EPSTEIN BECKER GREEN

ERIC

BENEFITS LITIGATION UPDATE

A Publication From Epstein Becker Green & The ERISA Industry Committee

Spring 2016 Issue 10

Message from ERIC President and CEO Annette Guarisco Fildes:

Welcome to the Spring edition of Benefits Litigation Update, brought to you by The ERISA Industry Committee (ERIC) and the law firm of Epstein Becker & Green.

While we all closely follow legal decisions and related media coverage, nothing compares to the heightened attention in the media to the U.S. Supreme Court after the death of Justice Scalia. We appreciate how one justice can significantly impact the Court's deliberations and decisions. This edition of the Benefits Litigation Update provides perspective on how the Court will operate with only eight sitting justices, especially with respect to cases involving ERISA and employee benefits, and will discuss key decisions recently handed down by the Court.

At ERIC, we engage frequently with inside legal counsel for our member companies and discuss cases important to them and their companies' ability to provide employee benefits. ERIC member companies have at least 10,000 employees and generally operate in many states across the country. Legal cases and any government action involving ERISA preemption can strike at the heart of these companies. The ERIC Legal Committee welcomes the participation of all our member company counsels and others concerned with the outcome and interpretation of legal cases.

Importantly, ERIC intervenes in legal cases to support issues important to our members. For example, on February 23, ERIC filed an amicus brief with the U.S. Court of Appeals for the Second Circuit in *Geoffrey Osberg v. Foot Locker, Inc. et al* arguing that the District Court was wrong when it found Foot Locker liable without proof of detrimental reliance and allowed the case to move forward despite tolling of ERISA's statute of limitations.

I would like to thank the legal team at Epstein Becker & Green for their expert legal insights and for their impressive contributions to this issue of the Benefits Litigation Update.

As always, we welcome your feedback on this newsletter as well as the cases highlighted.

EXECUTIVE EDITORS

Gretchen K. Young
gyoung@eric.org

Gretchen Harders
gharders@ebglaw.com

Adam C. Solander
asolander@ebglaw.com

ERIC will hold a conference call discussing cases addressed in this issue on Wednesday, March 30, 2016 from 2:00 to 3:30 pm EDT.

ERIC members and trial members can register for the call by clicking here. If you are a prospective member and would like to participate in the call, please contact ERIC at (202) 789-1400 or by email at memberservices@eric.org.

FEATURED ARTICLES

The Oddity of An Evenly Divided Supreme Court

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Labor and Employment practices

Nearly every retirement or death of a Supreme Court justice over the last seventy years took place when the Court was not in session. Not since Chief Justice Stone passed in April, 1946, has a justice died well into the months of the Term, October through June, when the Court is at work.

With Justice Scalia's sudden and unexpected death in February 2016, the Court is likely to finish the current Term with only eight justices. Republican threats to hold the seat open until the next President is inaugurated, however, could extend this deficiency until well after the next president is elected. Moreover, a heated, and potentially partisan, confirmation process could leave the court short-handed for an even longer period of time. For instance, a nominee proposed in January or February 2017 likely would not be confirmed before April, the usual last month of oral arguments in a Term.

Thus, the Court may not return to full strength until it opens for business on the first Monday of October 2017. And complicating this timeline is that the votes of the eight current justices often seem to be divided equally between "conservative" and "liberal" lines, with four on each side. Below we examine how this could affect ERISA and employee benefits litigation at the Court.

Two ERISA cases have already been decided this Term, one before Justice Scalia's passing and one after. His vote did not have a decisive effect in the subrogation case *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, No. 14-723, an 8-1 decision. His absence also did not potentially affect the outcome of *Gobeille v. Liberty Mutual Insurance Co.*, No. 14-181, a very significant case on ERISA preemption that was decided by a 6-2 vote. (As the *Gobeille* vote indicates, the Court does not report the vote that a departed Justice may have cast on a case if he or she left, or died, before the opinion is released.)

The other employee benefit case, which will be argued March 23, 2016, is the contraceptive mandate challenge by religious employers, *Zubik v. Burwell*, No. 14-1418. Given the 5-4 votes in similar cases decided by the Court, an equally close vote seems likely. With the conservative bloc reduced by one, a four-four tie could occur.

The Court can be expected to address potential tie votes either by accepting the outcome of a tie or by ordering reargument of the case in the next Term, in the hopes that a ninth justice will join the Court to break the tie. The Court already has carried five cases over to the next Term by failing to schedule them for oral argument this Term.

