AMERICAN BAR ASSOCIATION
Tort Trial and Insurance Practice Section

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COMMITTEE NEWS

Health and Disability & Life Insurance Law

ARIZONA

Summary Judgment Granted in Favor of Insurer on Bad Faith Claim

In the recent case of *Centeno v. American Liberty Insurance Company*, No. CV-18-01059-PHX-SMB, 2019 WL 4849548 (D. Ariz. Oct. 1, 2019), the U.S. District Court for the District of Arizona expounded upon the evidentiary burden a plaintiff must satisfy to demonstrate insurer bad faith.

Centeno was a traveling nurse employed by Beech Home Care ("Beech") and was covered under a policy issued by American Liberty Insurance Company ("American Liberty") providing workers' compensation coverage. On August 5, 2016, while retrieving medical supplies from her vehicle to continue treatment of a patient, Centeno allegedly fell and injured her back. No one witnessed the injury. Centeno, along with fellow nurse Jeuckstock, continued treating patients that day following Centeno's alleged injury.

Centeno reported her alleged injury to Beech three days later and began receiving medical care at Chandler Regional Medical Center that same day. The reports of

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Daniel's practice focuses primarily on ERISA and insurance litigation, where he represents ERISA plans and long term disability insurers in disputes regarding such matters as benefit determinations and bad faith. In addition, Daniel has extensive experience litigating stranger originated life insurance (STOLI) matters, in which he has represented insurers challenging the validity of life insurance policies due to a lack of insurable interest. He is licensed in Arizona, Pennsylvania, New Jersey and New York and has litigated cases in state and federal courts across the country. He received his J.D. from the University of Pennsylvania Law School in 2011.

In This Issue

Chairs Message

We hope you and your families are all well and staying safe. While we miss seeing so many of you during these challenging times, we are still hard at work with some exciting news to share. At the mid-winter symposium in Austin, Texas, the Life, Health and Disability committees met to discuss whether the committees should consider merging into a one combined committee. The committees are among the hosts of the mid-winter symposium each year and work together in other ways, such as the Newsletter. The benefits and potential negatives were fully considered and it was (at least initially) determined that the committees would like to move forward down this path and host a strategic planning meeting to further discuss, which is in the works.

The Health & Disability committee is planning a Webinar on Attorney's Fees in ERISA Litigation and the Life committee is expecting to announce webinars it will be hosting shortly. Both webinars will include excellent panelists. Further details will be announced by the ABA and we encourage everyone to attend and support these events.

The committees are also commencing discussions for next year's mid-winter symposium. With so much uncertainty, we will not only plan a live event, but will include a "Plan B" in case the symposium becomes a virtual event. Whatever form it takes, we are confident the next mid-winter symposium will be a successful event.

Sherril Colombo
Chair of the Health and Disability Insurance Law Committee

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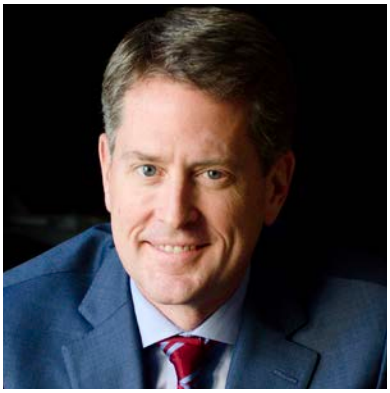

Joe Jeffrey
Chair of the Life Insurance Law Committee

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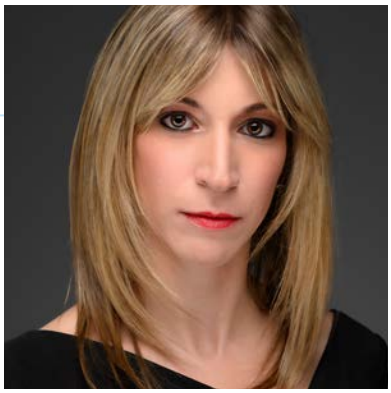
Connect with Life Insurance Law

website

Stay Connected with TIPS

We encourage you to stay up-to-date on important Section news, TIPS meetings and events and important topics in your area of practice by following TIPS on **Twitter** @ABATIPS, joining our groups on **LinkedIn**, following us on **Instagram**, and visiting our **YouTube** page! In addition, you can easily connect with TIPS substantive committees on these various social media outlets by clicking on any of the links.

Recent Trends in Transgender Healthcare Law



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Marie Casciari is a shareholder at DeBofsky Sherman Casciari Reynolds, P.C., in Chicago, Illinois, and practices exclusively in the areas of employee benefits, ERISA, mental health parity, and other insurance benefits litigation. Ms. Casciari handles litigation at the state court, federal district court, and federal appellate court levels; and manages internal appeals and benefit claim submissions under group and individual benefit plans. Ms. Casciari has argued before the United States Court of Appeals for the Seventh Circuit, the United States District Court for the Northern District of Illinois, and the Illinois Circuit Court.

Protecting LGBTQ rights is of great importance for this country, and the legal issues related to transgender healthcare can be particularly complicated.

Many employer-sponsored healthcare plans now explicitly cover transgender-related healthcare. Part of the reason is likely economic. According to the Williams Institute, there are currently just under 1.4 million Americans who identify as transgender, which equates to approximately 0.58% of the population.[1] In 2001, the City and County of San Francisco became the first major employer in the United States to publicly remove transgender access exclusions in its group health insurance plans.[2] Financial data from the first five years of the program confirmed that premium increases were not necessary and that total claims averaged less than $77,000 per year from just 6-24 participants.[3] Since then, an increasing number of employers offer transgender-inclusive healthcare coverage, including 65% of Fortune 500 companies and 89% of all major employers.[4] That is up from approximately 0% in 2002 and just 9% in 2010.[5]

Nevertheless, some employers still do not offer transgender-inclusive healthcare coverage, and there has been a recent uptick in litigation challenging exclusions for transgender-related healthcare in group plans, particularly state-sponsored group plans. For example, on September 18, 2018, the United States District Court for the Western Division of Wisconsin held that the exclusion for gender confirmation surgery and related services in the State of Wisconsin's group health plan for public employees constituted sex discrimination in violation of Title VII of the Civil Rights Act, Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), and the Equal Protection Clause of the Fourteenth Amendment.[6]

Similarly, on December 23, 2019, the United States District Court for the District of Arizona denied a motion to dismiss filed by the State of Arizona and others in a case challenging its group health plan's exclusion for gender confirmation surgery.[7] An Associate Professor at the University of Arizona filed the case, and the court sustained his claims under both Title VII and the Equal Protection Clause.

