THE AMERICAN COLLEGE OF EMPLOYEE BENEFITS COUNSEL AND CATHOLIC UNIVERSITY OF AMERICA, COLUMBUS SCHOOL OF LAW

SEVENTH ANNUAL ELLEN A. (NELL) HENNESSY EMPLOYEE BENEFITS MOOT COURT COMPETITION

COMPETITION PROBLEM

INCLUDED MATERIALS

I. Complaint
   - A. Exhibit A
   - B. Exhibit B
   - C. Exhibit C

II. Declaration of Dr. Evelyn Smith

III. District Court Memorandum Opinion and Order

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

J.D. and K.D.,	)	
	)	
Plaintiffs,	)	
	)	**CIVIL ACTION NO. 23-CV-499**
v.	)	
	)	
UNIVERSAL HEALTH INSURANCE CO.,	)	
	)	
Defendant.	)	
	)	

COMPLAINT

Plaintiffs, through their undersigned counsel, complain and allege as follows:

JURISDICTION AND VENUE

1. This action arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. This Court has jurisdiction over this action pursuant to 29 U.S.C. § 1132(e)(1), as well as 28 U.S.C. §1331, as this action involves a federal question.

2. Venue is proper within this district pursuant to 29 U.S.C. § 1132(e)(2), because Defendant maintains business activities in and may be found in this district.

PARTIES

3. Plaintiff J.D. is a resident of the District of Columbia. She was, at all times relevant, a covered participant under the CIA Consulting LLC Healthcare Plan (the "Plan"), an ERISA-governed employee welfare benefit plan sponsored by J.D.'s employer, CIA Consulting, LLC.

4. Plaintiff K.D. is a resident of the District of Columbia. She was, at all relevant times, a covered beneficiary under the Plan.

5. Defendant Universal Health Insurance Co. ("Universal") is authorized to transact and is transacting business in this judicial District and can be found in this District.

6. Defendant Universal both insures the Plan and administers claims for medical and mental health benefits under the Plan.

FACTUAL ALLEGATIONS

7. K.D. is a 19-year old woman with a complicated medical history of both mental illness and substance use disorder. She began to suffer from depression as a sophomore in high school. In the summer between her sophomore and junior year, she was sexually assaulted. The residual psychological and physical effects of this assault exacerbated her depression, triggered her anxiety and caused her to become withdrawn from her former social group. During this time, she began to drink and abuse other drugs such as marijuana. Although she had formerly been a gifted student, she began to lose interest in school and her grades declined. By her senior year, she was using opioids, first oxycontin and then heroin.

8. The Plan provides coverage for medically necessary mental health and substance use disorder services, including residential treatment. To assist it in administering claims for such benefits, Universal has developed its own internal guidelines. One such guideline specifies the requirements for residential treatment, including that "a less intense level of care would not result in significant improvement." *See* Ex. A (excerpt from Universal's Mental Health and Substance Use Disorder Guidelines). Upon information and belief, Universal applied this guideline to require that patients fail first at lower levels of care before they can receive long-term residential care needed to recover.

9. In early 2022, following her assault, K.D. began receiving intensive outpatient treatment three days a week for her depression and anxiety, paid for by her Plan, from a District

of Columbia facility called Road to Recovery. This treatment was not successful, and her condition worsened.

10. On March 1, 2022, K.D. attempted suicide by cutting her wrists. She was admitted first to an emergency room and then to a psychiatric hospital for three weeks, which recommended that she receive treatment at a "partial hospitalization" level of care five days a week through Road to Recovery.

11. However, almost immediately after her release, and before her partial hospitalization treatment could begin, K.D. overdosed on heroin that was laced with fentanyl. She was again admitted to the emergency room and then hospitalized for three weeks. Universal paid for this treatment.

12. Her doctor at the hospital and treatment team at Road to Recovery recommended that she receive residential treatment at a facility that could treat both her mental illness and her substance use disorder. They identified Lifeline Inc. as a nearby facility in Virginia that could provide such treatment. K.D. and her mother J.S. then sought authorization from Universal to have K.D.'s treatment there covered by the Plan. Universal approved three weeks of residential treatment.

13. Upon admittance to Lifeline on April 18, 2022, a treatment team performed a complete assessment and diagnosed K.D. with major depressive disorder, generalized anxiety disorder and substance use disorder. This team included the director of Lifeline, who is a physician, a psychiatrist, and a family nurse practitioner, all of whom specialize in treating substance use disorders as well as related mental illness and precipitating trauma.