Reargument

Ordering reargument in closely divided cases has been used frequently in the past when a vacancy impinged on a new Term. Although Justice Scalia is the first mid-Term death on the Court in a long time, other vacancies have occurred at a time when the seat could not be filled before the Court resumed its session in October. For example, Justice Thomas joined the Court on October 23, 1991, missing the first set of arguments earlier that month. Two of the cases from that sitting were set for reargument, and he cast a vote in each. Four cases were reargued when Justice Kennedy joined the Court in early 1988.

If, as suggested above, the nomination of a new justice does not occur until after the next inauguration, and the new justice cannot be confirmed and seated until late in the next Term, a reargument order may effectively push a case back yet another Term, to October Term 2017. An argument in the fall of that year would mean that the decision itself would probably not occur before 2018. Thus, two years may pass before the reargued case reaches disposition.

What happens when the Court's vote is a tie?

What does it mean when the Court has a tie vote on a case and, thus, there is no majority opinion? A four-to-four vote results in the lower court's decision being "affirmed by an equally divided court". That disposition is considered to be essentially the same as a dismissal without ruling on the case. The decision of the lower court stands and can be enforced as "the law of the case" against the parties in that particular case.

A tie vote, however, produces no precedent to be followed in the future. When the lower courts are divided, as in the *Zubik* contraceptive case, (eight circuit courts of appeals upheld the government, and one ruled against it), the division remains unresolved. This means that a tie vote may essentially leave the issue in limbo.

Cases decided by an equally divided Court may, however, be reconsidered by the Supreme Court if the parties timely seek rehearing.

One possible disposition of the contraceptive mandates cases, then, lies in an affirmance by an equally divided Court, followed by petitions for rehearing by the parties. Of course, this still means a potentially lengthy delay in deciding an issue of national significance.

Granting Review in New Cases

The most significant potential effect of a prolonged vacancy on the Court lies with the decision to grant review to cases. Under the Court's rules, the vote of only four justices can grant review. Normally, those votes mean that four justices believe a case deserves resolution, *and* they see a path to a fifth vote for the result they believe should occur.

Holding open the ninth seat until after the election means that neither the conservative bloc nor the liberal bloc of justices may be able to reliably predict the general leanings of the ninth justice who joins them. Either side could vote to hear an important case, only to find that the Court that ultimately hears the case will favor an outcome that the justices originally granting the review did not anticipate.

This uncertainty about future outcomes will probably color voting behavior in taking cases involving constitutional and controversial matters and could affect ERISA and employee benefits litigation.

Since 2010, fourteen significant ERISA and employee benefit cases (or ones having significant impact on these areas) have been decided by the Supreme Court. Only three of those cases might have come out differently with a justice other than Scalia on the Court.

Justice Scalia's vote was not an important factor in the outcome of eleven cases. Five were decided unanimously, or with only one dissent, on all issues. In five others (including two on the Affordable Care Act and two on same-sex marriages), he dissented. In one other, *Cigna Corp. v. Amara*, 563 U.S. 421 (2011), Justice Scalia joined a majority of six justices (meaning the Court had five votes without him), and concurred without fully endorsing the majority opinion.

One of the three ERISA/employee benefit cases in which Justice Scalia cast a decisive vote is *M&G Polymers v. Tackett*, 135 S. Ct. 926 (2015). The Court decided *Tackett* unanimously as to result, but a four justice concurrence by Justice Ginsberg would concede extremely favorable rules of contract interpretation to retirees who claim to have obtained vested healthcare benefits through collective bargaining. The recent Sixth Circuit decision, *Gallo v. Moen Inc.*, __ F.3d __, 2016 U.S. App. LEXIS 2118 (6th Cir. Feb. 8, 2016), noted elsewhere in this newsletter, would seem a prime case to test the competing schools of thought on the Court on this issue. With uncertainty surrounding that last spot on the Court, however, Gallo may get a pass. The liberal justices may not be willing to risk a Republican appointee who more firmly entrenches a conservative imprint following *Tackett*. Similarly, the conservative justices would not risk a modification of *Tackett* by a Democratic selection for the Court.

