No. 101561-5

SUPREME COURT
OF THE STATE OF WASHINGTON

No. 82800-2

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

PREMERA BLUE CROSS,

Petitioner,

v.

P.E.L., P.L & J.L.,

Respondents.

PREMERA BLUE CROSS'S PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER AND DECISION BELOW

Petitioner Premera Blue Cross respectfully asks this Court to accept review of Division One's published decision dated November 21, 2022 (the "Decision"). The Decision reversed the Superior Court's summary judgment dismissing the Respondents' Mental Health Parity and Addiction Equity Act ("the Federal Parity Act") and insurance bad faith claims. (App. A.)

II. ISSUES PRESENTED FOR REVIEW

1. Where Congress explicitly withheld a private cause of action for violation of a federal statute, may Washington courts allow a plaintiff to bring an action for violation of that statute as a breach of contract claim?

2. Can an insurance policyholder maintain an insurance bad faith claim for emotional distress damages where the policyholder fails to offer any evidence of objective symptomatology of emotional distress?

III. STATEMENT OF THE CASE

A. Factual background.

1. The Contract covers residential treatment centers for mental health and excludes wilderness programs or activities.

In 2016, Respondents purchased Premera's Blue Cross Preferred Gold 1000 Plan (the "Contract") through the Washington Health Benefit Exchange. CP 1528 ¶ 1; CP 1531 ¶ 12. The Contract provides reimbursement for a wide range of medical, surgical, and mental health services. CP 1592. The Contract covers residential treatment centers, partial hospitalization, and intensive outpatient services for mental health care. CP 1602-1604. The Contract covers skilled nursing facilities and rehabilitation hospitals for medical/surgical care. CP 1605-1606.

The Contract "does not cover: … [o]utward bound, wilderness, camping or tall ship programs or activities" (the "Wilderness Exclusion"). CP 1603-1604. It also does not cover

"[g]ym or swim therapy," "[e]xercise or maintenance-level programs," or "[r]ecreational … therapy." CP 1606.

For both mental health and medical/surgical services, the Contract covers only treatments by providers who are licensed to practice medicine. CP 1602-1603. To be covered, all programs must have the appropriate license to provide to provide the service at issue. CP 1614.

The Contract states that Premera

> will comply with the federal health care reform law, called the Affordable Care Act .... If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

CP 8.

Premera files all contracts with the Office of the Insurance Commissioner ("OIC") for review and approval before they can be sold. RCW 48.44.020(2). The OIC will not approve any

contract that violates the laws. RCW 48.44.020(2), (3); *see McCarthy Fin., Inc. v. Premera*, 182 Wn.2d 936, 941 (2015). The OIC approved the Contract containing the Wilderness Exclusion. CP 1945-1971.

2. P.E.L. attended the Evoke Wilderness Program, a licensed "child care agency."

In April 2016, P.E.L. attended the Evoke Wilderness Program in Bend, Oregon. CP 1672. Respondents picked Evoke because an educational consultant recommended it. CP 1672-1673.

Evoke does not have a medical license from the Oregon Health Authority, the state agency that licenses medical and mental health providers. The Oregon Health Authority issues a license for "residential treatment facilit[ies]," which treat "individuals with mental, emotional or behavioral disturbances or alcohol or drug dependence" and provide "residential care and treatment in one or more buildings on contiguous properties." O.R.S. § 443.400(4)(b), .400(11), .410(2). Oregon requires this

license to operate a Residential Treatment Center. O.A.R. 309-022-0160. Evoke did not have this license.

Instead, Evoke was licensed by the Oregon Department of Human Services as an "Outdoor Youth Program" and "Child Caring Agency." CP 1690. Evoke had a "Certificate of Approval to Operate a Child Care Agency," which states that the "type of childcare" it is "authorized to provide" is an "outdoor youth program." O.R.S. § 418.205(7).

Evoke calls itself an "outdoor program" and a "Wilderness Program." CP 1694; CP 1696-1697; CP 1701. Evoke requires a minimum residential stay of 42 days, with extensions in "seven-day increments." CP 1696; CP 1703.

3. Premera found that P.E.L.'s stay at Evoke was not covered under the Contract, and an independent psychiatrist agreed.

Respondents sought coverage for P.E.L.'s nine-week stay at Evoke. However, Premera denied coverage under the Wilderness Exclusion. CP 1531 ¶¶ 11-15; CP 1842-1844; CP 1900-1902. Respondents pursued an internal appeal, arguing

that the Wilderness Exclusion violated the Federal Parity Act and therefore the Affordable Care Act ("ACA").[1] CP 1910-1915. Premera denied the appeal, writing that the Contract complies with the Federal Parity Act. CP 1919.

Respondents then requested review by an Independent Review Organization ("IRO") selected by the OIC pursuant to Washington law. CP 1927-31. The IRO reviewer was a board-certified psychiatrist in adult and child psychiatry and was "chief of a hospital mental department of over 200 individuals." CP 1937. The IRO upheld Premera's denial because the Contract excludes wilderness programs. The IRO explained that the Contract covers residential treatment but "Wilderness programs are different enough in structure and care delivery process to be considered different than other residential treatment programs." CP 1934; CP 1936.

[1] The ACA incorporated the Federal Parity Act. *See* 42 U.S.C. § 300gg-26.

B. Procedural background.

Respondents sued Premera for (1) breach of insurance contract; (2) breach of the duty of good faith and fair dealing; (3) violation of the Washington Consumer Protection Act, and (4) negligent claims management. CP 5-6 ¶¶ 16-31; *see* CP 32 ¶¶ 33-37. All claims were premised on allegations that Premera violated the Federal Parity Act or the Washington Parity Act. Respondents did not assert a separate cause of action under either Parity Act but alleged that Premera breached the Contract because the Contract states that Premera will comply with ACA. *See id.*; App. A at 6.

The trial court granted Premera summary judgment, denied Respondents' motion for summary judgment, and dismissed all of Respondents' claims. RP 127:3-133:19; CP 2952. The court concluded that the Federal Parity Act does not provide Respondents a private cause of action,[2] and that

[2] The trial court explained that Congress provided a cause of action to members of ERISA plans, but Respondent's plan is not subject to ERISA. *Id.*

Respondents could not create a cause of action by alleging that Premera breached the Contract by violating the Federal Parity Act. RP 131:11-132:24. The court also concluded that, in any event, Premera excluded similar types of programs for both medical/surgical and mental health care. *Id.* Therefore, there was no showing that coverage for medical-surgical and mental health services were not in parity. *Id.* Finally, the court also concluded that Premera did not violate the Washington Parity Act because the statute expressly excludes these types of programs from its scope. *Id.*

Respondents appealed. In a published opinion (App. A), Division One rejected Respondents' argument that Premera breached the Contract by violating the Washington Parity Act. However, the Court of Appeals reversed the trial court's dismissal of the breach of contract allegation premised on the claim that Premera violated the Federal Parity Act. App. A at 6-7. The Court of Appeals concluded that "[b]ecause Premera promised to follow the ACA under the terms of the Plan, P.E.L.

can assert a common-law breach of contract claim to enforce that promise." *Id.* at 7. The Court of Appeals also concluded that an issue of fact precluded summary judgment in favor of Premera on Respondents' breach of contract claim because "a reasonable juror could conclude that the wilderness exclusion applies to only wilderness mental health services," and not medical/surgical services as well. *Id.* at 22-23. Finally, the Court of Appeals held that "[t]he trial court erred by dismissing P.E.L.'s bad faith insurance claim for failure to show objective symptomology of emotional distress." *Id.* at 26.

IV. REASONS THE COURT SHOULD GRANT THE PETITION

This petition raises issues that have not been, but should be, resolved in Washington. First, in addressing whether an alleged ACA violation can be framed as a breach of contract claim, the Court of Appeals disagreed with the overwhelming majority of courts nationwide that have considered this issue. Second, there are conflicting opinions among Washington appellate courts on whether an insurance bad faith claim for

emotional distress damages requires evidence of objective symptomatology.

A. This Court should review the Court of Appeals' decision that Respondents can assert a violation of the Federal Parity Act through a breach of contract claim, when Congress expressly declined to provide a cause of action. (RAP 13.4(b)(1), (2), (3), (4)).

While Washington courts recognize that a statute may create an implied private cause of action, courts cannot imply a private cause of action where the legislature has expressly withheld one. "If the statute itself does not display an intent to create a private remedy, then a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Ziglar v. Abbasi*, 137 S. Ct. 1843, 1856 (2017) (internal quotation marks and brackets omitted); *see also Keodalah v. Allstate Ins. Co*., 194 Wn.2d 339, 347-48 (2019) (holding that no claim against insurance adjusters exists under the Insurance Fair Conduct Act because the legislature's omission of a provision creating a private cause of action against adjusters was intentional). This is

because "the separation-of-powers doctrine requires that a branch not impair another in the performance of its constitutional duties." *Ziglar*, 137 S. Ct. at 1861; *see also, Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co*., 105 Wn. 2d 778 (1986) (the legislature, not the court, is the appropriate body to establish what conduct constitutes per se unfair trade practices under the Washington Consumer Protection Act.).

