Id.* at 20-21 (emphasis added). In addition, insurers cannot fail to disclose criteria based on claims of proprietary information. *See* U.S. Dep't of Labor, *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)* 21 (2018), https://perma.cc/Z86U-JH9E.

The guidance provided to enrollees as to what treatment limit information they are entitled to receive precisely tracks the guidance provided to insurers on what information they need to review to evaluate compliance. *Id.* The Departments have

thus made clear that MHPAEA's disclosure provisions require more of insurers than merely sending an insurer's policy or coverage statement. This level of disclosure is necessary to allow for a "meaningful analysis" of the factors used. *M. v. United Behavioral Health*, No. 2:18-cv-0080, 2020 WL 5107643, *3 (D. Utah Aug. 31, 2020). Health Net supplied no information regarding the processes, procedures, strategies, standards, etc. underpinning the treatment guidelines or limitations to the beneficiary in this case, despite multiple requests for it.

B. The Right to Administrative Appeal Does Not Remedy the Problem of Improper Service Denials Without Information Insurers Must Provide.

When insurers like Health Net manipulate how medical necessity determinations are made and deny necessary care, peoples' options to obtain the care they need are limited. While insurers must offer ways for people to appeal denials of care, these appeal processes are often time-consuming and ineffective. Putting aside the fact that many people do not understand their appeal rights or parity compliance requirements, filing an appeal to challenge their insurer's denial of treatment is challenging, complicated, expensive, and time-consuming. Consumer Reports Nat'l Res. Ctr. at 3 (2015) (noting that 72% of Americans "are unsure if they have the right to appeal to the state/independent medical expert if their health plan refuses coverage for medical services they think they need" and 87% "don't know the state agency/department tasked with handling health insurance complaints"); *see generally* The Kennedy Forum & NAMI, *The Health Insurance Appeals Guide* (2021),

https://perma.cc/Q3WN-RGA6 (highlighting how medical necessity may be used to deny care). If they appeal, individuals typically must prevail based on insurer's self-selected medical necessity criteria and cannot meaningfully challenge those criteria through an appeal, even when those criteria are inconsistent with generally accepted standards of care. *See* NAMI, *A Long Road Ahead* at 5. The uncertainty of the appeals process can in turn cause stress and anxiety that exacerbates the very behavioral health condition for which the person is seeking treatment. *See* Sircar at 16.

Moreover, without the information that MHPAEA requires the insurer to disclose, winning an appeal will be difficult. Most individuals will not have all the information needed to appeal the denial, since much of the information that would demonstrate the impropriety of the denial is within the insurer's exclusive control. *See* NAMI, *A Long Road Ahead* at 5. Thus, Congress has dictated that insurers provide information to their enrollees upon request. 42 U.S.C. § 300gg-26(a)(3)(A)(ii). "It would be challenging, if not impossible, for an average consumer to identify plan design features that raise 'red flags' for Parity Act violations based on [documents available from the insurer]." Parity Tracking Report, at 7. Although individuals may rarely, if ever, be able to conduct a full parity analysis, the lack of basic information about benefit classification and other essential information makes it nearly impossible for people to raise the question, much less succeed in an appeal. *Id.* at 9.

Most individuals are not in the position to take on appeals involving conflicts between their provider and their insurer over whether the behavioral health services they are seeking are medically necessary. To succeed, such battles require costly experts and the help of a professional advocate. The Kennedy Forum & NAMI at 49, 67. As a result, people with behavioral health conditions are often left high and dry because they cannot afford to obtain the behavioral health services they need if their insurer is not covering the expense. *See* Sircar at 15-16. Too often, instead of attempting to fight their insurers' denials of care, people simply go without behavioral health services, no matter how critically important they are.

IV. This Court Should Not Allow Insurers to Escape Their Parity Obligations to Disclose Information.

There is no doubt that the supporting analysis for a treatment limit must be disclosed to the beneficiary. But here, in response to repeated requests, Health Net provided almost nothing. In its order dismissing I.W. and E.W.'s MHPAEA claim, the District Court ignored allegations describing their repeated requests for information and Health Net's repeated failure to provide it. *See E.W.*, 2020 WL 2543353 at *6.