NOTEWORTHY PENDING CASES

Bell v. Anthem: Fee Litigation and Fiduciary Responsibility

By Michelle Capezza, Member of the Firm in the Employee Benefits and Health Care and Life Sciences practices

A case of considerable interest to sponsors of 401(k) plans and fiduciaries is *Bell v. Anthem, Inc., Pension Committee of ATH Holding Co., LLC et. al.*, a class action filed December 29, 2015 in the U.S. District Court, Southern District of Indiana seeking to represent a class of 59,000 participants and beneficiaries. The Bell complaint asserts various breaches of ERISA fiduciary responsibility and liability in connection with the Anthem 401(k) plan, based on allegations that the Anthem 401(k) plan offered high-fee retail-class mutual funds when lower cost institutional share classes of identical funds were available; other options such as collective trusts and separately managed accounts were not considered; the plan included a money market fund instead of a stable value fund providing higher returns; and plan fiduciaries paid excessive recordkeeping and administrative fees to Vanguard when better fees could have been negotiated given the plan's large size.

Fee litigation lawsuits are a significant cause for concern for employers and plan fiduciaries. In this environment, plan fiduciaries must not only engage in prudent decision-making to select and monitor plan investment options and their performance, but they also must devote considerable time and resources to fee benchmarking, review of investment share classes, revenue share arrangements and costs and fees of plan services, and negotiation of fees and costs based on plan size. Attention to overall plan governance and documentation of prudent decision-making in line with the plan documents themselves is also critical. Following such sensible steps is crucial to demonstrate adherence to fiduciary responsibilities and defend against fee litigation suits.

TAKEAWAYS: Plan fiduciaries should undertake a comprehensive review of plan investments and all fee arrangements.

EEOC v. Flambeau: ADA Benefit Plan Safe Harbor Trumps EEOC Wellness Program Voluntariness Attack

By Frank C. Morris, Jr., Member of the Firm in the Litigation and Employee Benefits practices

The EEOC's proposed wellness rule would impose limitations more stringent than the tri-agency (HHS, DOL and Treasury) wellness regulations under the Affordable Care Act. The EEOC premises its actions on the Americans with Disabilities Act's (ADA) prohibition of health-related inquiries or medical examinations of employees unless they are "voluntary" or justified by business necessity. The EEOC is still considering comments to its proposed rule, and the final rule is expected this spring. Even before the EEOC issued proposed regulations, however, it launched three litigation challenges to wellness programs, including *EEOC v. Flambeau,* No. 14-638 (W.D. Wis.).

Flambeau sponsored a self-funded group health plan and in 2011 adopted a wellness program, which included a health risk assessment ("HRA") and biometric screening (the "Wellness Program"). In 2012 and 2013, Flambeau offered company-paid health insurance only to employees who participated in the Wellness Program. As a result, it discontinued health coverage for an employee who did not complete the HRA and biometric test. The employee then filed an EEOC charge, which led to the EEOC suing and claiming that Flambeau was compelling employees to submit to medical examinations and thus violating the ADA.

Flambeau defended by arguing that its Wellness Program fell within the ADA safe harbor for bona fide benefit plans (42 U.S.C. 12201(c)(2)). The district court agreed with *Flambeau* and followed the Eleventh Circuit decision in *Seff v. Broward County* (2012), which had found that the wellness plan in question fell within the ADA safe harbor. The judge in *Flambeau* cited statements by Flambeau's benefit consultants that they relied on the aggregate wellness data to classify health risks and

determine plan costs and premiums under the health plan. The court rejected the EEOC's argument that the safe harbor did not apply because the wellness program provisions were not in an SPD. On February 25, 2016, the EEOC announced that it was appealing the *Flambeau* decision to the Seventh Circuit.

TAKEAWAYS: In light of both *Seff* and *Flambeau*, employers are well-advised to make their wellness programs one of the terms of their health benefit plans or to assure that a wellness program is itself a bona fide benefit plan so that they can better argue the program satisfies the ADA's bona fide benefit plan safe harbor and that it is therefore outside of the EEOC's review of its "voluntariness."

NOTEWORTHY DEVELOPMENTS

States Take Action to Shield Their Boards From Antitrust Laws

By Allison Wils, Director Health Policy, The ERISA Industry Committee (ERIC)

Despite a recent setback in Texas, some state medical boards and other similar entities may be receiving legislative support to engage in behavior that could constrain the expansion of telehealth activities across the country.

In mid-2015, Teladoc, a large national telehealth vendor, filed an antitrust suit against the Texas Medical Board (TMB) for adopting a rule that would restrict competition from telehealth doctors. TMB moved to dismiss the case arguing, in part, that TMB was not subject to antitrust laws because of a legal doctrine known as "state action immunity" that allows states to engage in anti-competitive practices if the state is acting in its sovereign capacity; this doctrine can be extended to immunize other entities as well if they are "actively supervised" by the state and the anti-competitive policies enacted are clearly articulated and expressed as state policy. The U.S. District Court for the Western District of Texas denied TMB's motion to dismiss finding, in part, that TMB failed to show active supervision by the state.