The Court of Appeals erred because the ACA—which incorporates the Federal Parity Act—does not provide Respondents a private cause of action. This Court should establish that, where Congress has withheld a private cause of action, Washington courts may not create one by allowing a claim alleging violation of the statute at issue recast as a breach of contract claim. Indeed, all contracts at least impliedly incorporate the governing law. The Court of Appeals' holding creates a loophole that defeats Congress's intent every time it declines to create a cause of action.

1. The ACA does not provide Respondents a cause of action.

Courts have repeatedly held that neither the Federal Parity Act nor the ACA provides a private cause of action. *A.Z. ex rel. E.Z. v. Regence Blueshield*, 333 F. Supp. 3d 1069, 1083 (W.D. Wash. 2018) (the ACA "does not create a private right of action" for violations of the Parity Act); *Mills v. Bluecross Blueshield of Tenn.*, No. 3:15-cv-552-PLR-HBG, 2017 WL 78488, at *6 (E.D. Tenn. Jan. 9, 2017) ("[T]here is no private right of action to enforce [the Federal Parity Act] itself."); *N.Y. State Psychiatric Ass'n, v. UnitedHealth Grp.*, 980 F. Supp. 2d 527, 544 (S.D.N.Y. 2013) ("Like the Parity Act, the ACA does not provide for any independent private right of action to enforce its provisions"), *aff'd in part, vacated in part on other grounds,* 798 F.3d 125 (2d Cir. 2015).

"Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). "Without evidence of a congressional intent to create both a private right and a private

remedy, a private right of action 'does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute.'" *UFCW Local 1500 Pension Fund v. Mayer*, 895 F.3d 695, 699 (9th Cir. 2018) (quoting *Alexander*, 532 U.S. at 286-87).

Thus, "[c]ustomers of individual plans cannot sue to enforce the Affordable Care Act or [the Parity Act]." *Mills*, 2017 WL 78488, at *6. They cannot sue alleging the violation of "the requirement that plans offered on exchanges follow the [Parity Act]." *Id.* "Likewise, there is no private right of action to enforce the [Parity Act] itself. It does not contain an enforcement provision." *Id*.

2. Respondents cannot pursue a Federal Parity Act claim through a state law breach of contract action because this would subvert Congress's intent and is contrary to the public interest.

Contrary to the Court of Appeals' decision, numerous courts have held that plaintiffs may not allege violations of a statute withholding a private cause of action, including the Federal Parity Act, through a state-law breach of contract claim.

These cases hold, as the Second Circuit has explained, that when "no private right of action exists under the relevant statute, the plaintiffs' efforts to bring their claims as state common-law claims are clearly an impermissible 'end run' around the [statute]." *Grochowski v. Phoenix Constr.*, 318 F.3d 80, 86 (2d Cir. 2003). Many other cases agree. *See, e.g., Hard2Find Accessories, Inc. v. Amazon.com,* 691 F. App'x 406, 408 (9th Cir. 2017) (holding that a statute that provides no private right of action "cannot serve as the predicate offense for [Washington Consumer Protection Act] claim"); *Umland v. PLANCO Fin Servs*., 542 F.3d 59, 66-67 (3d Cir. 2008) (holding that plaintiff could not bring common-law contract claim where the alleged contractual term only alleged violations of the Federal Insurance Contributions Act, which did not provide a private right of action); *Indemnified Capital Invests. v. R.J. O'Brien & Assocs.,* 12 F.3d 1406, 1412 (7th Cir. 1993) (rejecting a state law claim for breach of fiduciary duty based on violation of National Futures Association rule, which does not provide an independent

right of action); *Doe v. Vanderbilt Univ.*, No. 3:18-cv-00569, 2019 WL 4748310, at *18 (M.D. Tenn. Sept. 30, 2019) ("Plaintiff cannot circumvent the lack of a Clery Act private right of action by re-characterizing the cause of action as a state law negligence *per se* claim."); *Fossen v. Caring For Montanans, Inc.*, 993 F. Supp. 2d 1254, 1265-66 (D. Mont. 2014) ("Plaintiffs' breach of contract claim is merely another backdoor method of presenting an alleged violation of a statute that they have no right to enforce."), *aff'd*, 617 F. App'x 737 (9th Cir. 2015); *Acevado v. Citibank*, No. 10 Civ. 8030(PGG), 2012 WL 996902, at *10 (S.D.N.Y. Mar. 23, 2012) ("Because Plaintiffs' breach of contract claim 'relies entirely on incorporating the requirements of a statute with no private right of action [for damages] …, Plaintiffs' claim … is precisely the form of "artful pleading" … that state courts have identified as making an impermissible end run around statutes with no private right of action.'") (citation omitted); *Shrem v. Sw. Airlines Co*., No. 15-CV-04567-HSG, 2017 WL 1478624, at *2 (N.D. Cal. Apr. 25, 2017), *aff'd,* 747 F.

App'x 629 (9th Cir. 2019) ("Because the statute does not allow a private cause of action, '[p]laintiffs' breach of contract claim would thus create an end run around the implied right of action doctrine, permitting a private right of action based on violations of 14 C.F.R. §§ 253.4, 253.5, and 253.7 where there is none.'").

The Court of Appeals itself recognized that its decision contradicted numerous federal courts. *See* App. A at 7 n.8. But it disregarded these cases and instead relied on only one case that clearly does not apply here.

According to the Court of Appeals, *Briscoe v. Health Care Service Corp.*, 281 F. Supp. 3d 725 (N.D. Ill. 2017), stands for the rule that "'[g]iven the absence of any indication that Congress intended the ACA to preempt breach of contract claims,' courts should permit plaintiffs to pursue claims to enforce a promise to comply with the ACA under the terms of a health plan." App. A at 7 (quoting *Briscoe*, 281 F. Supp. 3d at 739).

But *Briscoe* does not support this conclusion. First, *Briscoe* involved an ERISA-governed health plan, not, as here,

an individual health plan offered on the exchange pursuant to the ACA. This is a critical difference overlooked by the Court of Appeals. ERISA explicitly provided ERISA plan members with a private right of action under the Federal Parity Act, but Congress expressly declined to do so for ACA plans. *Am. Psychiatric Ass'n v. Anthem Health Plans*, 50 F. Supp. 3d 157, 161 (D. Conn. 2014) ("Although there is no private right of action under the Parity Act, portions of the law are incorporated into ERISA and may be enforced using the civil enforcement provisions in ERISA § 502, to the extent they apply."), *aff'd*, 821 F.3d 352 (2d Cir. 2016). Thus, *Briscoe* is irrelevant because Congress had granted the ERISA plan member plaintiffs in that case a private cause of action for violation of the Federal Parity Act.

Second, the language quoted by the Court of Appeals from *Briscoe* involved a different issue—whether the ERISA plaintiffs could allege a breach of contract claim based only on the plan terms *in addition to* a claim alleging violation of the ACA. *See*

Briscoe, 281 F. Supp. 3d at 739-40 ("[T]aking as true Magierski's allegations that Defendants *violated her plan documents* by refusing to cover the full cost of lactation services, this Court finds that Magierski states a plausible claim for breach of contract.") (emphasis added). In *Briscoe*, the plaintiffs alleged that the plan contract provided coverage for lactation counseling separate from any requirement of federal law, and that the plan's denial conflicted with that plan language. *Id.* at 739. The court held that the plaintiffs could allege the breach of contract claim in addition to a violation of the Federal Parity Act. *Id.* at 739-40.

Here, there is no dispute that the Contract excludes wilderness programs. Respondents do not claim that Premera breached any express term of the Contract that provided coverage for wilderness programs. Instead, they claim that the Contract itself does not comply with the Parity Act because it excludes wilderness programs. Thus, Respondents do not assert a breach of contract claim beyond claiming that Premera violated its statement that it complies with applicable laws. Courts

emphasize this distinction. In *York v. Wellmark*, No. 4:16-cv-00627-RGE-CFB, 2017 WL 11261026 (S.D. Iowa Sept. 6, 2017), *aff'd*, 965 F.3d 633 (8th Cir. 2020), the court held that plaintiffs may not allege a breach of contract claim based on an alleged ACA violation just because the contract says it will comply with the statute. *Id.* at *19. But the court allowed the plaintiffs to allege a breach of contract claim contending that the plan had denied coverage for a specific treatment the plan promised to cover. *Id.* at *20.

In *York*, the contract explicitly stated that it covered lactation counseling, which is also required by the ACA. *Id.* The court held that plaintiffs could sue under state law alleging that the plan breached the contract when it refused to provide lactation counseling promised in the plan: "Thus, assuming Wellmark's health plan expressly guarantees York lactation counseling benefits in accordance with the ACA and provides a contractual remedy, the Court finds Plaintiffs state a plausible claim for breach of contract under state law." *Id*.

