

PSYCH APPEAL

Safeguarding Mental Health Care

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The Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions

*Meeting the Moment: Improving Access
To Behavioral and Mental Health Care*

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Good morning, Chairman DeSaulnier, Ranking Member Allen, and members of the Subcommittee. Thank you for the opportunity to testify at today's hearing, "Meeting The Moment: Improving Access to Behavioral and Mental Health Care."

I am Meiram Bendat, founder of California-based Psych-Appeal, Inc, the first private law firm in the country exclusively devoted to mental health insurance advocacy. I am, by education, training and practice, an attorney and psychotherapist. Since 2011, I have spearheaded cutting-edge litigation against managed care barriers to mental health and substance use treatment. Most of my cases have been brought under the Employee Retirement Security Income Act of 1974 ("ERISA").¹

ERISA's Relationship to Mental Health Benefits

ERISA establishes uniform, albeit limited, protections for participants and beneficiaries of employer-sponsored health plans that cover approximately 136 million people.² Approximately 67 percent of these individuals are covered by self-funded plans, which are entirely exempt from state insurance laws and regulation, while 33 percent are covered by fully-insured plans.³ ERISA's protections include disclosure requirements,⁴ standards of conduct for plan fiduciaries,⁵ and enforcement mechanisms.⁶ Significantly, because state insurance laws do not apply to self-funded health plans, the Department of Labor ("DOL") is the sole source of oversight for these plans.

Despite the prevalence of mental health and substance use disorders,⁷ until the Affordable Care Act ("ACA") amended ERISA to require fully-insured, small group health plans to provide essential health benefits,⁸ ERISA did not mandate any coverage for the treatment of mental health and substance use disorders. In fact, prior to the ACA, only a patchwork of state laws required mental health benefits to be covered by some fully-insured plans.⁹ The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act ("MHPAEA"), which amended ERISA in 2008,¹⁰ only required group health plans with more than 50 employees to cover mental health benefits at parity with medical/surgical benefits, if they chose to cover such benefits at all.

¹ 29 U.S.C. § 1001 *et seq.*

² DOL.gov. 2021. *FY 2020 MHPAEA Enforcement*. [online] Available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf> [Accessed 11 April 2021].

³ KFF. 2020. *2020 Employer Health Benefits Survey - Summary of Findings*. [online] Available at: <https://www.kff.org/report-section/ehbs-2020-summary-of-findings/> [Accessed 11 April 2021].

⁴ 29 U.S.C. § 1024.

⁵ 29 U.S.C. § 1104.

⁶ 29 U.S.C. § 1132.

⁷ McCance-Katz, E., 2020. *The National Survey on Drug Use and Health: 2019*. [online] SAMHSA.gov. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf [Accessed 11 April 2021].

⁸ See 29 U.S.C. § 1185d, incorporating 42 U.S.C. 300gg-6(a).

⁹ KFF. n.d. *Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health*. [online] Available at: <https://www.kff.org/other/state-indicator/pre-aca-state-mandated-benefits-in-the-individual-health-insurance-market-mandated-coverage-in-mental-health/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [Accessed 11 April 2021].

¹⁰ 29 U.S.C. § 1185a(c)(1).

Nonetheless, the adoption of MHPAEA marked a significant turning point for consumers and the managed care industry. No longer would federal law tolerate disparate lifetime or annual limits, financial requirements, or treatment limitations with respect to covered mental health and substance use disorder benefits,¹¹ discrimination that historically resulted in crushing debt and undertreatment. Under MHPAEA, “financial requirements” include deductibles, co-payments, co-insurance, and out-of-pocket expenses, whereas “treatment limitations” include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.¹² MHPAEA’s implementing regulations identify the following illustrative list of nonquantitative treatment limitations:¹³

- (1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- (2) Formulary design for prescription drugs;
- (3) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- (4) Standards for provider admission to participate in a network, including reimbursement rates;
- (5) Plan methods for determining usual, customary, and reasonable charges;
- (6) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- (7) Exclusions based on failure to complete a course of treatment; and
- (8) 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.

MHPAEA requires financial requirements and treatment limitations to be analyzed within six categories in which medical/surgical benefits are offered: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.¹⁴ Unsurprisingly, written plan terms that are expressed quantitatively are easier to identify and challenge than undisclosed, “as applied” nonquantitative treatment limitations imposed by health insurance issuers and claims administrators.

Consequently, MHPAEA, and in turn, ERISA, were recently amended by the Consolidated Appropriations Act of 2021 (“CAA”) to compel group health plans, including health insurance issuers, to robustly analyze and disclose their comparability analyses to plan participants and regulators,¹⁵ who were charged by the 21st Century Cures Act with monitoring and enforcing plan violations entailing nonquantitative treatment limitations.¹⁶ These mandatory disclosures include:

¹¹ 29 U.S.C. § 1185a(a)(1)-(3).