The requirement for active supervision by the state comes from a series of cases, most recently *North Carolina Board of Dental Examiners v. Federal Trade Commission*. In this case, the U.S. Supreme Court clarified that, in situations where a controlling number of decision-makers on the board are active market participants in the occupation the board regulates, the board can invoke state action immunity only if it is subject to active supervision by the state.

As a result of this decision, multiple states, including both Georgia and Wyoming, have introduced legislation to secure immunity for their medical boards.

State efforts to protect the immunity of these boards is particularly important given the growing number of policy issues that fall within the licensing boards' jurisdiction. The ongoing battle between Teladoc and TMB, and its ramifications for employers seeking access to telehealth services in Texas, is only one example of how this immunity may impact employers' ability to offer widespread access to benefits. In states that have adopted laws to protect boards from antitrust laws, the boards' incentive to avoid anti-competitive practices will be reduced or eliminated, which may lead to a reduction in board policies that allow open competition among providers.

TAKEAWAYS: These legislative efforts may encourage many different types of state licensing boards to increasingly pursue anti-competitive practices that would otherwise violate antitrust laws. The resulting erosion of market protections may make it difficult for employers to offer uniform, barrier-free services to employees across state lines. ERIC continues to weigh-in at the state level to promote favorable telehealth policies and achieve widespread access to telehealth services; we are closely tracking this legislative trend as a part of our efforts.

ADA Investigations: Do Your Benefit Websites Make You A Disability Discrimination Litigation Target?

By Frank C. Morris, Jr., Member of the Firm in the Litigation and Employee Benefits practices

Most employee benefit plans today feature access to plan information and the ability to enroll, perform transactions and other functions through websites. This promotes 24/7 access for participants and efficiency and economy for the plans and sponsors. An evolving concern, however, is whether plan participants who are disabled, especially those who are blind or have low vision, are able to successfully use benefit websites.

Many employers and other entities are facing ADA Title III and related claims if a website (or associated mobile apps) is not accessible to the public. The premise of such claims is that the ADA requires individuals with disabilities to be able to enjoy the goods, services, privileges, and advantages of "places of public accommodation". Similarly, Title I of the ADA requires employers to make all of the terms, privileges and benefits of employment equally available to all employees, including employees who are blind or have low vision or other disabilities.

There are currently no federal regulations covering the private sector as to what constitutes an accessible website. Nonetheless, the U.S. DOJ has investigated many Title III complaints and required companies and other entities to modify their websites to meet the Web Content Accessibility Guidelines (WCAG) 2.0 Success Levels A and AA in numerous settlements. In addition to DOJ activity, advocacy groups for the disabled have pursued litigation, and some enterprising law firms have sent out hundreds of demand letters concerning allegedly inaccessible websites based on checks by automated programs and seeking remediation to meet WCAG 2.0 Levels A & AA (and a monetary payment).

What does all of this mean for plan sponsors? It does not seem hard to foresee ADA claims by employees with disabilities if a plan website is not configured to permit effective use of screen readers and audio descriptions of pictorial materials. Otherwise, the employer may potentially face a discrimination claim that a blind or a low vision employee is not able to participate in the employer's benefit offerings as other employees can. Even worse, they may argue that an employee with a disability must have the assistance of someone else and thus must disclose confidential information or transactions in a way that an employee without a disability would not need to do.

In these circumstances, plan sponsors are beginning to address the risks associated with these websites and to assess their compliance with the ADA. Certainly when any benefit website refresh or redesign is occurring, accessibility issues should be considered. With appropriate proactive steps and assistance, employers and plan sponsors hopefully can avoid disability litigation over the accessibility of benefit plan websites and apps.

TAKEAWAYS: Employers that provide for plan disclosures and/or transactions through websites should consider ADA accessibility issues for plan participants and beneficiaries especially for those individuals who are blind or have low vision. ADA accessibility should also be considered by employers in negotiating service agreements with plan service providers that provide enrollment, election and communication materials to participants through the service providers' own websites.

NOTEWORTHY RECENT DECISIONS

Supreme Court Narrows Plans' Subrogation Remedies

By Kenneth J. Kelly, Member of the Firm and Chair of the National Litigation Steering Committee

In *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, decided January 20, 2016, the Supreme Court held that a plan administrator could not enforce a subrogation clause under the "appropriate equitable relief" provisions

under Section 502(a)(3) against a plan participant, where the participant had dissipated settlement money that could not be traced.