But the court held that the plaintiffs could not sue for violation of the ACA if the plan omitted the required benefit: "Individual parties cannot enforce violations of a federal law with no private cause of action by simply casting their claim in the language of a breach of contract or other state common law claim." *Id*. at *19 (citing *Palmer v. Ill. Farmers Ins.*, 666 F.3d 1081, 1086 (8th Cir. 2012) ("[i]n the absence of … [contractual language] specifying an independent right to the [relief] they seek," a plaintiff cannot use "claims for breach of [contract] to circumvent ... administrative remedies and create a private right of action when the legislature has not")); *MM&S Fin., Inc. v. Nat'l Ass'n of Sec. Dealers*, 364 F.3d 908, 911 (8th Cir. 2004) (plaintiff could not "avoid Congress's decision not to provide an express right of action and pursue instead a common-law breach of contract claim.").

This case is not about a benefit "expressly guaranteed" under the Contract and also required by the ACA. It is about a benefit that was *excluded* from the Contract and that

Respondents claim should have been included in it. Respondents claim that Premera's alleged violation of the Federal Parity Act is the breach of contract by Premera. As *York* held, there is no cause of action for that claim. *See also Mingus v. Blue Cross & Blue Shield of Kan.,* No. 2:17-CV-02362-JAR-KGS, 2017 WL 4882658, at *2 (D. Kan. Oct. 30, 2017) (remanding the removed case to state court because "[w]hile it is true that Plaintiff references a violation of this federal law in reciting his breach of contract claim, he does not seek relief under this federal statute. Indeed, no such private right of action exists.").

The Court should clarify that Washington courts cannot create a loophole enabling plaintiffs to allege statutory violations through breach of contract claims where Congress has withheld a private cause of action.

3. The Court of Appeals opinion conflicts with all courts who have reviewed the question.

Here the Court of Appeals rejected settled federal authorities as to both whether Respondents could bring an action for violation of the Federal Parity Act as a breach of contract

claim, and whether the Contract breached the Federal Parity Act by excluding wilderness programs. As the California Supreme Court has held, "[w]hile we are not bound by decisions of the lower federal courts, even on federal questions, they are persuasive and entitled to great weight. . . . [W]here the decisions of the lower federal courts on a federal question are 'both numerous and consistent,' we should hesitate to reject their authority." *Etcheverry v. Tri-Ag Serv., Inc*., 22 Cal. 4th 316, 320-21, 993 P.2d 366, 368 (2000) (internal citations omitted).

Here the Court of Appeals gave no explanation for its rejection of settled federal law. The Court of Appeals did not address why it rejected a multitude of federal cases, other than to misread the single federal case upon which it purported to rely. Nor did the Court of Appeals explain any reason under Washington law why it rejected numerous cases deciding two federal questions that are outcome determinative in this case. Indeed, absent explanation, the Court of Appeals rejected two unrelated lines of settled federal authority in order to find an

issue of fact regarding whether the Contract violated the Parity Act. Federal cases have unanimously held that where, as here, a plan covers licensed residential treatment centers in parity with skilled nursing facilities, but excludes wilderness programs, the plan complies with the Parity Act. *Alice F. v. Health Care Serv. Corp*., 367 F. Supp. 3d 817, 828 (N.D. Ill. 2019) (a plan that excluded wilderness programs did not violate the Federal Parity Act when it covered residential treatment centers in parity with skilled nursing facilities); *A.G. ex rel. N.G. v. Cmty. Ins. Co.*, 363 F. Supp. 3d 834, 841-42 (S.D. Ohio 2019) (same); *Julie L. v. Excellus Health Plan, Inc.*, 447 F. Supp. 3d 38, 57-58 (W.D.N.Y. 2020) (same). That is the case here: Premera covers residential treatment centers in parity with skilled nursing facilities. CP 110-112; CP 114.

In *Alice F.*, for example, the court held that a plan that did not cover wilderness programs complied with the Federal Parity Act because it covered both residential treatment centers and

skilled nursing facilities while excluding wilderness programs. 367 F. Supp. 3d at 828.

In unanimously allowing the exclusion of wilderness programs, the federal courts focus on the fundamental differences between residential treatment centers and wilderness programs. "RTCs [residential treatment centers] are defined as one type of program, offering therapeutic intervention in a controlled environment, medical monitoring, and 24-hour onsite nursing. By contrast, wilderness programs offer a different service providing merely a supportive environment and methods to address social needs." *Id.* at 824. In deciding whether Respondents had a cause of action in the first place, and that there is a question of fact as to whether Premera has to cover wilderness programs, the Court of Appeals rejected all applicable federal authorities.

B. The Court of Appeals' decision conflicts with published decisions from the Court of Appeals and this Court's decisions requiring evidence of objective symptomatology of emotional distress proximately

caused by alleged negligence and is contrary to the public interest (RAP 13.4 (b)(1), (2), (4)).

The Court of Appeals erred in reversing the trial court's dismissal of Respondents' emotional distress claim because they did not offer any evidence of objective symptomatology supporting their insurance bad faith claim. This Court should hold that to establish a claim for emotional distress for insurance bad faith, plaintiffs must offer evidence of objective symptomatology.

This Court has not clarified whether a plaintiff must offer evidence of objective symptomatology to recover for an insurance bad faith claim. *Schmidt v. Coogan*, 181 Wn.2d 661, 676 (2014) ("we have never before addressed the availability of emotional distress damages for insurance bad faith"). Moreover, the Courts of Appeals have issued inconsistent and confusing opinions on this issue. For example, unlike the Court of Appeals below, the court in *Dombrosky v. Farmers Insurance Co. of Washington*, 84 Wn. App. 245, 262 (1996), characterized a bad faith claim for emotional distress as negligent infliction of

emotional distress, requiring evidence of objective symptomatology. The Court of Appeals below relied on *Sykes v. Singh*, 5 Wn. App. 2d 721 (2018), for its conclusion, but that case involved no bad faith claim at all for emotional distress damages. Only the plaintiff in the underlying personal injury case alleged emotional distress, not the insured. *Sykes* merely held that plaintiffs who suffered bodily injury may recover for emotional distress absent evidence of objective symptomatology. *Id*. at 721 ("Sykes attributed his general damages to pain and suffering and the emotional trauma of the accident."). That is not an issue here and no one claims Premera caused bodily injury.

This Court should clarify that emotional distress damages are available for insurance bad faith on the same basis as any other tort sounding in negligence: Emotional distress damages are available only where the plaintiff shows objective symptomology supported by expert testimony establishing that the emotional distress was caused by the bad faith. Indeed, the Court of Appeals itself recognized this Court's "distinguishing

'torts of intention and torts of negligence' in holding there is no objective symptomatology requirement for intentional infliction of emotional distress." App. A at 25 (quoting *Kloepfel v. Bokor,* 149 Wn.2d 192, 201 (2003)). But the Court of Appeals erroneously characterized insurance bad faith as an intentional tort rather than sounding in negligence.

1. Insurance bad faith sounds in negligence and therefore requires objective symptomatology before a plaintiff can recover emotional distress damages for insurance bad faith.

An insurance bad faith claim sounds in negligence; it is not an intentional tort unless the plaintiff alleged intentional wrongdoing. Here, Respondents only allege negligent claims handling. CP 6 ¶ 24 ("Premera's unreasonable actions caused the Plaintiffs financial, emotional, and mental distress."). Washington courts adjudicate insurance bad faith under a negligence standard: "The insurer is entitled to summary judgment [on a bad faith claim] if reasonable minds could not differ that its denial of coverage was based upon reasonable grounds." *Smith v. Safeco Ins. Co*., 150 Wn. 2d 478, 486 (2003).

The Court's precedents establish that for any tort based on negligence, a plaintiff must show objective symptomology to recover emotional distress damages. *Kloepfel*, 149 Wn.2d at 198 ("Many states, including this one, have distinguished negligent infliction of emotional distress from intentional infliction of emotional distress by making bodily harm or objective symptomatology a requirement of negligent but not intentional infliction of emotional distress.").

2. Public policy dictates that this limitation applies to insurance bad faith cases.

The Court should clarify that a plaintiff must show objective symptomology to recover emotional distress damages in insurance bad faith cases, just as it has done for every other type of negligence-based tort. There is no reason insurance bad faith claims should be singled out for a lower proof standard for emotional distress damages among all other negligence claims. In contrast, Washington courts do not require objective symptomatology for intentional infliction of emotional distress because the elements of the underlying tort establish a sufficient

proof standard for emotional distress. *Kloepfel*, 149 Wn.2d at 201-02 ("The elements of outrage sufficiently limit recovery of emotional distress damages without necessity to prove severe emotional distress by objective symptomatology. Unlike causes of action based on negligence, a plaintiff claiming intentional or reckless infliction of emotional distress must show extreme and outrageous conduct intended to cause emotional distress to the plaintiff. Once these have been shown, it can be fairly presumed that severe emotional distress was suffered."). This Court's precedents establish that to recover damages absent a showing of objective symptomology for intentional infliction of emotional distress, "the conduct 'must be so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community." *Reyes v. Yakima Health Dist*., 191 Wn.2d 79, 91 (2018) (citation omitted). There is no allegation of such conduct here, and policyholders should be required to allege and prove such extreme conduct in order to recover

emotional distress damages for insurance bad faith absent objective manifestation.