14. Universal paid for this treatment for the three weeks it had pre-approved. At that time, on May 9, 2022, Universal sent a letter to K.D. at her home address (which her mother J.D. therefore received), informing K.D. that a reviewing physician for Universal, Dr. James Matzer,

had determined that her residential treatment was no longer medically necessary and that she could be treated at the lower level of "partial hospitalization" that she was slated to receive after being discharged following her suicide attempt. *See* Ex. B.

15. Both her mother and her treatment team at Lifeline disagreed. In response to an urgent appeal request received by Universal the following day, on May 10, 2022, Universal sent another letter to K.D., this time signed by Jennifer Lawrence, M.D. *See* Ex. C. This letter is similarly unenlightening about the specific reason for the denial of benefits. First, the letter notes that "review typically involves a telephone conversation with your provider," but then states that "Universal's attempts to reach your provider by phone were unsuccessful." *Id.* This letter goes on to state that "the requested residential treatment . . . is denied" because "[u]nder Universal Standard of Care Guidelines, residential treatment is no longer medically necessary because you could receive care at a lower level partial hospitalization level of care.'" *Id.*

16. Both the director of Lifeline and K.D.'s treating psychiatrist there cautioned that K.D. continued to be at high risk of relapse and mortality if she did not have round-the-clock monitoring and care. Based on this assessment, J.D. paid out-of-pocket for K.D.'s continued treatment at Lifeline. She took out a second mortgage on her home to pay for this treatment.

17. K.D. remained in residential treatment for an additional twelve months during which she received intensive round-the clock treatment addressing her trauma and the substance abuse and mental health issues that were caused and exacerbated by this trauma. At that time, her treatment team determined that she was in recovery from her substance use disorder and that her mental health disorders had improved to the point that she could receive continued mental health treatment on an outpatient basis.

18. Although K.D. continues to be at risk of relapse, she has now enrolled in college and continues to do well after finally receiving the sustained and intensive treatment she needed.

FIRST CAUSE OF ACTION

FOR IMPROPER DENIAL OF PLAN BENEFITS UNDER 29 U.S.C § 1132(a)(1)(B)

19. Plaintiffs incorporate by reference the preceding paragraphs as though fully set forth herein.

20. Plaintiffs are informed and believe and thereon allege that Plaintiff K.D. is entitled, under the terms of the Plan, to coverage of her complete course of residential treatment at Lifeline, and that Universal wrongfully denied her claim for benefits under the Plan.

21. Following the denial of her claim for benefits under the Plan, Plaintiff K.D., as described above, exhausted all administrative remedies required under ERISA and performed all duties and obligations on her part to be performed.

22. As a proximate result of the denial of medical benefits, Plaintiffs K.D. and J.D. have been damaged in the amount of all of the medical bills incurred for the treatment, in a total sum to be proved at the time of trial.

23. As a further direct and proximate result of this improper determination regarding the medical claim, Plaintiffs, in pursuing this action, have been required to incur attorneys' fees and costs. Pursuant to 29 U.S.C. § 1132(g)(l), Plaintiffs are entitled to have such fees and costs paid by Defendant.

24. Due to the wrongful conduct of Defendant, Plaintiff K.D. is entitled to enforce her rights to benefits under the terms of the Plan and to clarify her rights to future benefits under the terms of the Plan.

SECOND CAUSE OF ACTION

FOR EQUITABLE RELIEF UNDER 29 U.S.C. § 1132(a)(3) TO REMEDY VIOLATIONS OF 29 U.S.C. § 1185a

25. Plaintiffs incorporate by reference the preceding paragraphs as though fully set forth herein.

26. The Mental Health Parity and Addiction Equity Act of 2008, codified, in part, at 29 U.S.C. § 1185a, is an amendment to ERISA. This provision requires that plans providing for "both medical and surgical benefits and mental health or substance use disorder benefits" must not impose more coverage restrictions on the latter than it imposes on the former. 29 U.S.C. § 1185a(a)(3)(A). This prohibits plan administrators from applying treatment limitations to mental health benefits that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits," and it also prohibits plan administrators from applying "separate treatment limitations" only to mental health benefits. 29 U.S.C. § 1185a(a)(3)(A)(ii).

27. Upon information and belief, Universal violated this requirement by applying a "fail first" policy that required that K.D. be treated at and fail at a lower level of care before she could receive treatment to recovery at a residential level of care, despite Plan terms that provided for residential treatment of her mental health and substance use disorder if medically necessary.

28. Upon information and belief, the Plan does not apply such a "fail first" policy with respect to long-term inpatient medical and surgical treatment, such as skilled nursing care. Accordingly, Universal's application of a "fail first" requirement for residential mental health and substance use disorder treatment violates ERISA's parity requirements.