The plan had paid $120,000 for the participant's medical bills after a car accident. The participant then settled with the other driver and spent most of the settlement money. ERISA specifically authorizes fiduciaries such as plan administrators to bring lawsuits for "appropriate equitable" relief, which typically means an injunction of some kind, as opposed to a "legal" remedy, that is, a judgment requiring the defendant to pay the plaintiff a sum of money. Accordingly, the plan asserted various principles in equity, such as an equitable lien, to obtain an order that could be used to get money from the individual's general assets, as if the plan had won a money judgment.

Following Supreme Court precedents, the plan asserted various principles in equity to obtain a judgment that could be enforced against the individual's general assets.

The Court has for years interpreted ERISA by referring to the law of trusts and historical principles of equity, and continued that practice in *Montanile*, holding that the participant's obligation was to repay *out of a specific fund*. Once the fund was spent, any equitable lien could no longer exist, irrespective of the fact that as a result, the plan participant was able to brazenly breach his obligations to the plan. Calling this result "bizarre," Justice Ginsberg dissented, citing her long-standing view that the Court's focus on equity principles erroneously indulges in "recondite controversies better left to legal historians" instead of trying to effect the general goals of ERISA. Even more bizarre perhaps, the majority faulted the plan for not acting on very short notice to prevent the participant from spending the money.

TAKEAWAYS: To protect themselves against similar results, plans would be wise to closely monitor personal injury lawsuits brought by participants; make sure subrogation clauses (in states that allow subrogation at all) are clear; require the participant to keep the administrator advised of the progress of litigation; and be prepared to promptly seek equitable relief to enforce liens or even enjoin dissipation of settlement funds, as occurred in *Montanile*. All of such actions would appear to be prudent, although ultimately wasteful of plan assets by requiring needless monitoring and litigation.

Plans seeking to enforce subrogation clauses should actively monitor participant litigation and be prepared to act quickly to obtain equitable relief.

Gallo v. Moen Inc.: Progress in Repudiating Yard-Man

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Labor and Employment practices

Last year, in *M&G Polymers USA, LLC v. Tackett,* 135 S. Ct. 926 (2015), the U.S. Supreme Court repudiated the Sixth Circuit's Yard-Man doctrine, which had "placed a thumb on the scale" in favor of finding that retiree healthcare benefits vested if they were obtained through collective bargaining. In January, a panel of judges on the Sixth Circuit remanded that case to the District Court, expressing no opinion about the outcome, but providing a list of contract law principles to be considered by that court. *Tackett v. M&G Polymers USA, LLC*, __ F.3d __, 2006 U.S. App. LEXIS 998 (6th Cir. Jan. 21, 2016).

In February, 2016, a different panel of judges on the Sixth Circuit applied *Tackett* to reverse a District Court decision that had applied Yard-Man to find retiree benefits had vested. Significantly, the appellate court concluded that the record reflected an unambiguous intent not to vest those benefits. *Gallo v. Moen Inc.*, __ F.3d __, 2016 U.S. App. LEXIS 2118 (6th Cir. Feb. 8, 2016). While the opinion (like most judicial opinions) professes to resolve only the particular contracts before it, the reasoning provides a roadmap for assessing the ability of an employer to prevail on the vesting issue as a matter of law.

These principles decided *Gallo* in the employer's favor: (1) no agreement expressly committed the employer to provide retiree healthcare benefits for life; (2) the commitment that existed for retiree healthcare appeared in agreements with three year

terms; (3) the most recent collective bargaining agreements referred to providing "continued" coverage, which implied that prior promises had not established a right for life since it would not have to be "continued" if it already had established permanently; (4) some provisions of the CBAs expressly guaranteed lifetime benefits (such as pension), which implied that the absence of an express promise for retiree healthcare benefits represented an intentional choice; and (5) the CBAs contained reservation-of-rights clauses, which evidenced an intent not to vest benefits affected by those clauses.

The *Gallo* court also rejected the retirees' argument that the use of the word "will" -- for example, that future retirees "will be covered" -- created any dispute over the potential vesting of the benefits. As the Court explained, "If *Tackett* tells anything, ... it is that the use of the future tense without more -- without words committing to retain the benefit for life -- does not guarantee lifetime benefits."