Most recently, on March 6, 2020, the United States District Court for the District of Alaska granted partial summary judgment in favor of Jennifer Fletcher, a legislative librarian for the State of Alaska, who underwent gender confirmation surgery in Thailand after being denied coverage for the operation under the State of Alaska's group health plan.[8] The court found that the plan's exclusion for gender-transition

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MASSACHUSETTS

Claim to Recover Overpayment of LTD Benefits Dismissed Based on Insufficient Pleading

In *Jette v. United of Omaha Life Insurance Company*, 2019 WL 3027745 (D. Mass. 2019), the U.S. District Court of Massachusetts addressed the adequacy of the allegations necessary for a claim to recover an overpayment of long-term disability benefits.

Jette was covered by an employee welfare benefit plan, which included long-term disability coverage. The plan was funded by a group policy issued by United of Omaha, which also administered claims under the plan.

Jette filed a claim for benefits, which was approved by United of Omaha. Subsequently she also received Social Security Disability Income benefits. This resulted in an overpayment of LTD benefits of just over $15,000.

At some point, United of Omaha stopped paying LTD benefits to Jette, which prompted her lawsuit. United of Omaha counterclaimed for the overpayment. The benefit plan allowed United of Omaha to recover the overpayment. In addition, Jette signed a reimbursement agreement promising to repay any overpayments.

Jette moved to dismiss United of Omaha's counterclaims seeking to recover the overpayment. The court allowed the motion. The court reviewed the various Supreme Court decisions that address the recovery of overpayments as equitable relief. The court found that to satisfy these decisions, more specifically *Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016), United of Omaha must establish the following criteria to secure an equitable lien by agreement: (1) a promise by the beneficiary to reimburse the benefits paid in the event of a recovery from a third party; (2) the reimbursement agreement must identify a particular fund, distinct from the beneficiary's general assets, from which the reimbursement will come; and (3) the funds specifically identified must be within the possession and control of the beneficiary. The court noted that the expenditure of the identifiable fund on non-traceable items destroys the equitable lien.

Jette argued that United of Omaha's claims failed because they did not identify a separately identifiable fund from which United of Omaha could recover the overpayment. The court rejected Jette's argument that the fund must be entirely separate from any of Jette's other assets. However, noting that United of Omaha

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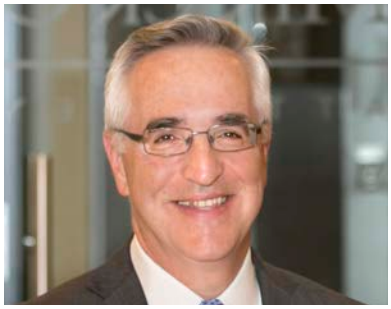

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did not allege in its counterclaim that the funds were in the possession of Jette, the court held the counterclaims were deficient and must be dismissed. The court granted the motion to dismiss without prejudice to United of Omaha moving to add the counterclaims after it conducted limited discovery on the issue.

The court also noted that United of Omaha did not seek to impose personal liability upon Jette, but rather sought the reimbursement of particular funds or property, namely the overpaid LTD benefits. This raises the issue of whether a counterclaim for breach of contract under the reimbursement agreement may have survived the motion to dismiss or would it have been preempted?

In any event, this case appears to be the first reported decision in the First Circuit since Montanile regarding the sufficiency of a claim to recover an overpayment. The takeaway is that a party seeking to recover the overpayment of ERISA benefits based on equitable grounds under ERISA must include an allegation that the funds sought by the plan are within the claimant's possession.

Eleventh Circuit Provides Guidance on the Application of Medical Evidence When Applying the Six-Part Test to Review a Plan Administrator's Benefit Decision

In *Kaviani v. Reliance Standard Life Ins. Co.*, 799 F. App'x 753 (11th Cir. 2020), the Eleventh Circuit reaffirmed its use of a six-part test to review a plan administrator's benefit decision and specifically focused on the weight that the plan administrator must give the evidence provided by the claimant.

Kaviani was a dentist who was covered by an employee welfare benefit plan, which included Long Term Disability ("LTD") benefits, and was governed by ERISA. Kaviani was involved in a car accident in April, 2012. Kaviani went to the emergency room two days after the accident complaining of neck and back pain. A subsequent MRI showed disc bulging, herniation, and mild stenosis at several levels of Kaviani's spine. Kaviani underwent "significant" treatment for the remainder of 2012 and remained under the care of an orthopedic surgeon for three years. He continued to work as a dentist during this time.

In June 2015, Kaviani reported to his treating surgeon that the pain in his back was making it difficult for him to work and causing him to drop tools. The surgeon recommended that Kaviani change occupations. He submitted his notice of resignation on July 10, 2015 and stopped working a month later.

On August 14, 2015, Kaviani submitted a claim for long term disability ("LTD") benefits with the plan administrator, Reliance. To be eligible for benefits under the plan, Kaviani had to be totally disabled, which was defined as being unable to perform the material duties of his regular occupation for a 180 day "Elimination Period." In support of his claim, Kaviani submitted a statement from his treating surgeon stating that Kaviani could not continue to work in his current occupation.

Reliance conducted two evaluations: an occupational analysis by a rehabilitation specialist, and a medical examination. Reliance used these two analyses to deny Kaviani's claim. Kaviani subsequently appealed, and submitted additional records, including a functional capacity evaluation ("FCE") and an independent medical examination ("IME"), which showed his inability to safely perform his essential job functions. Reliance hired an additional doctor to conduct a medical assessment of Kaviani's file, who "deem[ed] invalid" Kaviani's FCE without explanation. Reliance denied his appeal.