Public policy requires that this Court similarly limit emotional distress claims against insurers. Otherwise, even modest dollar-amount claims for insurance coverage, such as this one, will lead to protracted litigation and jury trials where plaintiffs' lawyers claim tens of millions or hundreds of millions of dollars in damages. Even without emotional distress damages, Washington law provides a sufficient deterrent to insurers unreasonably denying claims, by allowing attorney fees absent bad faith under *Olympic Steamship Co. v. Centennial Insurance Co.*, CPA claims for insurance bad faith, and, in non-health insurance cases, treble damages under the Insurance Fair Conduct Act.

In sum, because the decision below conflicts with other Courts of Appeals decisions, because the decision below is wrong under established Washington law, and because this is an issue that recurs frequently, this Court should grant review.

V. CONCLUSION

The Court should grant the petition.

I certify that this document contains 4,992 words, pursuant to RAP 18.17.

RESPECTFULLY SUBMITTED this 21st day of December, 2022.

Respectfully submitted,

/s/ *John R. Neeleman*

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CERTIFICATE OF SERVICE

I certify that on December 21, 2022, I caused to have served a true and correct copy of **PREMERA BLUE CROSS'S PETITION FOR REVIEW**, on the following by the method(s) indicated below:

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APPENDIX A

FILED
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Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

P.E.L.; and P.L. and J.L, a married couple and parents of P.E.L., Appellants, v. PREMERA BLUE CROSS, Respondent.	No. 82800-2-I PUBLISHED OPINION

BOWMAN, J. — Fifteen-year-old P.E.L. attended a residential wilderness program for mental health treatment through Evoke Therapy Programs. P.E.L.'s health insurer Premera Blue Cross denied coverage for P.E.L. because her policy excludes wilderness programs as nontreatment. P.E.L. sued Premera, claiming it breached its contract by not complying with the Washington State mental health parity act (WPA), RCW 48.44.341, and the federal parity act (FPA), 29 U.S.C. § 1185a, in violation of the Patient Protection Affordable Care Act (ACA), 42 U.S.C. § 300gg-26, and the state Consumer Protection Act (CPA), chapter 19.86 RCW. P.E.L. also sued for insurance bad faith and negligence. The trial court dismissed P.E.L.'s claims on summary judgment. P.E.L. appeals, arguing the trial court erred by granting Premera's motions for summary judgment. We conclude that the trial court erred because genuine issues of material fact remain as to whether Premera's exclusion of wilderness programs is a separate treatment limitation that applies to only mental health services. The

trial court also erred by dismissing P.E.L.'s insurance bad faith claim for failure to show objective symptomatology of emotional distress. We otherwise affirm. We reverse in part and remand.

FACTS

In 2016, P.L. and J.L bought health insurance under Premera's "Premera Blue Cross Preferred Gold 1000" plan (Plan) from the Washington Health Benefit Exchange. The Plan also covered their then-15-year-old daughter P.E.L., who was diagnosed with major depressive disorder, anxiety disorder, and post-traumatic stress disorder. The Plan covered some mental health services such as "[i]npatient, residential treatment," "outpatient care to manage or reduce the effects of the mental condition," and "[i]ndividual or group therapy." But it excluded others, including "[o]utward bound, wilderness, camping or tall ship programs or activities." The Plan also excluded coverage for nontreatment facilities, or facilities such as prisons or nursing homes "that do not provide medical or behavioral health treatment for covered conditions from licensed providers," but it did cover "medically necessary medical or behavioral health treatment received in th[o]se locations."

In February 2016, P.E.L. was hospitalized for acute suicidal ideation. After the hospital released her to her parents, P.L. and J.L. sent P.E.L. to Evoke in Bend, Oregon, for treatment. The therapy programs at Evoke included a wilderness program licensed as an "outdoor youth program" and "child caring agency." Evoke describes the program as "a licensed adolescent treatment program that utilizes the experiential opportunities of a wilderness setting with a

clinically focused intervention."[1] Evoke holds its wilderness participants to a structured schedule—they must complete daily chores and learn skills like fire making, shelter building, and food preparation. Trained field instructors supervise the participants and licensed mental health therapists meet with them twice a week. And they participate in team building activities and psychoeducational groups to learn healthy development and relationship management, assertive communication, problem solving, empathy, and awareness building. P.E.L. stayed at Evoke for 63 days from April 27 to June 28, 2016, where she "displayed significant progress . . . over time."

In July 2016, Evoke billed Premera for P.E.L.'s stay. In September, Premera denied the claim, stating, "Our medical staff reviewed this claim and determined this service is not covered by your [P]lan." P.E.L. submitted an internal appeal, arguing Premera's decision violated the WPA and FPA. Premera denied the appeal and upheld its denial of coverage. It explained that the "decision was made based on [P.E.L.]'s [P]lan language, which specifically excludes coverage for outward bound, wilderness, camping or tall ship programs or activities." It determined the exclusion complies with the FPA because the Plan "excludes wilderness programs for both mental health conditions and medical conditions." Premera later explained that it excludes wilderness

[1] The Association for Experiential Education accredited Evoke for "Outdoor Behavioral Healthcare."

programs under the Plan as a nontreatment facility.[2]

P.E.L. requested review by an independent review organization (IRO).[3] She argued that the clinical efficacy of programs like Evoke are "supported by evidence published in peer-reviewed journals," and that Premera must cover the service to comply with the FPA.[4] The IRO upheld Premera's determination that the Plan did not cover P.E.L.'s stay at Evoke. It also determined the exclusion "does not clearly violate" the FPA.

P.E.L. and her parents (collectively P.E.L.) sued Premera. She asserted claims of breach of contract and failure to comply with the WPA and FPA in violation of the ACA and CPA, insurance bad faith under RCW 48.01.030, and negligent claims management. In November 2020, the parties cross moved for summary judgment. The court granted Premera's motion in part, dismissing P.E.L.'s WPA related claims with prejudice. In May 2021, the parties again cross moved for summary judgment. The court granted Premera's motion and dismissed the rest of P.E.L.'s claims with prejudice.

P.E.L. appeals.

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[2] Because the Plan covered medically necessary treatment received at nontreatment facilities, Premera agreed to cover "the 17 therapy sessions that P.E.L. received during her 63 days at Evoke." But P.E.L. did not submit claims for the therapy sessions.

[3] An IRO is an outside "organization of medical and contract experts qualified to conduct an independent review of member appeals."

[4] P.E.L. also pointed to a decision by an IRO in Oregon that concluded the program at Evoke is a medically necessary service.

ANALYSIS

P.E.L. argues the trial court erred by granting Premera's motions for summary judgment.

We review rulings on summary judgment de novo, performing the same inquiry as the trial court. Kruse v. Hemp, 121 Wn.2d 715, 722, 853 P.2d 1373 (1993). Summary judgment is appropriate only where "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." CR 56(c).

The moving party "has the initial burden to show there is no genuine issue of material fact." Zonnebloem, LLC v. Blue Bay Holdings, LLC, 200 Wn. App. 178, 183, 401 P.3d 468 (2017). A moving defendant can meet this burden by establishing that there is a lack of evidence to support the plaintiff's claim. Id. Once the defendant has made such a showing, the burden shifts to the plaintiff to show a genuine issue of material fact. Id. Summary judgment is appropriate if a plaintiff fails to show sufficient evidence to establish a question of fact as to the existence of an element on which the plaintiff will have the burden of proof at trial. Lake Chelan Shores Homeowners Ass'n v. St. Paul Fire & Marine Ins. Co., 176 Wn. App. 168, 179, 313 P.3d 408 (2013). We consider all facts submitted and all reasonable inferences that we can draw from those facts in the light most favorable to the nonmoving party. Ellis v. City of Seattle, 142 Wn.2d 450, 458, 13 P.3d 1065 (2000).

1. Breach of Contract

P.E.L. argues the trial court erred by granting summary judgment on her breach of contract claim because genuine issues of material fact remain about whether Premera breached its contract by not complying with the WPA and FPA in violation of the ACA when it denied coverage for her stay at Evoke.[5] Premera argues that P.E.L. has no viable cause of action for breach of contract. In the alternative, it maintains that its denial of coverage for wilderness programs complies with state and federal parity requirements.