The *Gallo* court additionally rejected an argument suggested in Justice Ginsburg's concurrence in *Tackett* that language tying qualification for retiree healthcare benefits to receiving a pension meant that the benefits would last for the length of time that retirees (or their beneficiaries) receive the pension. According to the Gallo court, the duration of the promise to confer a benefit like retiree healthcare syncs with the duration of the collective bargaining agreement that confers the benefit; a qualification to receive the benefit, such as pension eligibility, does not extend the promise beyond the term of that agreement.

TAKEAWAYS: Employers should check their collective bargaining agreements for language that fits the *Gallo* mold and work to incorporate qualifying adjectives and phrases that express the durationally limited nature of retiree healthcare benefits.

Marin v. Dave & Buster's: ERISA Class Action Exposure from Reducing Employees' Hours

By Adam C. Solander, Member of the Firm in the Health Care and Life Sciences practice and Brandon C. Ge, Associate in the Health Care and Life Sciences practice

The Affordable Care Act requires large employers to offer minimum essential health coverage to full-time employees—defined as employees who work 30 hours or more per week—or potentially pay significant penalties. Some employers have attempted to minimize their obligations under the employer mandate by reducing the number of hours employees work, thereby reducing the number of full-time employees who must be offered health coverage.

On February 9, 2016, a federal district judge in the Southern District of New York denied a motion to dismiss in *Marin v. Dave & Buster's*. The named plaintiff, Maria De Lourdes Parra Marin, claimed that she regularly worked over 30 hours until mid-2013 when her hours were reduced, decreasing her pay and causing her to lose eligibility for medical and vision benefits. The approximately 10,000 employees named in the class action case allege that such reductions in their hours violated section 510 of ERISA, which prohibits discriminating against any participant or beneficiary for exercising any right to which he or she is entitled under ERISA or an ERISA benefit plan.

Dave & Buster's argued that employees are not entitled to benefits that have not yet accrued and the plaintiffs must therefore demonstrate more than lost opportunity to accrue additional benefits to sustain a section 510 claim. Judge Hellerstein rejected this argument, stating that Marin alleged that the discrimination affected her current benefits in addition to interfering with her ability to attain future benefit rights.

This will be an important case to monitor for the many employers who have considered managing employees' hours to minimize employer mandate obligations. The court's decision to deny the motion to dismiss will also likely encourage plaintiffs' lawyers and catalyze more litigation in this area.

TAKEAWAYS: Employers seeking to contain their ACA coverage obligations should be careful in making any changes to the terms and conditions of a participant's employment.

Group Health Plan's Residential Treatment Exclusion Violates Mental Health Parity Act

By Gretchen Harders, Member of the Firm in the Employee Benefits practice

On January 22, 2016, in *Joseph and Gail F. v. Sinclair Services Co., 2016 WL 309787 (D. Utah 2016)*, a Utah District Court ruled that an employer's self-insured group health plan violated the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Mental Health Parity Act") by excluding coverage for residential treatment for emotionally disturbed children and adolescents.

The plaintiffs had appealed the employer group health plan's denial for their daughter's physician-recommended residential treatment following in-patient hospitalization for severe depression and thoughts of suicide. Their claim focused on the requirement under the Mental Health Parity Act regulations that quantitative or non-quantitative treatment limitations applicable to mental health or substance use disorder benefits may not be "more restrictive" than the treatment limitations applied to substantially all medical and surgical benefits. They further claimed that, under the Mental Health Parity Act regulations, there may be no separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

In concluding that the exclusion of residential treatment violated the Mental Health Parity Act, the District Court relied on the plan's terms providing coverage for sub-acute inpatient services for medical and surgical conditions at skilled nursing facilities. The District Court determined the plan cannot exclude coverage for sub-acute inpatient services at a residential treatment facility that only treats mental health conditions and at the same time provide coverage for sub-acute inpatient services at a skilled nursing facility that only provides medical and surgical treatment. The District Court concluded that the residential treatment exclusion violated the clear and unambiguous language of the Mental Health Parity Act that there can be no separate treatment limitation applicable only to mental health benefits. (The District Court did not award benefits, but returned the claim to the plan administrator based on the argument that the benefits claimed were provided out-of-network.)

TAKEAWAYS: Employers should carefully review the terms of their group health plans for any categorical exclusions of types of treatment, treatment settings or facilities provided for mental health conditions and whether the exclusion violates the Mental Health Parity Act. The key question will be whether the same exclusions apply to similar or analogous types of treatment, treatment settings or facilities provided for medical or physical conditions.

Please send questions, comments, and related requests to Gretchen Young, Gretchen Harders or Adam C. Solander.