No. 20-1639

United States Court of Appeals for the First Circuit

N.R., by and through his parents and guardians, S.R. and T.R., individually and on behalf of all other similarly situated, and derivatively on behalf of the Raytheon Health Benefits Plan,

Plaintiff/Appellant

v.

RAYTHEON COMPANY; RAYTHEON HEALTH BENEFITS PLAN; AND WILLIAM M. BULL,

Defendants/Appellees

On Appeal from the United States District Court
District of Massachusetts
The Honorable Richard G. Stearns, U.S. District Judge
(No. 1:20-cv-10153-RGS)

[Proposed] Brief of Amici-Curiae National Health Law Program, Autism Legal Resource Center, LLC, Bazelon Center for Mental Health Law, Center for Health Law & Policy Innovation of Harvard Law School, Center for Public Representation, Disability Rights Education and Defense Fund (DREDF), Health Law Advocates, Inc., National Autism Law Center, and The Kennedy Forum in Support of Plaintiff/Appellant

Martha Jane Perkins
Abigail Coursolle*
Elizabeth Edwards*

Daniel Unumb*
Autism Legal Resource Center LLC
863 Corley Mill Road

National Health Law Program
1512 E. Franklin St., Suite 110
Chapel Hill, NC 27514
(919) 968-6308

Lexington, SC 29072
(803) 608-1160

*not admitted

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amici curiae* the National Health Law Program, Autism Legal Resource Center, LLC, Bazelon Center for Mental Health Law, Center for Health Law & Policy Innovation of Harvard Law School, Center for Public Representation, Disability Rights Education and Defense Fund (DREDF), Health Law Advocates, Inc., National Autism Law Center, and The Kennedy Forum disclose that they have no parent corporations and that no publicly held corporation owns 10 percent or more of their stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER AUTHORITIES

REGULATIONS

ADMINISTRATIVE MATERIALS

INTEREST OF AMICI CURIAE

The *amici* file this brief pursuant to Fed. R. App. P. 29. The parties have consented to its filing.[1] Amici the National Health Law Program (NHeLP), Autism Legal Resource Center, Center for Public Representation, Center for Health Law and Policy Innovation of Harvard Law School, Judge David L. Bazelon Center for Mental Health Law, Health Law Advocates, Disability Rights Education and Defense Fund (DREDF), National Autism Law Center (NALC), and The Kennedy Forum are health, disability, mental health, and civil rights advocacy organizations. These groups have advocated to promote a more equitable and effective health care system that ensures people have access to the quality health services they need. The work of these organizations has included fighting for robust implementation of mental health parity.

SUMMARY OF ARGUMENT

After denying mental health treatment for N.R., Raytheon Company and its health plan have refused to provide N.R. or his

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* states that no counsel for a party authored this 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.

attorney any disclosures concerning its parity practices, despite the fact that such disclosure is required by law. Then, when N.R. filed suit to contest their adverse benefit determination, Raytheon Company and its health plan used their refusal to comply with disclosure requirements as a sword: asserting that the Raytheon health plan applies a uniform policy applicable to both mental health and medical/surgical benefits, but without disclosing the very information in their exclusive control that could verify or disprove their assertions. Rather than compel Raytheon and its health plan to produce the information, the District Court instead allowed their refusal to disclose to be weaponized, dismissing N.R.'s case based on his failure to provide sufficient detail in his allegations. Yet, it is precisely because of the lack of disclosure by Raytheon and its health plan that N.R. cannot satisfy this standard. The District Court's approach places plaintiffs in an untenable position where it will be impossible to obtain the information needed to meet the court's standard to plead a violation of the parity act. Discrimination in mental health coverage has increasingly moved to nonquantitative treatment limitations (NQTLs) that by their nature require information from plans in order to evaluate. If the District Court's opinion is

allowed to stand, the progress towards ending discrimination will stop in its tracks and the promise of parity will be eviscerated. N.R. sufficiently pled a parity act violation in accordance with the reasonable pleading standards followed by most courts in these cases and should be allowed to proceed with his suit.