A. Viable Cause of Action

Premera argues that P.E.L. cannot sue for breach of contract alleging a violation of the ACA because the ACA affords no private cause of action.[6] P.E.L. argues that she is not suing under the ACA to enforce compliance with the act. Rather, she seeks only to enforce Premera's contractual promise that it would comply with the ACA through a common-law breach of contract claim.[7] We agree with P.E.L.

Washington courts have not yet considered whether a party may bring a breach of contract claim to enforce the ACA. But the United States District Court

[5] Amicus curiae Northwest Health Law Advocates filed a brief in support of P.E.L., arguing that if we do not allow breach of contract claims under a plan that promises to comply with state regulations and the ACA, we would leave individuals without recourse for mental health parity violations.

[6] See, e.g., A.Z. v. Regence Blueshield, 333 F. Supp. 3d 1069, 1083 (W.D. Wash. 2018) (the ACA "does not create a private right of action" to enforce the FPA).

[7] The ACA incorporated the FPA and expanded on it. See Mental Health and Substance Use Disorder Parity Task Force, 81 Fed. Reg. 19013, 19015 (Mar. 29, 2016) (to be codified at 42 U.S.C. § 300gg-26) ("The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to expand mental health and substance use disorder benefits and Federal parity protections for more than 60 million Americans.").

for the Northern District of Illinois addressed the issue in Briscoe v. Health Care Service Corp., 281 F. Supp. 3d 725 (2017). In that case, the court recognized that the ACA does not preempt consumers "from vindicating their rights under state contract law." Id. at 739. It determined that courts should "presume that states may continue regulating when Congress has not spoken to the contrary on an issue." Id. And "[g]iven the absence of any indication that Congress intended the ACA to preempt breach of contract claims," courts should permit plaintiffs to pursue claims to enforce a promise to comply with the ACA under the terms of a health plan.[8] Id.; see also R.J. Gaydos Ins. Agency, Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 281, 773 A.2d 1132 (2001) (allowing state common-law breach of good faith and fair dealing claim even though claim rested on allegations of violation of the Fair Automobile Insurance Reform Act of 1990, chapter 17:33B-1 N.J. Statutes Annotated, and that act did not confer a private right of action). We conclude that the reasoning in Briscoe is sound, and we adopt it here.

P.E.L.'s Plan provides that Premera

> will comply with the federal health care reform law, called the Affordable Care Act . . . . If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including

[8] Not all jurisdictions agree with this approach. See, e.g., Grochowski v. Phoenix Constr., 318 F.3d 80, 86 (2nd Cir. 2003) (because "no private right of action exists under the [former Davis-Bacon Act, 40 U.S.C. § 276a (2002)], the plaintiffs efforts to bring their claims" for breach of contract "are clearly an impermissible 'end run' around the [statute]"); Fossen v. Caring for Montanans, Inc., 993 F. Supp. 2d 1254, 1265 (D. Mont. 2014) (where Montana's Small Employer Health Insurance Availability Act, Montana Code Annotated § 33-22-1801 (2009), provided no private right of action, claim that depended on incorporating the requirements of the statute was "merely another backdoor method of presenting an alleged violation of a statute that they have no right to enforce"), aff'd, 617 F. App'x 737 (9th Cir. 2015).

> changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

Because Premera promised to follow the ACA under the terms of the Plan, P.E.L. can assert a common-law breach of contract claim to enforce that promise.

B. Compliance with the Plan

To prevail on a breach of contract claim, a plaintiff must show that a contract exists, that the contract imposes a duty, that the defendant breached that duty, and that the breach proximately caused damage to the plaintiff. Nw. Indep. Forest Mfrs. v. Dep't of Labor & Indus., 78 Wn. App. 707, 712, 899 P.2d 6 (1995). P.E.L. and Premera do not dispute that the Plan amounts to a contract and that Premera promised to comply with the ACA, FPA, and WPA.[9] The sole issue here is whether Premera's refusal to cover P.E.L.'s treatment at Evoke breached its promise to comply with the ACA by violating the WPA and FPA.[10]

i. Evolution of the WPA and FPA

Over the last 26 years, both the federal and our state legislatures have enacted laws aimed at improving parity for mental health services. Congress first passed the Mental Health Parity Act of 1996, Title VII § 702 U.S.C., which prohibited large group plans from setting annual or lifetime dollar limits on mental

[9] The Plan does not explicitly promise to follow the WPA. But Premera does not raise whether P.E.L. may bring a breach of contract claim to enforce that act, so we include it in our analysis.

[10] Amicus curiae Northwest Health Law Advocates also argues that Premera categorically excludes mental health treatment programs without conducting full parity and individualized medical necessity reviews in conflict with the legislative intent behind the ACA and state and federal parity laws.

health benefits lower than the limits for medical and surgical benefits. Pub. L. 104-204, 110 Stat. 2944 (1996).

In 2005, the Washington State Legislature created the WPA, its own parity act to expand coverage for mental health treatment. LAWS OF 2005, ch. 6, § 4; O.S.T. v. Regence BlueShield, 181 Wn.2d 691, 697, 335 P.3d 416 (2014); see RCW 48.44.341. The WPA provided that all health benefit plans that cover medical and surgical services must also cover comparable "[m]ental health services." Former RCW 48.44.341(2)(a)(i), (b)(i), (c)(i) (2005). The WPA defined "mental health services" as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders." Former RCW 48.44.341(1). But it excluded "residential treatment" from its definition of "mental health services." Former RCW 48.44.341(1)(c).[11]

In 2008, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Title V § 512 U.S.C., " 'to end discrimination in the provision of insurance coverage for mental health and substance use disorders as compared to coverage for medical and surgical conditions in employer-sponsored group health plans.' " Pub. L. 110-343, 122 Stat. 3881, 3892 (2008); Michael D. v. Anthem Health Plans of Ky., Inc., 369 F. Supp. 3d 1159, 1174 (D. Utah 2019) (quoting Am. Psychiatric Ass'n v. Anthem

[11] Effective January 1, 2021, the legislature removed the residential treatment exception from its definition of "mental health services." SUBSTITUTE H.B. 2338, 66th Leg., Reg. Sess. (Wash. 2020); see RCW 48.44.341(1)(b).

Health Plans, Inc., 821 F.3d 352, 356 (2d Cir. 2016)). The act amended the FPA to require group health plans to cover mental health services at parity with medical and surgical services. Former 29 U.S.C. § 1185a(a)(3) (2008).

Then, in 2010, the ACA expanded the FPA to individual insurance markets, not just group health plans. Pub. L. 111-148, 124 Stat. 119 (2010) (substituting the language "or health insurance coverage offered in connection with such a plan" with the language "or a health insurance issuer offering group or individual health insurance coverage"); see, e.g., 42 U.S.C. § 300gg-26(a)(1), (2), (3). Now, all health insurance plans must cover mental health and medical services at parity. The FPA includes "residential treatment" as a mental health service. See 29 U.S.C. § 1185a.

ii. Compliance with the WPA

P.E.L. argues Premera violated WAC provisions that implement the WPA by excluding coverage of her mental health services at Evoke without first evaluating whether the treatment was "medically necessary."

Our legislature authorized the Office of the Insurance Commissioner (OIC) to make rules and regulations to implement and aid in its administration of the WPA. RCW 48.02.060(3)(a), .062. In 2014, the OIC developed and adopted rules[12] related to insurance coverage of mental health services. Wash. St. Reg. (WSR) 14-23-057 (Nov. 17, 2014). The OIC codified those rules in WAC 284-43-7000 to -7120 (Subchapter K, "Mental Health and Substance Use Disorder").

[12] Under the Washington State Administrative Procedure Act, chapter 34.05 RCW.

P.E.L. argues Premera violated WAC 284-43-7080 when it denied her claim for treatment at Evoke. That WAC provides that mental health services "may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract." WAC 284-43-7080(2).[13] P.E.L. recognizes the WPA exempted residential treatment programs from the definition of "mental health services" at the time she filed her claim in 2016. See former RCW 48.44.341(1)(c) (2007).[14] And for the limited purpose of applying the WPA, the parties agree that Evoke is a form of residential treatment. But P.E.L. argues the WAC still applies to her claims for four reasons.

First, P.E.L. contends the WAC in existence when she made her claim defined "mental health services" to include residential treatment. In 2016, former WAC 284-43-130(22) (WSR 15-24-074) defined "mental health services" as "in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the Diagnostic and Statistical Manual (DSM) IV." But an administrative body cannot abrogate the definition of "mental health services" established by the legislature in the WPA. See, e.g., Littleton v. Whatcom County, 121 Wn. App. 108, 117, 86 P.3d 1253 (2004) (where legislature defined "solid waste," a statute that permitted the Department of Ecology to exempt certain items from the definition did not also authorize it to include new items in the legislature's definition). Because the

[13] We note the OIC amended this rule in 2020 and 2021. WSR 20-24-040 (Nov. 23, 2020); WSR 21-24-072 (Nov. 30, 2021). Because the amendments did not change the relevant language of the rule as it was in 2016, we cite the current WAC.