The District Court found that the complaint alleged that I.W. requested "'Plan Documents' . . . .to obtain medical necessity criteria for mental health and substance use disorder treatment and for skilled nursing or rehabilitation facilities to use in a claim that Health Net violated MHPAEA." *E.W.*, 2020 WL 2543353 at *2 (internal quotation marks omitted). The District Court explicitly noted that the Plaintiffs

plead that "Health Net did not provide a copy of the Plan Documents." *Id.*

Indeed, the Plaintiffs' pleadings to support their MHPAEA claim were ample. They pled that after Health Net initially denied coverage of I.W.'s care without written notice, her mother wrote a letter to Health Net requesting both I.W.'s medical records and an explanation of the plan's denial, since she had "no documented information as to how the determination to deny care was made and was unable to properly appeal any adverse determination." Complaint ¶ 16. In response, the plan provided only I.W.'s medical records and the criteria it used to deny coverage, which "incorrectly mandated acute symptomology for a non-acute level of care." *Id.* ¶ 20; *see also id.* ¶ 18. Thereafter, I.W. appealed Health Net's denial, and specifically requested:

> [A] copy of all documents under which the Plan was operated including the Certificate of Coverage, any insurance policies in place for the benefits she was seeking, any administrative service agreements that existed, the Plan's mental health and substance abuse criteria, the Plan's skilled nursing and rehabilitation facility criteria, and any opinions from any physician or other professional regarding the claim.

Id. ¶ 23. Nevertheless, Health Net failed to provide the requested documents, including the relevant medical necessity criteria. *Id.* ¶ 30 On a motion to dismiss, where the District Court must accept the Plaintiffs' allegations as true and construe them in the light most favorable to the Plaintiffs, these pleadings alone sustain a claim for a violation of MHPAEA. *See Ashcroft v. Iqbal*, 556 U.S. 662, 679 (2009).

Yet, the District Court also refused to allow discovery on this claim, calling plaintiffs' request for discovery "a fishing expedition." *Id.* at *6. Left standing, this ruling would devastate the ability of enrollees to gain access to essential information. MHPAEA was not intended to impose a technical gauntlet on those with mental health conditions. *See N.R. v. Raytheon*, 24 F.4th 740, 753-55 (1st Cir. 2022). Congress's overriding intent was that enrollees receive the required documents and disclosures. Thus, this Court should require disclosures where plans have reasonable notice of the request and place the burden on plans to clearly communicate to requesters any reasonable procedures that must be followed to obtain the information.

V. Requiring a Plaintiff to Do More Than Plausibly Plead a Parity Claim Impermissibly Shifts the Burden from Insurers to Individuals.

The District Court summarily dismissed E.W.'s "as applied" parity act claims as "conclusory." *E.W.*, 2020 WL 2543353, at *5. The precision apparently sought by the District Court, however, requires access to information which is within the sole control of Health Net and which Health Net refused to provide in response to pre-litigation requests. Dismissing E.W.'s claim in these circumstances rewards Health Net for failing to meet their disclosure obligations and emboldens others to do the same. *See Heather v. California Phys. Servs.* Case No. 2:19-cv-415, 2020 WL 4365500, *3 (D. Utah July 30, 2020) ("Plaintiffs cannot be expected to plead facts that are in the sole possession of Blue Shield, and they will not be punished for not offering those facts when their requests to learn the same were ignored."); *N.R.*, 24 F.4th at 754.

Insurers already are incentivized to avoid making required disclosures. *See generally* GAO 2019 Report. Dismissing claims against non-disclosing insurers for inadequate factual allegations will substantially compound this problem.

VI. Failure to Identify and Enforce Parity Noncompliance Harms People Who Need Care.

Where parity noncompliance remains, people cannot access the behavioral health services they need to treat serious conditions. Parity noncompliance leads to people going without needed services, paying more for services, and difficulty finding providers, and not receiving services at the intensity or frequency needed. Parity at 10, *Consumer Health Insurance Knowledge and Experience Survey* 12-13 (2019), https://perma.cc/M4S4-HB55; *see also* Melek et al. 2019 at 6-7 (finding increasing disparities with associated costs and reimbursement disparities that impact access).