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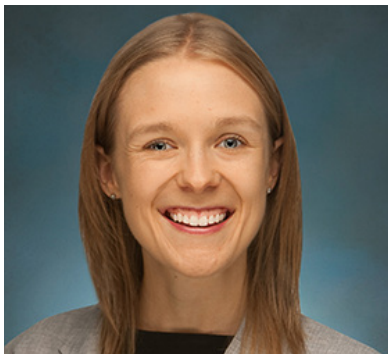

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MASSACHUSETTS

Denial of Total Disability Benefits Not Arbitrary or Capricious

In *Hammond v. Proctor & Gamble Health and Long Term Disability Plan,* 2019 WL 3027644 (D. Mass. 2019), the U.S. District Court of Massachusetts held that Proctor & Gamble's decision to classify Hammond's disability as partial, rather than total, was not arbitrary or capricious.

Hammond was covered under Proctor & Gamble's employee benefit plan. He worked as a production mechanic for Gillette Company working 12 hours shifts, three or four days per week. Hammond, who was pro se, was diagnosed with plantar fasciitis and peroneal tendonitis of the right foot.

After receiving the diagnosis, Gillette permitted Hammond to work part-time while he received partial disability benefits. The plan paid a maximum benefit of 52 weeks for partial disability. After reaching the 52 week maximum benefit period, Hammond sought total disability benefits. Proctor & Gamble denied them, and suit followed.

The court applied the arbitrary and capricious standard of review. In support of its decision, Proctor & Gamble pointed out that Hammond's treating physician opined that Hammond could return to work with restrictions of eight hours working per day with a maximum of four hours walking. The benefit plan defined total disability to be a condition of such severity as to require care in a hospital or restriction to the home. Partial disability was defined as the ability to perform useful roles at the company site or at jobs outside the company. Because Hammond's physician opined that although Hammond had work restrictions, he could work with those restrictions given the appropriate job, the court found that Proctor & Gamble's decision was not arbitrary and capricious and entered summary judgment in favor of Proctor & Gamble.

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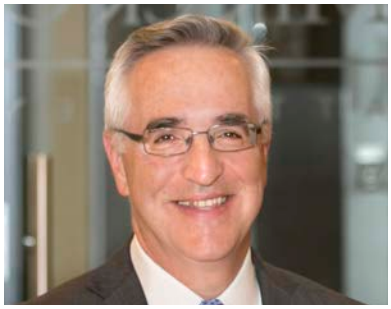

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Rule 12(b)(6) Motions to Dismiss Mental Health Parity Act Claims:

Various Approaches Within The District of Utah Provide Lessons for Plaintiffs and Defendants

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Introduction

Recent ERISA decisions out of the United States District Court for the District of Utah addressing Rule 12(b)(6) motions to dismiss claims asserted under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act" or "MHPAEA")[1] offer valuable lessons to plaintiff and defense attorneys when it comes to pleading Parity Act claims. This article highlights some of the more notable decisions.

Brief Overview of Mental Health Parity Legislation

The MHPAEA amended the Mental Health Parity Act of 1996 (the "MHPA"), requiring "a much greater degree of parity from plans that offer mental health or 'substance use disorder' benefits."[2] "The MHPA provisions were added to the Employment Retirement Income Security Act (ERISA), as if they had been included in HIPAA."[3] The MHPAEA applies to group health plans covering both (1) medical and/or surgical benefits, and (2) mental health benefits and substance use disorder ("MH/SUD") benefits, but does not apply to benefits that are excepted, such as a retiree only plan, plans sponsored by employers with fewer than 50 employees[4], individual health insurance, and if application of the MHPAEA would increase plan costs by a certain percentage[5]. As the United States District Court for the District of Utah noted, "'[i]n effect, the Parity Act prevents insurance providers from writing or enforcing group health plans in a way that treats mental and medical health claims differently.'"[6]

A Series of District of Utah Cases Shows Differing Approaches in the ERISA Context

Recent ERISA cases in which plaintiffs alleged violations of the MHPAEA in the District of Utah show the court's differing approaches regarding plaintiffs' lack of

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Discovery on Structural Conflicts in ERISA Matters

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Recent decisions continue to highlight the difference between applying the de novo and arbitrary and capricious standards of review to discovery on structural conflicts in matters concerning ERISA policy denials.

In *DeMarco v. Life Ins. Co. of N. Am.*, 2020 WL 906461, U.S. Dist. LEXIS 31723 (D. Ariz. Feb. 25, 2020), the District Court of Arizona denied conflict discovery in a de novo matter. In that case, the plaintiff requested discovery regarding a number of topics, including the structural conflicts of interest. In reviewing that request, the DeMarco court noted that *Opeta v. Nw. Airlines Pension Plan for Contract Employees*, 484 F.3d 1211, 1217 (9th Cir. 2007), has caused confusion about the scope of discovery because, although it provided that discovery in an ERISA case involving de novo review should be rare, the court went on to identify a "non-exhaustive list of exceptional circumstances" that may trigger the need for discovery, including where a structural conflict of interest is present. In an effort to resolve the conflict in *Opeta,* the *DeMarco* court concluded that a plaintiff in an ERISA matter on de novo review only has the ability to conduct discovery when he or she asserts that the record was kept incomplete by the claims administrator's structural conflict of interest. *DeMarco*, 2020 U.S. Dist. LEXIS 31723, at *8. It explained that is the case because, on de novo review, the court is not giving deference to the finding of the claims administrator and, as such, its conflict of interest is not relevant to the review. *Id.* In *DeMarco* the plaintiff had not argued that the record was kept incomplete by the claims administrator's structural conflict of interest so the discovery was denied.

In contrast, in an opinion published only days later, the United States Court in the District of Kansas granted the same line of discovery in relation to a matter applying the arbitrary and capricious standard. See *Bribiesca v. Metro. Life Ins. Co.*, No. 19-1339-DDC-ADM, 2020 WL 996799 (D. Kan. Feb. 28, 2020). Specifically, the *Bribiesca* court determined that, where red flags are arguably present in the administrative record, limited discovery on the dual-role conflict is relevant. *Bribiesca*, 2020 WL 996799, at *8. In that matter, the plaintiff cited as "red flags" that (1) the insurance company contracted with a physician without training or experience in the relevant medical fields to perform an IME; (2) the majority of the physician's work was for the insurance company; (3) another district court did not afford weight to the physician's opinion because it was contrary to other medical professionals' opinions; and (4) the insurance company used improper internal appellate procedures. As a result, the plaintiff was entitled to discovery, although the defendant could still raise appropriate discovery objections.