ARGUMENT

I. Disclosure by Plans is Essential to Identifying and Addressing Ongoing Harmful Parity Violations.

Federal mental health parity laws are intended to end the long-standing discriminatory practices of health plans that have limited access to mental health and substance use disorder ("MH/SUD") services and to "yield successful treatment for people with mental health or substance use disorder problems." *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program*, 78 Fed. Reg. 68,240, 68,258 (codified at 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 CFR Parts 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 health plans cover MH/SUD services comparably to medical and surgical ("M/S") services. The law essentially "requires ERISA 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) (quoting *Munnely v. Fordham Univ. Faculty*, 316 F. Supp. 3d 714, 728 (S.D.N.Y. 2018)). Parity requires that "the treatment limitations applicable to . . . mental health or substance use disorder benefits are no more restrictive than the . . . treatment limitations applied to . . . medical and surgical benefits." 42 U.S.C. § 300gg-26(a)(3)(A)(ii).

Although straightforward in concept, ensuring compliance becomes more challenging when the limitation on treatment is not an obvious quantitative limit on treatment (QTL) but a nonquantitative treatment limitation (NQTL), such as the habilitative/non-restorative treatment exclusion at issue here, that can have equally devastating, discriminatory effects. Because MH/SUD conditions and M/S conditions often differ in nature and treatment protocols, a thorough explication of the factors used by

the plan 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 ("[T]he disclosure of detailed information for both the behavioral health treatment at issue and a comparable physical service is necessary to determine if a parity violation took place."). Without such information, it is difficult if not impossible to evaluate whether a NQTL is comparable and no more restrictively applied to MH/SUD conditions than M/S conditions. Allowing plans to evade disclosure of this information sharply inhibits people's ability to identify and thus file complaints about parity noncompliance, since people cannot complain about what they do not know or do not understand. Such complaints are the heart of parity enforcement. Limiting information only serves to limit compliance and thus restrict access to necessary MH/SUD services.

II. Congress Has Repeatedly Recognized that Disclosure is Key to Enforcing Parity Requirements.

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 attempts by insurers to move the goalposts. Parity efforts in states and at the federal level began decades earlier, but Congress first addressed the disparities in coverage of MH/SUD benefits perpetuated by health plans in the 1996 Mental Health Parity Act (MHPA). While a significant step forward for parity in private insurance, the MHPA had numerous holes that allowed insurers to continue to make coverage for MH/SUD benefits starkly narrower than that for services to treat physical health conditions. *See* Gov't Accountability Office (GAO), *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* (2000), https://www.gao.gov/assets/240/230309.pdf ("2000 GAO Report"). The GAO found that after enactment of the MHPA, about two-thirds of plans 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 2000 GAO Report also found that most plans contained design features that were more restrictive for mental health than for medical and surgical benefits. *Id.* at 12. This same report found only

patchwork compliance with MHPA and problems with relying on complaints for compliance. *Id.*

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 and apply protections to the treatment of substance use disorders. P.L. 110-343, Div. C, 122 Stat. 3765 (2008). In 2010, the Affordable Care Act (ACA) applied MHPAEA to other types of insurance plans and instituted additional requirements related to coverage of MH/SUD services. P.L. 111-148 (2010), as amended in the Health Care and Education Reconciliation Act, modified by P.L. 111-152 (2010). Most recently, in the 21st Century Cures Act, Congress again recognized compliance with parity requirements remained a significant issue. P.L. 114-255 (2016).

The 21st Century Cures Act contained several provisions to enhance enforcement of parity by increasing transparency. These 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 plans were complying with the NQTL requirements, including medical necessity transparency requirements. *Id.* §§ 13002-13007; *see* Gov't Accountability Office (GAO), *Mental Health and Substance Abuse: State and Federal Oversight of Compliance with Parity Requirements Varies* (2019), https://www.gao.gov/assets/710/703239.pdf ("GAO 2019 Report").