The impact of parity noncompliance goes beyond the increased costs or deprivation of services to individuals. When people cannot access the care they need, they may not be able to find or maintain employment, pursue education or training, or maintain stable housing. Mental Health & Substance Use Disorder Parity Task Force, *Final Report* 5 (2016), https://perma.cc/LLT5-SQZE. Lack of chronic care leads to an "overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care." Substance Abuse & Mental Health Servs. Admin., *National Guidelines*

for Behavioral Health Crisis Care 8 (2020), https://perma.cc/KGX5-29LD. People who do not have access to routine care end up in emergency departments and jails when they are in crisis; neither of which are suited to provide needed treatment. *Id.* at 27, 41. The failure of private insurers to provide access to behavioral health services, particularly SUD services, has a stark impact by shifting costs onto public insurance and state-funded programs, drawing public funds away from other necessary services. *See, e.g.*, Tami L. Mark et al., *Insurance Financing Increased for Mental Health Conditions but Not for Substance Use Disorders, 1984-2014*, 35 Health Affairs 958, 963 (2016), https://perma.cc/DD66-XFQL. There are additional indirect costs. For example, studies have shown the prevalence of depression causes $31 billion to $51 billion annually in lost productivity in the United States, while treatment has significant positive effects on labor supply. SAMHSA, The Essential Aspects of Parity, at 5-6.

CONCLUSION

Amici ask the Court to reverse the District Court's dismissal of the parity claim and remand for further proceedings so that E.W. and I.W. may access the information needed to analyze parity compliance.

Dated: June 28, 2022

Respectfully submitted,

/s/ Abigail K. Coursolle
Abigail K. Coursolle
Attorney for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limitation of the Federal Rule of Appellate Procedure 32(a)(7)(B)(i) because, excluding the parts of the document exempted by the Federal Rule of Appellate Procedure 32(f) and 10th Cir. L.R. 32(B), this document contains 6425 words. This word count was calculated by Microsoft Word, the word processing system used to prepare this brief.

This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in fourteen-point Californian FB font.

Dated: June 28, 2022

Respectfully submitted,

/s/ Abigail K. Coursolle
Abigail K. Coursolle
Attorney for *Amici Curiae*

CERTIFICATE OF SERVICE

I certify that on June 28, 2022, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Date: June 28, 2022

/s/ Abigail K. Coursolle_
Abigail K. Coursolle
Attorney for *Amici Curiae*

Exhibit A

Abbi Coursolle <coursolle@healthlaw.org>

Consent to file amicus in E.W. v Health Net No. 21-4110

Brian King <brian@briansking.com> Mon, Jun 27, 2022 at 11:57 AM
To: Abbi Coursolle <coursolle@healthlaw.org>
Cc: Tera Peterson <tera@briansking.com>

You have our consent, Abbi. Thank you.

Sent from my iPhone

On Jun 27, 2022, at 12:31 PM, Abbi Coursolle <coursolle@healthlaw.org> wrote:

Counsel:

Please confirm for the record your consent to our filing an amicus in E.W. v Health Net No. 21-4110 on behalf of the National Health Law Program and the Kennedy Forum.

Thank you,
Abbi

--

Abbi Coursolle (she/her/hers)
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Exhibit B

Abbi Coursolle <coursolle@healthlaw.org>

Consent to file amicus in E.W. v. Health Net, case # 21-4110

Lieberman, Michael <MLieberman@crowell.com> Fri, Apr 22, 2022 at 10:59 AM
To: Abbi Coursolle <coursolle@healthlaw.org>, "Ruddy, Samuel" <SRuddy@crowell.com>

Abbi, Defendants/Appellees consent to your filing an amicus brief.

Regards,

Mike

Mike Lieberman

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From: Abbi Coursolle <coursolle@healthlaw.org>
Sent: Thursday, April 21, 2022 4:53 PM
To: Ruddy, Samuel <SRuddy@crowell.com>; Lieberman, Michael <MLieberman@crowell.com>
Subject: Consent to file amicus in E.W. v. Health Net, case # 21-4110

External Email

Counselors:

My firm, the National Health Law Program, is planning to file an *amicus* brief in support of the Plaintiffs/Appellants in *E.W. v. Health Net*, case # 21-4110 on behalf of ourselves and the Kennedy Forum. Will Defendants/Appellees consent to our filing an *amicus*?

Thank you,

Abbi

--

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