Significantly, in *DeMarco,* the court reiterated, and its findings seem to be based on, the concept that discovery such as that requested by the plaintiff "undermines the policy goal of ERISA in keeping proceedings inexpensive and expeditious." *DeMarco,* 2020 U.S. Dist. LEXIS 31723, at *14-15. On the other hand, the *Bribiesca* court outright rejected the argument that discovery runs afoul of ERISA's policy goal in keeping proceedings inexpensive and expeditious, contending that the insurance company had not cited with particularity the manner in which the discovery would be unduly burdensome, cumulative or otherwise objectionable. *Bribiesca*, 2020 WL 996799, at *8–9.

Ultimately, the applicable standard in an ERISA claim denial matter varies depending on whether discretionary authority is available to the claims administrator. If the claims administrator does not have discretion, like in *DeMarco,* the de novo standard applies and the chances of obtaining conflicts discovery is reduced because the court reviews the record without deference to the claims administrator's decision. Where the claims administrator does have discretion, like in *Bribiesca,* the arbitrary and capricious standard applies and the likelihood of discovery into conflicts issues increases. Notably, however, even where the arbitrary and capricious standard applies, discovery of extra-record materials may not be appropriate. While Bribiesca provides guidance on a situation where discovery may be granted, the circumstances in that matter were unusual as compared to most ERISA claims denial matters and a defendant can in good faith argue against discovery in a matter applying the arbitrary and capricious standard. For instance, where the discovery that the plaintiff seeks is merely duplicative of the information already contained within the administrative record, the policy goal of ERISA is best served by precluding discovery.

Summary... Continued from page 1

Centeno's attending physician and radiologist, who both administered treatment that day, differed as to whether Centeno's injury occurred during or after work. Three weeks passed before Centeno next sought medical treatment by visiting her personal physician. After complaining of continued back and neck pain to her supervisors, Centeno visited a workers compensation clinic, after which she was recommended for light duty. Then, nearly a month after the alleged accident, Centeno reported her injury to American Liberty for the first time.

After conducting an investigation, American Liberty's claims adjuster determined that Centeno's claim was initially compensable. Shortly thereafter, however, the initial approval of Centeno's claim was thrown into doubt by two co-workers' independent reports indicating that Centeno's injury was not job-related. One of those reports came from Jueckstock, who insisted that Centeno did not exhibit any signs or symptoms of injury, nor complain of an injury either before or after the time of the alleged accident. The claims adjuster asked a third party adjuster to investigate these reports while continuing to approve Centeno's medical treatment. Centeno's medical treatment included the scheduling of therapy sessions, pre-operative surgical appointments, and the setting of a tentative surgery date of October 20, 2016.

On October 13, 2016, noting the final claim determination deadline of October 18, 2016, the adjuster denied Centeno's claim, in part due to the conflicting accounts of Centeno's co-workers indicating that the injury occurred outside of work and was therefore non-compensable. The adjuster also cited the minimal medical treatment sought in the three-week period immediately following the alleged accident and Centeno's delay in reporting the claim to American Liberty as additional support for the denial. The adjuster maintained that the timing of the denial – five days before the claim determination deadline – was motivated by a desire to meet the deadline and to allow Centeno to pursue other surgery options given her fast approaching surgery date. Following the claim denial, Centeno postponed her surgery and contested the denial. The Arizona Industrial Commission ultimately reversed the claim denial and Centeno's claim was found compensable.

Centeno thereafter filed a bad faith action against American Liberty and the claims adjuster, arguing, among other things, that they failed to conduct an adequate investigation and terminated her workers' compensation benefits without a reasonable basis. More specifically, Centeno argued that American Liberty unreasonably denied her claim in order to save money. As support for this theory, Centeno presented an excerpted section from the claims handler's website entitled "Philosophy," which outlined the adjuster's responsibilities and goals to both employers and their injured

workers. These responsibilities and goals included approving meritorious claims and assured that the claims handler "is fully aware of the fact that every dollar spent on workers' compensation comes directly off the employers' bottom line. We are committed to working closely with employers and risk management to save every dollar that is legally possible." 2019 WL 4849548, at *4 (citing Plaintiff's Response to Defendant's Motion for Summary Judgment, Exhibit 3).

American Liberty moved for summary judgment, arguing that the record did not show a genuine dispute of material fact regarding whether American Liberty's conduct was objectively unreasonable or that it acted with the requisite intent required to show bad faith in Arizona. The Court agreed.

Specifically, the Court found that "to establish bad faith, a plaintiff must demonstrate that its insurer acted unreasonably with respect to the *plaintiff's* claim." 2019 WL 4849548, at *4 (emphasis in original). With respect to the adjuster's "Philosophy," the Court found that "[o]utside of conclusory inferences, Centeno [did] not show that this 'Philosophy' is considered in American Liberty's evaluation of claims generally, much less in the consideration of her claim specifically." *Id.* "Evidence of an insurer's allegedly inappropriate claims management practices does not prove bad faith unless those practices were applied to the insurer's handling of the plaintiff's particular claim." *Id.* "Without any evidence to make this inference reasonable or show a single instance where cost was considered in [Centeno's] claim evaluation, the Court will not indulge in such a tenuous inferential leap." *Id.* at *5.

With respect to Centeno's argument that American Liberty's conduct in handling her claim was objectively unreasonable, the Court found that (i) Centeno did not identify any particular delay in the processing of her claim as unreasonable; (ii) the timing of reports from two disinterested co-workers, requiring American Liberty to conduct additional investigation through a third-party adjuster, explained any internal delay in claim processing; (iii) the reports of Centeno's medical providers were in conflict, which further justified American Liberty's continued investigation and eventual claim denial; and (iv) despite Centeno's argument that American Liberty failed to directly confront her with her two co-workers' statements, Centeno failed to show that American Liberty had such a duty to do so. *Id.* at *5. In short, the Court held that American Liberty's "investigation was not unreasonable merely because Centeno disagree[d] with the outcome." *Id.*

Recent Trends... Continued from page 4

related surgery violated Title VII's prohibition on sex discrimination. The court reasoned that the "policy of excluding coverage for medically necessary surgery such as vaginoplasty and mammoplasty for employees, such a[s] plaintiff, whose natal sex is male while providing coverage for such medically necessary surgery for employees whose natal sex is female is discriminatory on its face and is direct evidence of sex discrimination."[9]

Additional cases have been filed as well. On October 2, 2019, Anna Lange, a Deputy Sheriff in Houston County, Georgia, filed suit against the County for failing to cover gender confirmation surgery. Sgt. Lange's claims were denied under the County's plan's exclusion for "drugs for sex change surgery" and "services and supplies for a sex change."[10] Sgt. Lange alleged violations of the Equal Protection Clause, Georgia Equal Protection Guarantee, Title VII, and Title I and II of the Americans with Disabilities Act.