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

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. Nearly 40 million (or one in five) U.S. adults live with a mental health diagnosis, with nearly 20 million people having a perceived unmet need for mental health services. Substance Abuse & Mental Health Servs. Admin., *2019 National Survey on Drug Use and Health* 4-5 (2020), https://perma.cc/Y8SC-GEX2. In addition, 20.4 million people age

12 or older in the U.S. have a SUD, with about half of those individuals also having a mental health diagnosis. *Id.* at 3, 46. About one in six children aged 3-17 years have been diagnosed with a developmental disability, and that percentage has increased over the past eight years. Ctrs. for Disease Control, *Increase in Developmental Disabilities Among Children in the United States* (2019), https://perma.cc/6MNC-KTTP. .

Even as the need for MH/SUD services grows, compliance with parity requirements continues to be a problem, with plans' use of NQTLs in particular creating serious disparities in access and coverage. *See, e.g.,* U.S. Dep't of Labor, *FY 2017 MHPAEA Enforcement Fact Sheet* 1 (2018), https://perma.cc/GFP9-3PCQ (NQTLs comprise nearly half of violations). While progress has been made, recent studies have found that disparities have actually increased in several key areas of parity.[2] Steve Melek et al.,

[2] Since the MHPAEA was enacted, an increased proportion of children were able to access mental health services, and the financial burden on households for accessing treatment decreased. Mental Health & Substance Use Disorder Parity Task Force, *Final Report* 12 (2016), https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF.

Milliman, *Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (2019), http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf (parity issues remain in NQTLs of network adequacy and provider reimbursement); *see also* NAMI, *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care* (2017), https://perma.cc/3CA3-4RWG (network adequacy and costs for mental health care remain a significant parity issue).

Where parity noncompliance remains, individuals cannot access the MH/SUD services they need to treat serious health conditions. The result is children do not receive services that will help them with developmental conditions or necessary mental health services. The provision of necessary services to children allows them to fully participate in school, develop social and other needed skills, and generally reach their full potential. For adults, a lack of parity for MH/SUDs often results in higher costs for those

services, an inability to receive services (particularly at the intensity or frequency needed), failure to find providers, and thus missed services. Parity at 10, *Consumer Health Insurance Knowledge and Experience Survey* (2019), https://perma.cc/M4S4-HB55 (reporting that one in five of those surveyed reported difficulties finding a provider, one-third described denials, delays, or limitations on MH/SUD services, and of those denied treatment, 47% paid out of pocket and 34% did not receive the requested treatment); *see also* Melek et al., *supra* at 6-7 (finding increasing disparities in NQTLs involving use of out of network MH/SUD services, with associated costs, and reimbursement rate disparities that impact access). It is axiomatic that increased costs for services often results in people accessing MH/SUD services less because of the financial burden.

The impact of parity noncompliance goes beyond the increased costs or deprivation of services to individuals seeking care. When people cannot access the care they need, this may impact their ability 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://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF. There are additional indirect costs. For example, the costs of turnover, lost productivity, absenteeism, and disability from MH/SUD conditions have been estimated to be as high as $105 billion annually. Mental Health America, *Issue Brief: Parity* (2006), https://www.mhanational.org/issues/issue-brief-parity.

IV. Disclosure of All Factors Used is Particularly Vital for Evaluating Parity for Nonquantitative Treatment Limitations.

Eliminating discriminatory treatment limitations is at the heart of federal parity law. Thus MHPAEA broadly prohibits not only discriminatory QTLs on coverage but also NQTLs that serve to limit the scope or duration of MH/SUD treatment relative to M/S 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). Hand in hand with this obligation is the need for disclosures by plans imposing these treatment limitations. Disclosure of information by

insurers and plans is particularly important for the enforcement of parity with respect to NQTLs.