¹² 29 C.F.R. § 2590.712(a).

¹³ 29 C.F.R. § 2590.712(c)(4)(ii).

¹⁴ 29 C.F.R. § 2590.712(c)(2)(ii)(A).

¹⁵ 29 U.S.C. § 1185a(a)(8).

¹⁶ 29 U.S.C. § 1185a(a)(6)-(7).

- (1) The specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations, that apply to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
- (2) The factors used to determine which nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.
- (3) The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.
- (4) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.
- (5) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

Fundamental Gaps in ERISA

1. Medical Necessity

While the ACA requires access to essential health benefits, it does not define “medical necessity,” a core term of coverage under ERISA benefit plans. And while MHPAEA requires nonquantitative treatment limitations such as medical necessity¹⁷ to be applied comparably to mental health and medical/surgical benefits, it does not require medical necessity determinations to comport with generally accepted standards of clinical practice. Thus, absent ERISA expressly conditioning “medical necessity” on adherence to generally accepted standards of clinical practice,¹⁸ health plans are free to create and operationalize self-serving, overly restrictive medical necessity definitions that undermine access to essential health benefits, including mental health and substance use treatment.

Even when ERISA plans include reasonable definitions of “medical necessity” that are contingent on coverage determinations being consistent with generally accepted standards of

¹⁷ 29 C.F.R. § 2590.712(c)(4)(ii)(A).

¹⁸ While some state laws, like California’s [SB855](#), define “medical necessity” for fully-insured plans, such laws are inapplicable to self-funded ERISA plans.

clinical practice,¹⁹ ERISA fiduciaries who actually make final and binding coverage determinations in mental health cases all too often base their decisions on deficient, non-transparent utilization review criteria developed or licensed by them.²⁰ There is method to this madness: the ERISA fiduciaries who act as third-party administrators for self-funded plans generally apply the same utilization review criteria across their entire commercial book of business, including in the fully-insured markets where they are health insurance issuers and therefore directly assume the financial risk associated with benefit expense. This dynamic was fleshed out in the landmark class action, *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

In *Wit*, the United States District Court for the Northern District of California found that over a seven-year period, United Behavioral Health, the nation's largest managed behavioral health company, breached its fiduciary duties to nationwide classes of well over 50,000 ERISA plan members, including thousands of children, by developing and applying pervasively flawed utilization review criteria to wrongly deny nearly 70,000 claims for outpatient, intensive outpatient, and residential treatment for mental health and substance use disorders. Though "[e]very class member's health benefit plan include[d], as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care,"²¹ the court found that UBH's utilization review criteria "result[ed] in a significantly narrower scope of coverage than is consistent with generally accepted standards of care."²² While mental health and substance use disorders are, by nature, largely chronic and pervasive, UBH's utilization review criteria operationalized an "Acute Care Utilization Management Model" limited to crisis stabilization.²³ In fact, UBH's primary guideline author acknowledged that "services for severely and persistently ill members that are intended to endure[] don't play to an acute care UR [utilization review] model,"²⁴ and even UBH's sole retained expert testified that "'any practitioner worth his salt' would not rely on the [UBH] Guidelines themselves but instead, would go straight to the underlying documents that set forth generally accepted standards of care."²⁵

The *Wit* court also noted that:

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 [benefit expense]" down.²⁶

[T]he evidence shows that UBH had a structural conflict of interest throughout the class period because a large portion of its revenues came from fully insured plans.

¹⁹ Policysearch.ama-assn.org. n.d. *Policy Finder / AMA*. [online] Available at: <https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml> [Accessed 11 April 2021].

²⁰ Mental Health Association in New York State, Inc. 2020. *MH Update - 11/24/20 - Behavioral Health Parity in New York State: Redefining Medical Necessity*. [online] Available at: <https://mhanys.org/mh-update-11-24-20-behavioral-health-parity-in-new-york-state-redefining-medical-necessity/> [Accessed 11 April 2021].

²¹ *Id.* at *13.

²² *Id.* at *22.

²³ *Id.* at *23.

²⁴ *Id.*

²⁵ *Id.* at *7.

²⁶ *Id.* at *48.

Moreover, the evidence shows that even as to the self-funded plans, UBH felt pressure to keep benefit expenses down so that it could offer competitive rates to employers. Second, regardless of whether the financial incentive to keep benefit expenses down was stronger with respect to the fully insured plans or the self-funded plans, the conflict of interest affected all members equally, regardless of which type of plan they were insured under, because UBH used a single set of Guidelines to make coverage determinations.²⁷

As a consequence of its years-long fiduciary breaches, UBH was ordered to exclusively apply, over a 10-year period, utilization review criteria developed by nonprofit clinical specialty associations, including the American Society of Addiction Medicine, the American Academy of Child and Adolescent Psychiatry, and the American Association for Community Psychiatry, across all the ERISA plans it administers that condition coverage on adherence to generally accepted standards of clinical practice. *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2020 WL 6469764 (N.D. Cal. Nov. 3, 2020).