[14] For the remainder of this opinion, all citations to former RCW 48.44.341 are to the 2007 version, the statute in effect when P.E.L. filed her claim in 2016.

WPA defines "mental health services" and does not authorize the OIC to expand that definition, the definition in the WPA controls. See former RCW 48.44.341(1)(c).

Second, P.E.L. contends that the federal definition of "mental health services," which includes residential treatment, should apply to her claim because the OIC, which implements and enforces both WPA and FPA requirements, considered both regulatory schemes when enacting its rules. But P.E.L. offers no authority that an agency may alter a statutory provision because it must enforce both state and federal regulations. See RAP 10.3(a)(6) (appellate brief should contain citations to legal authority to support argument). If a party fails to support argument with citation to legal authority, we may presume none exists. Or. Mut. Ins. Co. v. Barton, 109 Wn. App. 405, 418, 36 P.3d 1065 (2001).

Third, P.E.L. argues that "if the [WPA] exempts residential treatment, but federal law applies to such services, federal law controls." P.E.L. seems to argue that the FPA preempts the WPA because it conflicts with the FPA. But " '[t]here is a strong presumption against preemption[,] and state laws are not superseded by federal law unless that is the clear and manifest purpose of Congress.' " Rollins v. Bombardier Recreational Prods, Inc., 191 Wn. App. 876, 884, 366 P.3d 33 (2015)[15] (quoting Stevedoring Servs. of Am., Inc. v. Eggert, 129 Wn.2d 17, 24, 914 P.2d 737 (1996)). Conflict preemption occurs only " 'where compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes

[15] Internal quotation marks omitted.

and objectives of Congress.' " Id. at 883-84[16] (quoting Gade v. Nat'l Sold Wastes Mgmt. Ass'n, 505 U.S. 88, 98, 112 S. Ct. 2374, 120 L. Ed. 2d 73 (1992)). P.E.L. offers no argument that Washington's exemption of residential treatment as a mental health service under the WPA makes compliance with the FPA impossible or prohibits the execution of Congress' full objectives. "Passing treatment of an issue or lack of reasoned argument is insufficient to merit judicial consideration." Palmer v. Jensen, 81 Wn. App. 148, 153, 913 P.2d 413 (1996).

Fourth, P.E.L. argues that "Premera promised to follow the state regulations even if they conflicted with the literal terms of the policy." But we can reasonably interpret Premera's promise as only agreeing to comply with those state laws that apply. Because the WPA does not apply to residential treatment, Premera complied with the WPA and its implementing regulations.

The trial court properly granted summary judgment dismissing P.E.L.'s claim for breach of contract for failure to comply with the WPA.

iii. Compliance with the FPA

P.E.L. argues that Premera's refusal to provide benefits for wilderness programs violates the FPA because the limitations used to exclude the program are more restrictive than those applied to equivalent medical benefits and the exclusion amounts to a separate treatment limitation applicable to only mental health benefits.

[16] Internal quotation marks omitted.

Under the FPA, insurers that offer a health plan that covers both medical and mental health benefits must ensure that

> the treatment limitations applicable to such mental health . . . benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan . . . and there are no separate treatment limitations that are applicable only with respect to mental health . . . benefits.

29 U.S.C. § 1185a(a)(3)(A)(ii).[17]

a. More Restrictive Limitation

P.E.L. argues that Premera applied a more restrictive treatment limitation to wilderness programs than it applied to comparable medical and surgical benefits. We disagree.

Treatment limitations can be either quantitative or nonquantitative. 45 C.F.R. § 146.136(a). Quantitative treatment limitations "are expressed numerically (such as 50 outpatient visits per year)," while nonquantitative treatment limitations (NQTLs) "otherwise limit the scope or duration of benefits for treatment under a plan or coverage." 45 C.F.R. § 146.136(a). NQTLs include medical management standards limiting or excluding benefits based on medical necessity, medical appropriateness, or whether the treatment is experimental or

[17] The parties do not dispute that the Plan covers both medical and mental health benefits.

investigative. 45 C.F.R. § 146.136(c)(4)(ii)(A).[18]

Regulations establish six "classifications of benefits" used for determining compliance with the FPA: (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. 45 C.F.R. § 146.136(c)(2)(ii)(A). If a plan provides a mental health service in a classification but imposes a quantitative limitation on benefits, the insurer must show that the same limitation applies to at least "two-thirds of all medical/surgical benefits in that classification." 45 C.F.R. § 146.136(c)(3)(i)(A). But if a plan imposes a NQTL for mental health benefits in any classification, the insurer must show that

> under the terms of the plan . . . as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the [NQTL] to mental health . . . benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

45 C.F.R. § 146.136(c)(4)(i).

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[18] NQTLs also include:

> (B) Formulary design for prescription drugs;
> (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
> (D) Standards for provider admission to participate in a network, including reimbursement rates;
> (E) Plan methods for determining usual, customary, and reasonable charges;
> (F) 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);
> (G) Exclusions based on failure to complete a course of treatment; and
> (H) 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.

45 C.F.R. § 146.136(c)(4)(ii).

Premera excludes wilderness programs as medically unnecessary nontreatment. The Plan defines "medically necessary services" as:

> Services a physician, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:
>
> - Agree with generally accepted standards of medical practice
> - Be clinically appropriate in type, frequency, extent, site and duration. . . . They must also be considered effective for the patient's illness, injury or disease
> - Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.
>
> For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

The Plan excludes from coverage "[s]ervices and places of service that are not medically necessary." And it excludes as nontreatment "programs from facilities that do not provide medical or behavioral health treatment for covered conditions from licensed providers."[19]

The Plan shows a neutral policy for making medical necessity and nontreatment determinations. It explains:

> Premera has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity

[19] But the Plan covers medically necessary medical or behavioral health treatment received in these locations.

> determinations.[20] The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria.

That provision applies generally to mental health and medical services.

Premera's 2017 NQTL disclosure statement aligns with the language in the Plan. It explains:

> The [P]lan bases decisions to cover services on whether the service is generally accepted in the medical community as an effective medical treatment, the availability of scientific research addressing the service's medical efficacy, whether there are state licensing standards for providers of the service, whether there are generally accepted medical standards for evaluating medical necessity, and whether the service actually treats a medical or mental health . . . condition. Services that do not meet these criteria are plan exclusions.

The disclosure says the same procedures "apply both to services to treat mental health . . . conditions and to services to treat medical and surgical conditions."

In operation, the uncontroverted testimony of psychiatrist Dr. Robert Small, Premera Blue Cross Assistant Medical Director of Behavioral Health, confirmed that "Premera uses the same approach for evaluating the reliability and clinical usefulness of clinical trials and studies for both mental health and medical/surgical services." Dr. Small said Premera periodically reviews literature for both mental health and medical programs using the "Delfini Group model." Under that model, a trained reviewer evaluates studies using "numerous" criteria, including (1) potential bias; (2) whether the study's makeup, including the number and selection of participants, demographics, randomization, and reporting is

[20] Premera directs its members to its website to view those guidelines and medical policies.

appropriately designed; (3) whether the study's design is appropriate for the research question being asked; (4) whether a confounding variable may account for the study's conclusion; (5) the amount of participant attrition; (6) whether the assessors are blinded; and (7) whether the study used an appropriate comparator to determine whether the suggested intervention made a recognizable difference.

As for wilderness programs specifically, Dr. Small testified that his first periodic review of their medical necessity was about 20 years ago, and his last review was "probably about a month" before his October 2020 deposition in this case. He said he reviews the two primary journals in psychiatry—the American Journal of Psychiatry and the Journal of the American Academy of Child & Adolescent Psychiatry. He also periodically reviews "POP Med"[21] for new literature. Across his reviews, Dr. Small said he considered "numerous studies that purportedly support wilderness programs" but found they "contained significant methodological flaws," including bias, inadequate study design, and unreliable reporting methods. So, Dr. Small repeatedly determined that under the Delfini Group model, "there is not sufficient credible scientific evidence that demonstrates that wilderness programs are an effective form of treatment."

P.E.L. argues that Premera "deviated from its procedures when it added the [Wilderness] Exclusion without conducting any formal review to determine whether Wilderness treatment was medically necessary or experimental and investigational." She claims Premera "never convened its Medical Policy

[21] See https://popmednet.org.

Committee to consider any aspect of wilderness programs" and made its determination based on only Dr. Small "occasionally and informally perus[ing] 'the literature' related to wilderness treatment."