As the preamble to the 2013 MHPAEA Final Rule acknowledged, "it is difficult to understand whether a plan complies with the NQTL provisions without information showing that the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health or substance use disorder benefits and medical/surgical benefits are comparable, impairing plan participants' means of ensuring compliance with MHPAEA." *See* 78 Fed. Reg. at 68,247. Indeed, experts have stressed that after the passage of MHPAEA, discrimination has increasingly shifted from quantitative limits, which are typically obvious, to discriminatory NQTLs, which can easily have the same discriminatory effect but typically require a much greater deal of analysis and information that is uniquely within control of the plan 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://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/faq-39/00021.pdf ("The most significant problem area of MHPAEA and ERISA compliance during the last 7 years has been and remains the unwillingness of plans to provide . . . a detailed summary of the key steps taken to analyze a NQTL when requested to do so. This failure occurs consistently, even when a benefit denial is appealed and a request for disclosure . . . is made . . . .").

The lack of adequate disclosures contributes to a lack of parity enforcement in numerous ways. The GAO report that resulted from the 21st Century Cures Act detailed continuing issues with identifying and enforcing compliance. *See* GAO 2019 Report, *supra*. The report concluded that relatively low numbers of parity complaints were a poor indicator of the extent of noncompliance because of the general lack of parity requirement knowledge. The GAO 2019 Report also noted that where non-compliance findings

are based on complaints, plans may be incentivized by the lack of complaints, and subsequent enforcement, not to comply because the risk is not significant. *Id.* at 28. In its review of NQTL noncompliance, the GAO cited state officials and others as reporting that: "It was difficult to assess NQTL noncompliance based on issuer documentation because NQTLs may not be listed in documentation or may be hard to compare." *Id.* at 16-17. GAO went on: "Also, it is difficult to determine based on plan documents how an NQTL is actually being implemented and experienced by beneficiaries in practice." *Id.* at 37. Indeed, most of the parity issues GAO identified involved NQTLs. *Id.* at 30.

Plans' and issuers' failure to adhere to disclosure requirements not only affect beneficiaries' individual efforts to vindicate their rights but also the ability of regulators to enforce the law. The GAO 2019 Report echoes other studies that found problems with identifying parity compliance. In one study, a team of individuals with substantive expertise in parity concluded that they could not conduct a complete assessment of parity compliance through form reviews because the available documents did not

include the necessary information. *See, e.g.,* Legal Action Ctr. et al., *Parity Tracking Project: Making Parity a Reality* 6 (2017), https://www.lac.org/resource/parity-tracking-project ("Parity Tracking Report"). The team also performed additional searches for information and could not conduct its parity analysis. The review was particularly stymied with respect to NQTLs because of a lack of information. *Id.* at 7-8, 11-12; *see also* U.S. Dep't of Labor, *Factsheet: FY 2019 MHPAEA Enforcement* (2019) (finding noncompliance where plan could not establish that comparable processes, strategies, evidentiary standards, and other factors were used to apply the NQTL to a MH/SUD service as compared to M/S benefits), https://perma.cc/GFP9-3PCQ.

The Parity Tracking Report further found that "[i]t 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 [available documents]." Parity Tracking Report, *supra* at 7. Although plan beneficiaries 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 beneficiaries to be able to identify the red flags of parity compliance that would cause them to file a complaint. *Id.* at 9. And even if they did, under the trial court's approach in this case, their claims would be dismissed.

The resistance by plans that may actually be discriminating to disclosing the factors underlying their design and implementation of an NQTL is not surprising. Indeed, it is precisely those plans which may be 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 (preamble to final MHPAEA rule). 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 NQTLs they use, issuers and plans must ensure that:

> [U]nder the terms of the plan (or insurance coverage) as written and in operation, any processes, strategies,

> evidentiary standards, or other factors used in applying the limitation with respect to mental health or substance use and disorder benefits in the classification 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). This information must also be disclosed to beneficiaries. 29 C.F.R. § 2590.712(c)(4)(i). These provisions are necessary to ensure that "individuals have the necessary information to compare NQTLs of medical/surgical benefits and mental health or substance use disorder 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://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf (emphasizing that a MHPAEA analysis requires information about both behavioral health and medical / surgical benefits).