A few months later, on January 13, 2020, Jami Claire and Kathryn Lane filed suit against the Florida Department of Management Services and the University of Florida Board of Trustees. Ms. Claire is a Senior Biological Scientist at the University of Florida's College of Veterinary Medicine, and Ms. Lane is an attorney with the appellate division of Florida's Public Defender Office. Both women sought gender confirmation-related medical care, and both women's claims were denied under the State of Florida's healthcare plan's exclusion for "gender reassignment or modification services or supplies."[11] Similar to the others, Mss. Claire and Lane alleged violations of the Equal Protection Clause and Title VII.

Although 22 states and the District of Columbia have now passed laws that bar health insurers from explicitly refusing to cover transgender-related health care benefits,[12] Wisconsin, Arizona, Alaska, Georgia, and Florida are not among the states that have enacted any LGBTQ inclusive insurance protections. Moreover, while the United States Department of Health and Human Services ("HHS") promulgated regulations to expressly prohibit discrimination on the basis of gender identity in healthcare under Section 1557 of the ACA, they were never enforced,[13] and have now been vacated.[14]

In addition, none of the recent cases has challenged these exclusions under the Federal Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") or their state counterpart laws, which generally require health plans that cover mental health treatment to do so in parity to medical/surgical treatment claims. That is significant because gender dysphoria – defined as "a marked incongruence between one's experienced/expressed gender and assigned gender" at birth, accompanied by distress caused by that incongruence – is codified in the American Psychiatric

Association's Diagnostic and Statistical Manual of Mental Disorders (5th ed.) ("DSM-V").[15] Thus, for example, if a group healthcare plan covers spinal fusion operations for participants with herniated spinal discs, but does not cover gender confirmation surgery for participants diagnosed with gender dysphoria, that could constitute a violation of the applicable parity laws.

No matter which legal bases are raised, these cases are critical for ensuring the legal rights and protections for the transgender population; and will almost certainly continue to be brought until all healthcare plans provide access to transgender-inclusive coverage.

Endnotes

1 The Williams Institute, How Many Adults Identify as Transgender in the United States? (June 2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf (last visited March 4, 2020).

2 Human Rights Campaign, San Francisco Transgender Benefit: Actual Cost & Utilization (2001-2006), https://www.hrc.org/resources/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006 (last visited March 4, 2020).

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5 *Id.*

6 *Boyden v. Conlin,* 341 F. Supp. 3d 979 (W.D. Wis. 2018).

7 *Toomey v. Arizona*, No. CV1900035TUCRMLAB, 2019 WL 7172144 (D. Ariz. Dec. 23, 2019).

8 *Fletcher v. Alaska*, No. 1:18-cv-0007, 2020 WL 2487060, U.S. Dist. LEXIS 45208 (D. Alaska Mar. 6, 2020).

9 *Id.* at *11.

10 *Lange v. Hous. Cnty., Ga.*, No. 5:19-cv-00392 (M.D. Ga.) (Doc. 1 at ¶ 4).

11 *Claire & Lane v. Fla. Dep't of Mgmt. Servs. et al.*, No. 4:20-cv-20 (N.D. Fla.) (Doc. 1 at ¶ 1).

12 Movement Advancement Project, Healthcare Laws and Policies Equality Maps, https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last visited March 4, 2020).

13 *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

14 *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928 (N.D. Tex. 2019).

15 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 452-53 (5th ed. 2013).

Eleventh... Continued from page 7

Kaviani brought suit, claiming he satisfied all requirements to be entitled to LTD benefits. The parties cross-moved for summary judgment, and the district court granted Kaviani's motion. The district court found Reliance's denial unreasonable, specifically admonishing Reliance for not giving Kaviani's evidence significant weight because he did not have a clear reason for continuing to work after the accident, and for "cherry picking" favorable evidence, while ignoring the rest. The court awarded Kavani his past-due benefits, interest, and $100,000 in attorney's fees and costs. Reliance timely appealed.

On appeal, the Eleventh Circuit re-affirmed its six-part test for reviewing a plan administrator's benefits decision: (1) conduct a de novo review to determine whether the administrator's benefits-denial decision was "wrong;" (2) if the decision is "de novo wrong," determine whether the administrator was vested with discretion in reviewing claims, if not reverse the decision; (3) if the administrator was "de novo wrong" and vested with discretion, determine whether reasonable grounds supported the decision; (4) if no reasonable grounds exist, reverse the decision, if reasonable grounds do exist, determine if the administrator had a conflict of interest; (5) if there is no conflict, affirm the decision; and (6) if there is a conflict the court may take into account the conflict as a factor in determining if the administrator's decision was arbitrary and capricious. In Kaviani's case, the Court's decision hinged on the third step of the test – whether Reliance had reasonable grounds for its decision.

Reliance argued it had reasonable grounds to deny the claim because Kaviani worked for three years before filing his claim, went a year and a half without treatment, and continued to work from the date of the accident until thirty days after giving notice of his resignation. Reliance also criticized the district court for allegedly hinging its decision on Kaviani's credibility. The Court rejected the argument, finding that the district court had based its decision on the insufficiency of Reliance's stated reasons for its denial, not a finding that Kaviani was credible. The Court also criticized Reliance's arguments related to the timing of Kaviani's claim and his decision to continue working during the three years before submitting his claim. The Court re-iterated existing law that "disability is not disproved by the fact that a claimant continues to work" and that "attempt to work does not forever bar" a disability claim.

The Court was also critical of the inadequate weight Reliance gave to Kaviani's IME and FCE reports submitted as part of its appeal. Reliance argued the FCE did not carry sufficient weight because it was conducted outside the Elimination Period and, therefore, did not document Kaviani's condition during the relevant time period. Reliance also dismissed the IME report as invalid because the physician failed to consider all of the treatment records, including some that disagreed with his findings. The Court found that Reliance's evaluation of the merits of the reports

ignored their relevance to Kaviani's disability and, therefore, its decision to ignore them lacked a "reasoned basis."