But P.E.L. points to no provision in the Plan requiring Premera to convene its medical policy committee to determine whether it should exclude a service. To the contrary, Dr. Small testified that Premera's purpose for convening a medical policy committee is not to exclude services from coverage. Instead, Premera's medical policy committee convenes monthly to determine whether it should reclassify a service from "excluded" to "experimental or investigational." According to Dr. Small, Premera had already excluded wilderness programs from coverage when he arrived at Premera in 1997. And since then, he has not recommended a change in the status because the medical literature does not support Premera treating wilderness programs as experimental or investigational—that is, the literature "has not shown critical scientific evidence that wilderness programs are effective forms of treatment."

P.E.L also appears to claim that Premera violated the FPA because it failed to categorize wilderness programs under one of the six classifications of services that an insurer generally uses for determining compliance with the FPA before excluding it as nontreatment. See 45 C.F.R. § 146.136(c)(2)(ii)(A); see also 45 C.F.R. § 146.136(c)(4).

P.E.L. is correct that the record does not show Premera categorized wilderness programs in one of the six categories of services under 45 C.F.R. § 146.136(c)(2)(ii)(A). But the limitation at issue is an NQTL, so the analysis of

parity is different than that used for a quantitative limitation. As discussed above, an NQTL meets the parity requirement if under the terms of the health plan, the process used in applying the NQTL to mental health benefits is comparable to, and applied no more stringently than, the process used with respect to medical and surgical benefits in the classification. 45 C.F.R. § 146.136(c)(4)(i). Premera showed that the process it used to determine whether a mental health service is nontreatment is the same process it used to determine whether a medical service is nontreatment. So, no matter which category wilderness programs fall under, the process Premera used to determine whether it is nontreatment would be the same process used to determine whether medical services in the same category are nontreatment.

Even so, Premera provides several examples of analogous nontreatment medical services to show it does not apply its process more stringently to mental health services. For example, under the "Common Medical Services" and "Surgery Services" sections of the Plan, Premera covers inpatient and outpatient hospital services but excludes as nontreatment "[g]ym memberships or exercise classes and programs." Under "Mental Health Care" benefits, the Plan covers "[i]npatient, residential treatment and outpatient care to manage or reduce the effects of the mental condition" and "[i]ndividual or group therapy." But it does not cover "[o]utward bound, wilderness, camping or tall ship programs or activities." The NQTL disclosure statement provides the same information:

> Examples of excluded medical/surgical benefits are recreational and vocational therapy, exercise and maintenance-level programs, and gym and swim therapy. Examples of excluded mental health . . . benefits are wilderness programs (Outward Bound), equine

> therapy, Tall Ships programs, therapeutic boarding schools, and therapeutic foster or group homes.

The trial court did not err by dismissing P.E.L.'s breach of contract claim alleging that Premera's wilderness exclusion violates the FPA as a treatment limitation applied more restrictively to mental health services than comparable medical and surgical services.

b. Separate Treatment Limitation

P.E.L. also argues that the trial court erred by dismissing her breach of contract claim because a genuine dispute of material fact remains as to whether Premera's exclusion of wilderness programs is a separate limitation that applies to only mental health services. We agree.

P.E.L. claims that Premera facially excludes wilderness programs for only mental health treatment because it placed the exclusion under the "Mental Health, Behavioral Health and Substance Abuse Benefit" section of the Plan, and there "is no listing of 'wilderness' as an excluded service for medical conditions, nor does it appear under the contract's general Exclusions." P.E.L also stresses that Premera has never used the exclusion to deny coverage for medical or surgical services.

Premera offers Dr. Small's testimony in response. Dr. Small testified that Premera does not cover wilderness programs "regardless of whether the scope of the wilderness program was mental health or medical or surgical." He testified that Premera does not list every excluded service in its plans because "there are thousands of services that are not appropriate for coverage with new ones arising frequently." So, historically, "Premera did not list wilderness programs as

a separate exclusion" and instead denied "requests for coverage under the nontreatment exclusion," which applies to both medical and mental health services. According to Dr. Small, around 2012, Premera began receiving an increase in mental health claims for wilderness programs, so he recommended they list the exclusion in the mental health section of their health care plans "[i]n order to be as clear as possible" and "to avoid member confusion." He maintained that even though the Plan listed the exclusion under only mental health services, "the wilderness exclusion remains an application of the general non-treatment exclusion."

But in denying P.E.L.'s claim, Premera explained several times that the contractual provision excluding wilderness programs under "mental health services" was the basis of the denial of her claim—not the general nontreatment exclusion. Further, Dr. Small acknowledged that wilderness programs are "typically used to treat mental health conditions" and admitted that he was unaware of any medical or surgical treatment for which a wilderness component is "central" to its activities. He said that there are wilderness or outdoor programs for medical conditions such as camps "that operate for individuals with diabetes and camps that operate for individuals with seizure disorders," and that Premera would exclude those services from coverage as well. But the Plan does not list those programs as excluded medical benefits like it excludes wilderness mental health services.

Viewing the evidence and all reasonable inferences in a light most favorable to P.E.L., a reasonable juror could conclude that the wilderness

exclusion applies to only wilderness mental health services. See Christiano v. Spokane County Health Dist., 93 Wn. App, 90, 93, 969 P.2d 1078 (1998) (a court may rule on a disputed fact on summary judgment as a matter of law only if reasonable minds could reach but one conclusion). We reverse and remand the separate treatment limitation issue for determination by a trier of fact.[22]

2. Negligent Claims Management

P.E.L. argues that the trial court erred by dismissing her negligent claims-management allegation because she did not support it with objective symptomatology of emotional distress. We disagree.

To prevail on a negligence claim, a plaintiff must show (1) the defendant owed them a duty, (2) the defendant breached that duty, (3) the plaintiff suffered an injury, and (4) proximate cause between the breach and the injury. Tincani v. Inland Empire Zoological Soc'y, 124 Wn.2d 121, 127-28, 875 P.2d 621 (1994). But in deciding whether to allow damages for emotional distress without physical injury, Washington courts have balanced the right to compensation for emotional distress against competing interests in preventing fraudulent claims and holding tortfeasors responsible proportionately with their degree of culpability. Bylsma v. Burger King Corp., 176 Wn.2d 555, 560, 293 P.3d 1168 (2013).

We allow claims for emotional distress without physical injury "only where emotional distress is (1) within the scope of foreseeable harm of the negligent conduct, (2) a reasonable reaction given the circumstances, and (3) manifested

[22] P.E.L. also contends the trial court erred by dismissing her CPA claim. Premera says that dismissal was appropriate because it turned on the breach of contract claim. Because we reverse the trial court's dismissal of P.E.L.'s breach of contract claim, we also reverse dismissal of the CPA claim.

by objective symptomatology." Bylsma, 176 Wn.2d at 560. "These requirements were developed to address past concerns that feigned claims of emotional distress would lead to 'intolerable and interminable litigation.' " Id.[23] (quoting Corcoran v. Postal Tel.-Cable Co., 80 Wash. 570, 579-80, 142 P. 29 (1914)). Objective symptomatology requires that a plaintiff's emotional distress amounts to "a diagnosable emotional disorder" and that objective medical evidence proves both "the severity of the distress" and "the causal link between the [negligent behavior] and the subsequent emotional reaction." Hegel v. McMahon, 136 Wn.2d 122, 135, 960 P.2d 424 (1998); Haubry v. Snow, 106 Wn. App. 666, 678-79, 31 P.3d 1186 (2001).

Because P.E.L. shows no objective symptomatology of emotional distress, summary judgment dismissal of her negligence claim was appropriate.[24]

3. Insurance Bad Faith Claim

P.E.L. also argues the trial court erred by dismissing her insurance bad faith claim because she did not support it with objective symptomatology of emotional distress. We agree.

Under RCW 48.01.030, insurance providers have an obligation to deal with policy holders in good faith:

> The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their

[23] Internal quotation marks omitted.

[24] P.E.L. argues she did not allege negligent infliction of emotional distress (NIED) but, rather, a claim of negligence in which she seeks only emotional distress damages. But Washington courts generally construe such claims as NIED. Bylsma, 176 Wn.2d at 560.

> representatives rests the duty of preserving inviolate the integrity of insurance.

A breach of that statutory duty "sounds in the tort of bad faith." Woo v. Fireman's Fund Ins. Co., 150 Wn. App. 158, 170, 208 P.3d 557 (2009). To establish bad faith, an insured must show that a breach of the insurer's statutory duty was unreasonable, frivolous, or unfounded. Id. at 171.

We have recognized that traditional contract damages do not provide an adequate remedy for bad faith breach of contract because "an insurance contract is typically an agreement to pay money, and recovery of damages is limited to the amount due under the contract plus interest." Woo, 150 Wn. App. at 171 (quoting Kirk v. Mt. Airy Ins. Co., 134 Wn.2d 558, 560, 951 P.2d 1124 (1998)). So, we have determined that emotional distress damages are available in insurance bad faith actions. See Singh v. Zurich Am. Ins. Co., 5 Wn. App. 2d 739, 759, 428 P.3d 1237 (2018).