The numerous findings of improprieties in the development and application of mental health coverage guidelines in *Wit v. United Behavioral Health* illustrate the necessity of disclosure that goes beyond the basic statement of coverage. No. 14-cv-02346, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019). The court in *Wit* found based on information revealed in discovery that the plan was using mental health coverage guidelines that "were riddled with requirements that provided for narrower coverage than is consistent with generally accepted standards of care" and that development of the guidelines was "infected" by financial considerations. *Id.* at *48, 47. Much of the information the *Wit* court based its findings upon is the very type of information, in terms of the processes, strategies, evidentiary standards, or other factors used as written or in operation, that is required to be disclosed under parity regulations and has not been disclosed in the instant case.

As indicated by the examples set forth in the regulations and the case law, where an NQTL is facially applied to some extent on medical/surgical coverage, the details of the issuers NQTL 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 NQTL compliance also confirms that the existence of disparate results warrants further, more careful examination of the NQTL in operation as the greater the disparity of outcomes between M/S and MH/SUD, the more likely that a comprehensive operational audit will show parity noncompliance. Steve Melek & Stoddard Davenport, Milliman, *Nonquantitative Treatment Limitation Analyses to Assess MHPAEA Compliance: A Uniform Approach Emerges* 2 (2019), https://us.milliman.com/en/insight/nonquantitative-treatment-limitation-analyses-to-assess-mhpaea-compliance-a-uniform-appro.

V. Required Disclosures Must be Sufficiently Transparent and Informative to Identify Parity Issues.

In issuing the final regulations for MHPAEA in 2013, the Departments acknowledged that transparency around treatment limitations is important because both the limitations and the tests

for compliance can be complicated.[3] *See* MHPAEA Final Rule, 78 Fed. Reg. at 68,262. To ensure that information required to be disclosed was sufficient, the Departments required information that tracked the key components of the plans' duties to ensure parity. In addition to the requirement that plans produce the processes, strategies, evidentiary standards and other factors used to apply to NQTLs, in their Final Rule implementing MHPAEA, the Departments added a provision to make clear that plans must disclose within 30 days of a request "information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder 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 substance use disorder 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

[3] The "Departments" refers to the federal Department of Health & Human Services, Department of Labor (DOL), and Department of Treasury, which are tasked by MHPAEA to issue related regulations and guidance.

C.F.R. § 2590.712(d)(3); 29 C.F.R. § 2520.104b-1; 29 C.F.R. § 2575.502c-1. Plans must also produce information on medical necessity criteria for both M/S benefits and MH/SUD benefits as well as the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation upon request when a beneficiary appeals an adverse benefit determination that applied that treatment limitation. *See id.* § 2590.712(d).

Since the Departments issued their final regulations in 2013, Congress subsequently affirmed the importance of meaningful disclosures to realize parity's promise in the 21st Century Cures Act. Under this Act, Congress required that the relevant federal agencies issue a compliance guidance document that would include specific examples illustrating 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 help implement the disclosure requirements more generally, to include, among other things, "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 plans so as to improve parity compliance. *Id.* § 300gg-26(a)(6)(C)(i). The agencies were also directed to solicit public comment on the proposed guidance, which was to include clarifying information and illustrative examples used for disclosing information to ensure parity compliance. 42 U.S.C. § 300gg-26(a)(7)(B).

In 2019, the Departments released its final FAQ 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://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf. The disclosure form sets clear expectations about the information an individual should receive:

- the plan language about limitations and the M/S and MH/SUD benefits to which they apply;

- the factors used in the development of the limitations, which may include but are not limited to, excessive utilization, and safety and effectiveness of treatment;
- the sources used to identify the factors identified, including any processes, strategies, or evidentiary standards (including safety and efficacy in treatment);
- the methods and analysis used in the development of the limitations; and
- any evidence and documentation to establish that the limitation is applied no more stringently, as written *and in operation*, to MH/SUD benefits than to M/S benefits.

Id. at 20-21 (emphasis added).