Reliance did not claim the IME report was irrelevant even though it was conducted outside the Elimination Period. Also, Reliance's own physician had concluded that the IME report "prov[ed]" Kaviani was in pain. The Court also noted that the IME physician had used the FCE's findings to develop his opinions and that the FCE findings were consistent with the IME report. As a result, Reliance was dismissing relevant evidence of Kaviani's condition without a reasonable basis for doing so.

Finally, the Court found that Reliance had improperly relied on select portions of its own physician's reports while "willfully blind[ing]" itself to the other objective evidence supporting Kaviani's disability. The Court affirmed the decision of the district court that Reliance had acted without a reasonable basis in rejecting the claim.

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relevant Plan documents necessary to sufficiently state Parity Act claims. As one court noted:

> [a]lthough 'there is no clear law on how to state a claim for a Parity Act violation,' [citation omitted], numerous courts have adopted the helpful format set forth in *Welp v. Cigna Health & Life Ins. Co.*, No. 17-80237-CIV, 2017 WL 3263138, at *6 (S.D. Fla. July 20, 2017). Under that framework, a plaintiff should identify a specific limitation on behavioral health treatment coverage, identify medical or surgical services that are covered under the plan and analogous to the specific behavioral health services at issue, and plausibly allege a disparity in the limitation criteria applicable to this analogous medical or surgical service on the one hand and the mental health or substance use treatment on the other.[7]

In two recent cases, the District Court for the District of Utah focused on the plaintiffs' failure to meet their responsibility for obtaining relevant Plan documents during the administrative appeals process in granting the defendants' Rule 12(b)(6) motions to dismiss the MHPAEA claims. In other cases, the judges dismissed MHPAEA claims under Rule 12(b)(6), but did not engage in any analysis of the plaintiffs' need for any underlying Plan documents. In contrast, without discussing why the plaintiff lacked the documents needed to sufficiently state an MHPAEA claim, a judge allowed the plaintiff in another case to conduct limited discovery to obtain relevant documents to support the MHPAEA claim and to amend their complaint accordingly. Finally, in another case, the judge denied the motion to dismiss, despite the fact that the plaintiffs did not have all the supporting documents necessary for their Parity Act claim.

Dismissing MHPAEA Claims Where Plaintiffs Lacked Supporting Documents

In two cases from the District of Utah, *Laurel R. v. United Healthcare Ins. Co.*[8], and *Jarrell O. v. Blue Cross Blue Shield of Ill.*[9], the court granted the ERISA plan defendants' Rule 12(b)(6) motions to dismiss claims for violations of the Parity Act, because the plaintiffs lacked the Plan documents necessary to sufficiently plead violations of the Parity Act. In both cases, the court noted:

> The Parity Act "requires that a plan's treatment and financial limitations on mental health or substance abuse disorder benefits cannot be more restrictive than the limitations for medical and surgical benefits." *Roy C. v. Aetna Life Ins. Co.*, No. 2:17CV1216, 2018 WL 4511972, at *3 (D. Utah Sept. 20, 2018) (citing 29 U.S.C. § 1185a(a)(3)(A)(ii)); see also 75 Fed.

> Reg. 5410, 5412–13 (Feb. 2, 2010). "Because the Parity Act 'targets limitations that discriminate against mental health and substance abuse treatments in comparison to medical or surgical treatments,' to survive the dismissal of a Parity Act claim, a plaintiff must allege a medical or surgical analogue that the plan treats differently than the disputed mental health or substance abuse services." *Roy C.*, 2018 WL 4511972, at *3 (emphasis in original).[10]

In *Laurel R.*, a minor beneficiary of an ERISA plan was admitted for inpatient treatment after showing "troubling behavior after entering middle school, including substance abuse , selling drugs, stealing, and lying" and being "diagnosed with Attention Deficit Disorder, Oppositional Defiance Disorder, and Feature of Narcissistic Personality Disorder."[11] After the defendant insurer paid for the inpatient treatment for about four months, it denied coverage because it determined the beneficiary no longer met the Plan's guidelines for additional "coverage in a residential treatment setting."[12] The insurer upheld the denial on both levels of the administrative appeals.[13] The plaintiffs, the minor plan beneficiary and his parents, asserted a Parity Act claim.[14] The plaintiffs alleged that the defendants violated the Parity Act because they required the beneficiary to satisfy medical necessity criteria for acute care to be covered for residential treatment, but the Plan did not have the same requirements for "individual seeking treatment at sub-acute inpatient facilities for medical/surgical conditions."[15] They alleged that:

> 'the terms of the Plan and the medical necessity criteria utilized by the Plan and United ... use processes, strategies, standards or other factors to limit coverage for mental health or substance use disorder treatment in a way that is inconsistent with, and more stringently applied, than the processes, strategies, standards or other factors used to limit coverage for medical/surgical treatment in the same classification.'[16]

The defendants - the Plan and the insurer - moved to dismiss the Parity Act claim under Rule 12(b)(6).[17] The court found the allegations were insufficient to state a Parity Act claim because they lacked well-pleaded facts in support.[18] Rather, the court found that the plaintiffs merely supported the claim with "speculative statements, legal conclusions, and recitals of the statutory language of the Parity Act."[19] The plaintiffs argued that they requested, but the defendants did not supply them with, "the Plan's governing documents," including "the medical necessity criteria for mental health and substance abuse and the criteria for skilled nursing and rehabilitation facilities."[20] The court found that the plaintiffs in fact had reasonable access to those documents because the letters denying coverage informed the

plaintiffs of online resources for obtaining them. It determined that because the plaintiffs did not obtain the documents, their Parity Act violation claim was "vague, conclusory, and speculative."[21] The court dismissed the Parity Act claim.[22]