2. Network Adequacy

The lack of a uniform definition of “medical necessity” is not the only impediment to meaningful coverage of mental health and substance use treatment under ERISA plans. While the ACA established a network adequacy requirement for qualified health plans sold on ACA Exchanges,²⁸ it did not amend ERISA to require non-exchange plans to establish network adequacy standards for timely and geographic access to care.²⁹ Although MHPAEA identifies network adequacy as a non-quantitative treatment limitation,³⁰ it too does not set timeliness or geographic access standards for mental health and substance use treatment. While state laws may establish network adequacy standards for fully-insured plans, self-funded ERISA plans are not subject to them and generally do not provide participants with any notice of timeliness or geographic access standards in plan documents. Absent notice of any such standards set by their plans, or any remedies for the unavailability of in-network services, ERISA plan participants must often wait protracted periods or travel extensive distances to receive mental health and substance use treatment, or to obtain authorizations for out-of-network care, which are inconsistently granted. Given the prevalence of narrow and phantom networks, it is unsurprising that mental health and substance use treatment is disproportionately rendered out-of-network or forsaken altogether.

A fundamental driver of network inadequacy is that, in general, health insurance issuers and claims administrators significantly underpay in-network behavioral health providers, particularly in comparison to in-network medical providers. Given such low and discrepant reimbursement rates, it is hardly surprising that a far lower percentage of behavioral health providers choose to participate in networks, resulting in a much higher percentage of behavioral

²⁷ *Id.* at *53.

²⁸ 42 U.S.C. § 18031(c)(1)(D)(1).

²⁹ 42 U.S.C. § 18021(b)(1)(B).

³⁰ See 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013) (“[N]etwork adequacy, while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with these final regulations.”).

health services being rendered out-of-network, with the concomitant increase in out-of-pocket expenses.³¹

At a minimum, ERISA plans should be required to protect plan participants from cost-sharing that exceeds their in-network financial responsibility when out-of-network services must be sought due to network inadequacy.

3. Enforcement

The systematic application of substandard utilization review criteria for the treatment of mental health and substance use disorders, and the pervasive lack of access to timely and geographically proximate in-network mental health and substance use disorder treatment, would be far less likely if ERISA did not insulate plan fiduciaries, namely health insurance issuers that sell group health coverage and claims administrators of group health plans, from damages,³² and further entitle them to a deferential standard of judicial review when challenged for their wrongful benefit denials.³³

ERISA's remedial scheme should be updated to account for the modern reality that health plan issuers (of fully-insured group plans), who also serve as claims administrators (for self-funded group plans), are the actual fiduciaries who adjudicate benefits using self-selected, uniform utilization review criteria across their commercial lines of business, and who sell shared network access to group health plans. With annual profits in the billions,³⁴ they should not be incentivized to short-change premium-paying participants by artificially limiting their coverage for medically necessary mental health and substance use treatment, or by selling access to networks that are known to lack mental health and substance use providers.

Currently, ERISA constrains the Secretary of Labor from enforcing the ACA's and MHPAEA's protections against health insurance issuers that offer substandard mental health insurance coverage to group health plans.³⁵ Yet as noted earlier, approximately one third of ERISA participants and beneficiaries are covered by fully-insured ERISA plans. Legislation proposed by Congressman Norcross, H.R.1364—Parity Enforcement Act of 2021, would go a long way toward ensuring accountability and leveling the managed care playing field.

³¹ Melek, S., Davenport, S. and Gray, T., 2019. *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. [online] Milliman.com. Available at: <https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx> [Accessed 11 April 2021].

³² Courts have interpreted ERISA's remedial scheme as precluding all extra-contractual damages, including compensatory and punitive damages. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

³³ *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) ("ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations. To fill this gap, federal courts have adopted the arbitrary and capricious standard developed under 61 Stat. 157, 29 U.S.C. § 186(c), a provision of the Labor Management Relations Act, 1947 (LMRA).").

³⁴ Abelson, R., 2020. *Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic*. [online] Nytimes.com. Available at: <https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html> [Accessed 11 April 2021].

³⁵ 29 U.S.C. § 1132(b)(3).

To truly guarantee meaningful access to mental health care, I urge Congress to consider legislation that: conditions “medical necessity” on adherence to generally accepted standards of clinical practice; eliminates the deferential standard of judicial review in health benefit cases; permits damages against health insurance issuers and claims administrators that discriminate against and undermine access to mental health treatment; and protects access to open courts by exempting ERISA claims from binding arbitration.