The Departments have thus made clear that MHPAEA's disclosure provisions require more of plans than merely sending a plan's policy or coverage statement, such as the simple exclusionary statement at question in this case, but rather require plans to also provide information upon request about the basis for that exclusion, the sources of that basis, and how it is applied across different services. 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).

The guidance provided to beneficiaries as to what NQTL information they are entitled to receive precisely tracks the guidance provided to plans on what information they need to review to evaluate compliance. *See* U.S. Dep't of Labor, *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)* (2018), https://perma.cc/Z86U-JH9E. To evaluate an NQTL, plans must:

- Identify the factors considered in the design of the NQTL (*e.g.* "clinical efficiency" and "quality standards");
- Name the sources used to define the design factors (*e.g.* "[m]edical expert reviews");
- For NQTLS that apply to only some medical/surgical benefits, "substantiate how the applicable factors were used to apply the specific NQTL";
- "[E]xplain the process and factors relied upon" for any variation in the application of a guideline or standard used;

- Identify the "processes, strategies, and evidentiary standards" used in applying the NQTL to MH/SUD benefits and M/S benefits and show that they are "comparable and no more stringently applied . . . both as written and in operation"; and
- Demonstrate that any "factor," "evidentiary standard," or "process" used in developing and applying the NQTL for MH/SUD services and M/S services are "comparable" with "no arbitrary or discriminatory differences" in application.

Id. The information set forth in the self-compliance tool is the same information that a plan beneficiary also needs to evaluate whether a violation has occurred. Yet none of this information was supplied to N.R.

VI. This Court Should Not Allow Health Plans to Escape Their Parity Obligations by Imposing Inappropriate Requirements for Requesting Information.

There is no doubt that the supporting analysis for an NQTL must be *disclosed* to the beneficiary. But here, in response to beneficiary requests, Raytheon and its health plan provided nothing. Upholding the District Court's decision finding that N.R.

failed to use the right words or ask the right person to trigger the plans' obligation to disclose would render MHPAEA's parity and disclosure requirements meaningless.

When the Departments solicited comment on their draft model disclosure request form in 2018, commenters emphasized the importance of making obtaining disclosures easy for consumers. The Massachusetts Mental Health Parity Coalition noted:

> [D]isclosure requirements that require the plan to identify the factors used in the development of the limitation and evidentiary standards used promote transparency, and provide consumers an opportunity to identify a parity violation. . . . As advocates for consumers who struggle to access needed mental health and substance use disorder treatment, we see how consumers faced with a denial of service by a health plan are very vulnerable. In this context, they must deal with a lack of service, while also simultaneously trying to access this parity information. During such times, even small administrative obstacles can be so burdensome that individuals or their representatives can easily become discouraged from attempting to understand and assert their rights under MHPAEA.

Mass. Mental Health Parity Coalition, *Comments on Draft Model Form for Improved Enforcement of the Disclosure Provisions of the Mental Health Parity and Addiction Equity Act* 2 (2018), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/faq-

39/00026.pdf. Commenters emphasized that this is particularly important since "many patients are told by insurers they're not required to provide information regarding their plan exclusions as it is proprietary information and/or has commercial value. However, MHPAEA prohibits insurers from claiming this rationale for withholding information from patients. . . ." Eating Disorders Coalition, *Comments on Proposed FAQs Part 39, Self-Compliance Toolkit, and Request for Information/Model Disclosure Form* 12 (2018), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/faq-39/00017.pdf; *see* 42 U.S.C. § 300gg-26(a)(7)(B)(ii).