In another case, plaintiffs who failed to allege they requested the necessary documents to support their MHPAEA claim faced dismissal of the claim with prejudice. In *Jarrell O.*, the plaintiffs made a similar Parity Act claim with respect to a denial of coverage for inpatient treatment for a minor ERISA plan beneficiary who exhibited "manipulative, destructive, and inappropriate behavior from a young age."[23] The defendants, the Plan and the insurer, moved to dismiss the Parity Act claim under Rule 12(b)(6).[24] In that case, the plaintiffs also argued they lacked the necessary information for the Parity Act claim.[25] The court found they failed to allege they actually requested the necessary information during the administrative appeal process.[26] The court determined the plaintiffs' request for "the medical necessity criteria 'utilized to evaluate the claim' for benefits" was ambiguous and limited to the Section 502(a)(1)(B) claim for benefits and did not include the medical necessity criteria for skilled nursing and rehabilitation facilities."[27] The court dismissed the Parity Act claim with prejudice.[28]

Dismissing MHPAEA Claims Without Considering Plaintiffs' Access to Supporting Documents

The U.S. District Court for the District of Utah also dismissed Parity Act claims under Rule 12(b)(6) in other cases, but did not discuss the plaintiffs' lack of or need for underlying documents that would assist them in sufficiently pleading such claims. In *Andy B. v. Avmed, Inc.*[29], the plaintiffs were the parents of a minor and the minor, who showed "social and academic difficulties," attempted suicide, and received mental health treatment from two providers, Aspiro Academy and Daniels Academy.[30] Citing a lack of medical necessity, the defendant denied all payments for treatment at the first facility and denied payments for treatment at the second facility after a certain date.[31] The defendant upheld its decisions after "numerous" administrative appeals.[32] An external review agency also upheld the defendant's decisions.[33] In *Andy B.*, the plaintiffs alleged the defendant violated the Parity Act "because the Plan's medical necessity requirements for inpatient mental health treatment benefits are more stringent or restrictive than the medical necessity criteria applied to analogous medical or surgical benefits, such as skilled nursing facilities, inpatient hospice care, and rehabilitation facilities."[34] In dismissing the MHPAEA claim, the court held that the plaintiffs' allegations were insufficient and "supported by speculative statements, legal conclusions, and recitals of the statutory language …."[35] The decision, however, does not address whether the plaintiffs lacked the relevant underlying documents needed to sufficiently state such a claim.[36]

Leave to Amend and to Conduct Limited Discovery Granted

In other decisions, where supporting documents were lacking, the court allowed limited discovery and granted leave to amend the complaint. In *Randall R. v. Regence Blue Cross Shield of Utah*,[37] another recent District of Utah case with facts similar to those in *Laurel R.* and *Jarrell O.*, the plaintiffs also sued for a violation of the Parity Act. The same judge who ruled in *Laurel R.* and *Jarrell O.* allowed the plaintiffs to file a second amended complaint to "state the Parity Act claims more clearly," and referred the case to a magistrate judge, who addressed the plaintiffs' motion to conduct discovery with respect to the Parity Act claim.[38] The defendant opposed the motion, arguing the Parity Act claim was merely a repackaged Section 502(a)(1)(B) claim for benefits.[39] The magistrate judge granted the motion, noting that although discovery in ERISA matters is generally unnecessary, "'the nature of Parity Act claims is that they generally require further discovery to evaluate whether there is a disparity between the availability of treatments for mental health and substance abuse disorders and treatment for medical/surgical conditions.'"[40] The magistrate judge noted that, with respect to Parity Act claims, "discovery is essential to allow Plaintiffs to learn and compare processes, strategies, evidentiary standards, and other factors Defendant used to show whether mental health and substance abuse benefits were discerningly limited."[41]

Similarly, in *Kurt W. v. United Healthcare Ins. Co.*[42], the court dismissed the plaintiffs' Parity Act claim because the allegations were "ambiguous." In that case, the minor plaintiff attended the same facilities as the minor plaintiff in *Andy B.*: "Aspiro Academy, an outdoor behavioral health program" and "Daniels Academy, a residential treatment facility."[43] The court granted the plaintiffs leave to amend their complaint, because "it is by no fault of Plaintiffs' that their claim is ambiguous."[44] The court noted the plaintiffs "repeatedly requested 'the Plan's criteria for skilled nursing and rehabilitation facilities'" from the defendants, who failed to produce them.[45] The court noted that "Plaintiffs are entitled to that information pursuant to 29 C.F.R. § 2590.712(d) (2019). Plaintiffs may also be missing, and entitled to, other pertinent information that will help them more fully develop their claims in this action."[46]

Denying Motion to Dismiss Parity Act Claim, Despite Lack of Supporting Documents

In yet another decision, the District Court for the District of Utah acknowledged that the plaintiffs lacked certain Plan documents to support their Parity Act claim, but found the plaintiffs sufficiently pled the claim based on the documents they had at the time. The court denied the defendants' Rule 12(b)(6) motion to dismiss. In *David P. v. United Healthcare Ins. Co.*[47], the minor plaintiff was admitted to "a mental health/

substance abuse residential treatment program … in Maine ….”[48] Her parents then transferred her to a “mental health/substance abuse residential treatment program” in Utah.[49] The defendant third-party administrator denied payment for the first facility and paid for one week only at the second. The plaintiffs sought to recover for the medical expenses that were not covered.[50]

The defendants moved to dismiss the Parity Act claim under Rule 12(b)(6), and the parties agreed to a three-pronged analysis for determining the sufficiency of a Parity Act claim:

> Parity Act plaintiffs must (1) identify a specific treatment limitation on mental health benefits; (2) identify medical/surgical care covered by the plan that is analogous to the mental health/substance abuse care for which the plaintiffs seek benefits; and (3) plausibly allege a disparity between the treatment limitation on mental health/substance abuse benefits as compared to the limitations that defendants would apply to the covered medical/surgical analog.[51]

The court determined that the plaintiffs satisfied the first two parts of the test.[52] In addition, with respect to the third part of the test, the court found that the plaintiffs plausibly alleged the defendants “would not have applied acute-level criteria if L.P. sought benefits for analogous medical/surgical treatment of an inpatient hospice facility, skilled nursing facility, or inpatient rehabilitation facility, which the Plan lists as examples of ‘non-acute care.’”[53] At the same time, however, the court acknowledged that although plaintiffs did not “specify with precision what criteria Defendants apply to benefits determination for the identified analogous medical/surgical services, *it is impossible for them to do so*, because the defendants did not produce the requested documents.”[54] Noting the Parity Act does not require a “rigid pleading standard,” the court held that the plaintiffs sufficiently alleged a “treatment limitation disparity” based on the information they had at the time.[55] The court denied the Rule 12(b)(6) motion to dismiss the Parity Act claim.[56]

Conclusion

As these cases show, attorneys representing plan participants during the administrative appeal process should decide which documents are needed from the Plan or Plan Administrator in order to properly allege a Parity Act claim and specifically request them *before* a final administrative appeal decision is issued. Likewise, Plans and Plan Administrators should promptly comply with such requests. Some courts might allow limited discovery when plaintiffs lack such documents, but that might depend on whether the plaintiffs requested the documents previously. In

addition, defendants who do not produce requested documents might face denials of their motions to dismiss, even when plaintiffs lack all the documentary support they need for their Parity Act claims.