Premera argues that P.E.L. must support her insurance bad faith claim for emotional damages with expert testimony. It relies on Dombrosky v. Farmers Insurance Co. of Washington, 84 Wn. App. 245, 262, 928 P.2d 1127 (1996). But Dombrosky involved a claim for NIED. Id. And Washington courts have not required expert testimony to support claims for emotional damages outside the general breach standard in negligence claims. Cf. Kloepfel v. Bokor, 149 Wn.2d 192, 201, 198, 66 P.3d 630 (2003) (distinguishing "torts of intention and torts of negligence" in holding there is no objective symptomatology requirement for intentional infliction of emotional distress). Along those lines, we have rejected the need for expert support of a claim for emotional damages arising from a bad

faith insurance action. See Sykes v. Singh, 5 Wn. App. 2d 721, 732, 428 P.3d 1228 (2018) (in bad faith insurance settlement, court rejected insurer's challenge to award of damages for pain and suffering and emotional trauma based on the lack of expert testimony because insurer failed to show that insured needed expert testimony to support an award of general damages). We decline to impose such a requirement here.

The trial court erred by dismissing P.E.L.'s bad faith insurance claim for failure to show objective symptomology of emotional distress.

We conclude that genuine issues of material fact remain as to whether Premera's exclusion of wilderness programs is a separate limitation that applies to only mental health services and that the trial court erred by dismissing P.E.L.'s insurance bad faith claim for failure to show objective symptomatology of emotional distress. We otherwise affirm. Reversed in part and remanded.

Bowman, J.

WE CONCUR:

Chung, J.

Andrus, C.J.

APPENDIX B

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 6A. Public Health Service (Refs & Annos)
Subchapter XXV. Requirements Relating to Health Insurance Coverage (Refs & Annos)
Part A. Individual and Group Market Reforms (Refs & Annos)
Subpart 2. Exclusion of Plans; Enforcement; Preemption (Refs & Annos)

42 U.S.C.A. § 300gg-26

§ 300gg-26. Parity in mental health and substance use disorder benefits

Effective: December 27, 2020

Currentness

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either--

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No annual limit

If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either--

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual

limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) Compliance program guidance document

(A) In general

Not later than 12 months after December 13, 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 1185a of Title 29, and section 9812 of Title 26, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled "Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance".

(B) Examples illustrating compliance and noncompliance

(i) In general

The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, based on investigations of violations of such sections, including--

(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) Nonquantitative treatment limitations

To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

(iii) Access to additional information regarding compliance

In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)--

(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable; and

(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(C) Recommendations

The compliance program guidance document shall include recommendations to advance compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder

benefits, which may fail to comply with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) Updating the compliance program guidance document

The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(7) Additional guidance

(A) In general

Not later than 12 months after December 13, 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(B) Disclosure

(i) Guidance for plans and issuers

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is

comparative in nature with respect to--

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) Nonquantitative treatment limitations

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable, (and any regulations promulgated pursuant to such respective section), including--

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to--

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining--

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 1185a of Title 29, or section 9812 of Title 26, as applicable.

(D) Public comment

Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

(8) Compliance requirements

(A) Nonquantitative treatment limitation (NQTL) requirements

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as "NQTLs") on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs 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.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 NQTLs to medical or surgical benefits in the benefits classification.

(v) 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.

(B) Secretary request process

(i) Submission upon request

The Secretary shall request that a group health plan or a health insurance issuer offering group or individual health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

(ii) Additional information

In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

(iii) Required action

(I) In general

In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer--

(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance; and

(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

(II) Exemption from disclosure

Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of Title 5.

(iv) Report

Not later than 1 year after December 27, 2020, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains--

(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

(II) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section;

(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

(V) the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

(C) Compliance program guidance document update process

(i) In general

The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

(ii) Guidance and regulations

Not later than 18 months after December 27, 2020, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers

being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

(iii) State

The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).

(b) Construction

Nothing in this section shall be construed--

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption

This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 300gg-91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption

(A) In general

With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual

total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include--

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section--

(1) Aggregate lifetime limit

The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit

The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits

The term "mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

CREDIT(S)

(July 1, 1944, c. 373, Title XXVII, § 2726, formerly § 2705, as added Pub.L. 104-204, Title VII, § 703(a), Sept. 26, 1996, 110 Stat. 2947; amended Pub.L. 107-116, Title VII, § 701(b), Jan. 10, 2002, 115 Stat. 2228; Pub.L. 107-313, § 2(b), Dec. 2, 2002, 116 Stat. 2457; Pub.L. 108-197, § 2(b), Dec. 19, 2003, 117 Stat. 2898; Pub.L. 108-311, Title III, § 302(c), Oct. 4, 2004, 118 Stat. 1179; Pub.L. 109-151, § 1(b), Dec. 30, 2005, 119 Stat. 2886; Pub.L. 109-432, Div. A, Title I, § 115(c), Dec. 20, 2006, 120 Stat. 2941; Pub.L. 110-245, Title IV, § 401(c), June 17, 2008, 122 Stat. 1650; Pub.L. 110-343, Div. C, Title V, § 512(b), (g)(2), Oct. 3, 2008, 122 Stat. 3885, 3892; renumbered § 2726 and amended Pub.L. 111-148, Title I, §§ 1001(2), 1563(c)(4), formerly § 1562(c)(4), Title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911; Pub.L. 114-255, Div. B, Title XIII, § 13001(a), (b), Dec. 13, 2016, 130 Stat. 1278, 1280; Pub.L. 116-260, Div. BB, Title II, § 203(a)(1), Dec. 27, 2020, 134 Stat. 2900.)

MEMORANDA OF PRESIDENT

PRESIDENTIAL MEMORANDUM

<March 29, 2016, 81 F.R. 19015>

Mental Health and Substance Use Disorder Parity Task Force

Memorandum for the Heads of Executive Departments and Agencies

My Administration has made behavioral health a priority and taken a number of steps to improve the prevention, early intervention, and treatment of mental health and substance use disorders. These actions are especially important in light of the prescription drug abuse and heroin epidemic as well as the suicide and substance use-related fatalities that have reversed increases in longevity in certain populations. One important response has been the expansion and implementation of mental health and substance use disorder parity protections to ensure that coverage for these benefits is comparable to coverage for medical and surgical care. The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to expand mental health and substance use disorder benefits and Federal parity protections for more than 60 million Americans. To realize the promise of coverage expansion and parity protections in helping individuals with mental health and substance use disorders, executive departments and agencies need to work together to ensure that Americans are benefiting from the Federal parity protections the law intends. To that end, I hereby direct the following:

Section 1. Mental Health and Substance Use Disorder Parity Task Force. There is established an interagency Mental Health and Substance Use Disorder Parity Task Force (Task Force), which will identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance. The Director of the Domestic Policy Council shall serve as Chair of the Task Force.

(a) Membership of the Task Force. In addition to the Director of the Domestic Policy Council, the Task Force shall consist of the heads of the following agencies and offices, or their designees:

(i) the Department of the Treasury;

(ii) the Department of Defense;

(iii) the Department of Justice;

(iv) the Department of Labor;

(v) the Department of Health and Human Services;

(vi) the Department of Veterans Affairs;

(vii) the Office of Personnel Management;

(viii) the Office of National Drug Control Policy: and

(ix) such other agencies or offices as the President may designate.

At the request of the Chair, the Task Force may establish subgroups consisting exclusively of Task Force members or their designees under this section, as appropriate.

(b) Administration of the Task Force. The Department of Health and Human Services shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations.

Sec. 2. Mission and Functions of the Task Force. The Task Force shall coordinate across agencies to:

(a) identify and promote best practices for compliance and implementation;

(b) identify and address gaps in guidance, particularly with regard to substance use disorder parity: and

(c) implement actions during its tenure and at its conclusion to advance parity in mental health and substance use disorder treatment.

Sec. 3. Outreach. Consistent with the objectives set out in section 2 of this memorandum, the Task Force, in accordance with applicable law, shall conduct outreach to patients, consumer advocates, health care providers, specialists in mental health care and substance use disorder treatment, employers, insurers, State regulators, and other stakeholders as the Task Force deems appropriate.

Sec. 4. Transparency and Reports. The Task Force shall present to the President a report before October 31, 2016, on its findings and recommendations, which shall be made public.

Sec. 5. General Provisions. (a) The heads of agencies shall assist and provide information to the Task Force, consistent with applicable law, as may be necessary to carry out the functions of the Task Force.

(b) Nothing in this memorandum shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department, agency, or the head thereof: or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(c) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(d) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(e) The Secretary of Health and Human Services is authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA

Notes of Decisions (5)

42 U.S.C.A. § 300gg-26, 42 USCA § 300gg-26
Current through P.L. 117-228. Some statute sections may be more current, see credits for details.

KILPATRICK TOWNSEND & STOCKTON LLP

December 21, 2022 - 2:53 PM

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