The District Court's determination that disclosures were not required because N.R.'s attorneys did not properly direct this request is based on a hyper-technical reading of the statute not followed by other courts. Affirming this approach, coupled with the trial court's denial of discovery and dismissal for lack of factual precision in pleading, would have devastating consequences on the ability of beneficiaries to gain access to this essential information. MHPAEA was not intended to impose a technical gauntlet on those

with mental health conditions. The regulations impose a duty on the plan administrator to ensure that disclosures are made, and not a duty on beneficiaries to make their requests in any specific fashion. 29 C.F.R. § 1185a(a)(4) (documents "shall be made available by the plan administrator"). Here there is no question that the plan administrator was aware of the requests for required disclosures even if they arrived in an envelope not specifically addressed to him. If experienced ERISA attorneys can be faulted on the precise manner in which the request was made, laypersons are highly unlikely to be able to navigate this process. Given Congress's overriding intent that beneficiaries receive the required documents and disclosures, the better approach is to require disclosures where plans have reasonable notice of the request and place the burden on plans in such cases to clearly communicate to requesters any other reasonable plan procedures that must be followed to obtain the information. This is especially important where, contrary to trial court's assertion that the failure to make the required disclosures is not relevant to the MHPAEA violation,

the court itself has made this link when it refused to allow the case to go forward citing an insufficiency of factual allegations.

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

The District Court dismissed N.R.'s "as applied" parity act claim in a single sentence, without analysis or guidance, because it could not "make out from the opaque pleadings the precise nature of N.R.s 'as-applied' Parity Act claim." *N.R. v. Raytheon Company*, 2020 WL 3065415 *9 (D. Mass. Jun. 9, 2020). The precision apparently sought by the District Court, however, requires access to information which is within the sole control of Raytheon and its health plan and which they consistently refused to provide in response to pre-litigation requests; requests that met the DOL standards for requesting disclosure. Dismissing N.R.'s claim in these circumstances rewards Raytheon and its health plan for failing to meet their disclosure obligations and emboldens others to do the same. As noted by the GAO, plans already are incentivized to avoid making required disclosures. *See generally* GAO 2019 Report, *supra*. Dismissing claims against non-disclosing issuers

and plans for inadequate factual allegations will substantially compound this problem.

The fact that the dismissal was without prejudice is of little solace to N.R. where the detailed information the court is apparently requiring to go forward remains in the hands of the plan. *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.")

The District Court concluded there was no clear pleading standard for these cases. *N.R.*, 2020 WL 3065415 *8. This Court should take the opportunity presented and hold that in the case of a challenge to an NQTL "in operation," "it is enough to plausibly plead that there is a categorical exclusion for mental health benefits but not for medical benefits." *Bushell v. Unitedhealth Grp., Inc*., 17-cv-2021, 2018 WL 1578167, *8 (S.D.N.Y. Mar. 27, 2018).[4]

[4] "[I]t is unlikely that a reasonable application of the NQTL requirement would result in all [MH/SUD] benefits being subject to an

"Discovery will reveal what sort of process, strategy, evidentiary standard, or other factors [the insurer] used in setting its treatment limitations" and applying them to medical and mental health benefits. *Id.* at *8. Adopting the majority pleading standard in accord with *Bushell* as detailed in N.R.'s brief will ensure that claims are plausible and not speculative without imposing an undue burden effectively depriving vulnerable beneficiaries with mental health conditions of a remedy in NQTL challenges.

CONCLUSION

For foregoing reasons, *amici* ask the court to reverse the District Court's dismissal of this case and remand for further proceedings so that the N.R. may access the additional information needed to further analyze parity compliance in this case.

Date: October 7, 2020

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins
Abigail Coursolle*

NQTL in the same classification in which less than all medical/surgical benefits are subject to the NQTL." 78 Fed. Reg. at 68,245.

Elizabeth Edwards*
National Health Law Program
1512 E. Franklin St., Suite 110
Chapel Hill, NC 27514
(919) 968-6308

Daniel Unumb*
Autism Legal Resource Center, LLC
863 Corley Mill Road
Lexington, SC 29072
(803) 608-1160

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Century Schoolbook, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(A)(7)(B) and 29(a)(5), and that the total number of words in this brief is 5460 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

/s/ Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I certify that on October 7, 2020, I served the counsel of record in this case by electronically filing the foregoing brief with the Clerk of the Court using the ECF/CM system.

/s/ Martha Jane Perkins
Martha Jane Perkins