Endnotes

1 29 U.S.C. § 1185a.

2 Employer's Guide to the Health Insurance Portability and Accountability Act, ¶920 Mental Health 'Parity' (Mar. 2017 Supp.).

3 Employer's Guide to the Health Insurance Portability and Accountability Act, ¶920 Mental Health 'Parity' (Mar. 2017 Supp.).

4 29 C.F.R. § 2590.712(e).

5 29 C.F.R. § 2590.712(f)(1), (2)(iv); see also Stacey A. Tovino, Will Neuroscience Redefine Mental Injury? Disability Benefit Law, Mental Health Parity Law, and Disability Discrimination Law, 12 Ind. Health L. Rev. 695, 711 n.81 (2015) ("'self-insured non-federal government employee plans can opt out,'" MPHAEA does not apply to church-sponsored plans or retiree-only plans) (quoting Substance Abuse and Mental Health Services Administration, Implementation of the Mental Health Parity and Addiction Equity Act, (MPHAEA), U.S. Dep't Health & Human Serv., http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act).

6 Id. (quoting David S. v. United Healthcare Ins. Co., No. 2:18-cv-803, 2019 WL 4393341, at *3 (D. Utah Sept. 13, 2019)).

7 Charles W. v. United Behavioral Health, No. 2:18-cv-829-TC, 2020 WL 6895331, at *1 (D. Utah Dec. 18, 2019).

8 No. 2:19-cv-00473-DB, 2020 WL 570257, at *1 (D. Utah Feb. 5, 2020).

9 No. 2:19-cv-00470-DB-CMR, 2020 WL 291437, at *1 (D. Utah Jan. 21, 2020).

10 Laurel R., No. 2:19-cv-00473-DB, 2020 WL 570257, at *2; Jarrell O., No. 2:19-cv-00470-DB-CMR, 2020 WL 291437, at *2.

11 Laurel R., No. 2:19-cv-00473-DB, 2020 WL 570257, at *1.

12 *Id.*

13 *Id.*

14 *Id.*

15 *Id.* at *2.

16 *Id.*

17 *Id.* at *1.

18 *Id.* at *2.

19 *Id.*

20 *Laurel R.*, No. 2:19-cv-00473-DB, 2020 WL 570257, at *2 ("Under the Parity Act's Final Rules, claimants have the right, upon request, to be provided with 'reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits'") (quoting Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ('Final Rules'), 2013 WL 5981462, 78 Fed. Reg. 68247-68248).

21 *Laurel R.*, No. 2:19-cv-00473-DB, 2020 WL 570257, at *3.

22 *Id.*

23 *Jarrell O.*, No. 2:19-cv-00470-DB-CMR, 2020 WL 291437, at *1.

24 *Id.*

25 *Id.* at *2.

26 *Id.*

27 *Id.*

28 *Id.* at *3.

29 No. 2:19-cv-00396-DB-PMW, 2020 WL 838041, at *1 (D. Utah Feb. 20, 2020).

30 *Id.*

31 *Id.*

32 *Id.*

33 *Id.*

34 *Id.* at *3.

35 *Id.*

36 *Id.* at *3-4; see also *Charles W.*, No. 2:18-cv-829-TC, 2019 WL 6895331, at *1, 4-5 (the court dismissed the plaintiffs' Parity Act claim with respect to a denial of payments for residential treatment of a minor because the allegations were "vague, conclusory, and generic," and did not address the plaintiffs' access or lack of access to any relevant underlying documents).

37 No. 2:18-cv-00381-DB-PMW, 2020 WL 109512, at *1 (D. Utah Jan. 9, 2020).

38 *Id.* at *1-2.

39 *Id.* at *1.

40 *Id.* at *2 (quoting *Robert L. v. Cigna Health & Life Ins. Co.*, No. 2:18-CV-976 RJS DBP, 2019 WL 6220062, at *2 (D. Utah Nov. 21, 2019)).

41 *Id.*

42 No. 2:19-cv-223, 2019 WL 6790823, at *1 (D. Utah Dec. 12, 2019).

43 *Id.*

44 *Id.* at *6.

45 *Id.*

46 *Id.*

47 No. 2:19-cv-00225-JNP-PMW, 2020 WL 607620, at *1 (D. Utah Feb. 7, 2020).

48 *Id.*

49 *Id.* at *1.

50 *Id.*

51 *Id.*

52 *Id.* at *14-16.

53 *Id.* at *1.

54 *Id.* at *1. (Emphasis added.)

55 *Id.* at *1; see also *D.K., K.K., and A.K. v. United Behavioral Health*, No. 2:17-cv-01328-DAK, 2020 WL 262980, at *5 (Jan. 17, 2020) ("'the nature of Parity Act claims is that they generally require further discovery to evaluate whether there is a disparity between the availability of treatments for mental health and substance abuse disorders and treatment for medical/surgical conditions.'") (quoting T*imothy D. v. Aetna Health & Life Ins. Co.*, No. 2:18CV753DAK, 2019 WL 2493449, at 4 (D. Utah June 14, 2019)).

56 *David P. v. United Healthcare Ins. Co.*, No. 2:19-cv-00225-JNP-PMW, 2020 WL 607620, at *1 (D. Utah Feb. 7, 2020); see also *Johnathan Z. v. Oxford Health Plans*, No. 2:18-cv-383-JNP-PMW, 2020 WL 607896, at *1 (D. Utah Feb. 7, 2020) (denying motion to dismiss Parity Act claim).

Calendar

July 29-Aug 4, 2020	**ABA Annual Meeting** Contact: Juel Jones – 312/988-5597	Virtual Meeting
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