29. As a direct and proximate result of these actions, and the resulting injuries and damages sustained by Plaintiff K.D. as alleged herein, K.D. is entitled to and hereby requests that this Court grant Plaintiff the following relief pursuant to 29 U.S.C. § 1132(a)(3):

a. An injunction requiring Universal to follow the terms of the Plan in making future benefit determinations and to refrain from applying internal guidelines inconsistent with the parity provisions of ERISA; and

b. Such other appropriate equitable relief as the Court deems necessary and proper to protect the interests of Plaintiff under the Plan.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Universal as follows:

1. An order requiring payment of health insurance benefits due to Plaintiff under the Plan;
2. Injunctive and other equitable relief requiring Universal to follow the terms of the Plan in making benefit determinations and to refrain from applying internal guidelines inconsistent with the terms of the Plan and the requirements of ERISA;
3. Pursuant to 29 U.S.C. § 1132(g), payment of all costs and attorneys' fees incurred in pursuing this action;
4. Payment of prejudgment and post-judgment interest as allowed for under ERISA; and
5. For such other and further relief as the Court deems just and proper.

Dated this 2nd day of August, 2023.

Respectfully Submitted,

BY: */s/ Paula Wellstone*
Paula Wellstone
ATTORNEY FOR PLAINTIFFS

EXHIBIT A

Excerpt From Universal Health Insurance Company's
Mental Health and Substance Use Disorder Guidelines

Residential treatment means:

> A 24-hour, 7-days a week facility-based program that provides assessment, diagnostic services, and active health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient hospitalization and for whom a less intense level of care would not result in significant improvement.

EXHIBIT B

Universal Health Insurance Company
P.O. Box 5678
Los Angeles, CA 90022

May 9, 2022

K[redacted] D[redacted]
1234 Main Street
Los Angeles, CA 90012

RE: Member Name: K[redacted] D[redacted]
Health Plan/Group: Universal Health Insurance Company
Provider: Lifeline Inc.
Level of Care: Residential
Service Type: Mental Health Services

Dear Ms. D[redacted]:

Universal Health Insurance Company (UHIC) is responsible for making benefit coverage determinations for mental health and substance use disorder services that are provided by your health plan. The availability of benefit coverage for a service is determined by the terms of your benefit plan. To review information about your specific plan coverage, please refer to the benefit information provided by your health plan.

I have reviewed the plan for your admission to Lifeline Inc. Based on my review of the available documentation and all information received to date, I have determined that coverage is not available under your benefit plan after May 9, 2022, for the following reason(s):

> You are receiving treatment for behavioral health and substance use disorder problems. You received three weeks of such treatment and, based on your improvement, residential treatment is no longer **Medically Necessary** because you may be successfully treated as a lower level of care.

It is my determination that no authorization can be provided for residential treatment at Lifeline Inc. as of May 9, 2022.

This determination does not mean that you do not require additional health care, or that you need to be discharged. Decisions about continuation of treatment should be made by you and your provider. The purpose of this letter is to inform you that, based on my review of the available information, I have determined that coverage is not available under your benefit plan for continued residential treatment after May 9, 2022 at Lifeline because such treatment is no longer medically necessary.

On May 9, 2022, we notified your provider of this determination by telephone.

Under federal law, you have a right to request the diagnosis and diagnosis code provided to us by your provider. Alternately, you may request this information from your provider. Please refer to the enclosed form(s) for information about your available options to appeal or dispute this determination.

Sincerely,

James Matzer, M.D.

Appeals Coordinator
Universal Health Insurance Company

Universal Health Insurance Company
P.O. Box 5678
Los Angeles, CA 90022

May 9, 2022

K[redacted] D[redacted]
1234 Main Street
Los Angeles, CA 90012

RE: Member Name: K[redacted] D[redacted]
Health Plan/Group: Universal Health Insurance Company
Provider: Attending MD
Level of Care: Residential
Service Type: Mental Health Services

Dear Ms. D[redacted]:

An experienced healthcare professional has reviewed the request for care that you or your doctor recently sent us.

Your request is important and personal to you and to us. Our decisions affect you. Because of that, our review included more than clinical guidelines and scientific data alone. Information about your health and your health plan were a part of it, too.

Results of the review
Our review showed that the care you've requested is **Not Medically Necessary**. We can't approve your request because your plan doesn't cover care that is **Not Medically Necessary**.

Details from the review (consider discussing with your doctor)
You went to the Lifeline Inc. residential treatment facility to treat your substance abuse and mental health disorders following an overdose. Universal approved three weeks of coverage. The program asked to extend your stay. The plan clinical criteria considers residential care medically necessary for those who meet all the following: 1) they cannot cooperate with treatment unless they have round-the clock structured care; and 2) they are a danger to themselves or others; and 3) they cannot be safely treated at a lower level of care. In addition, the person must be willing to participate, and is expected to either improve with this care, or to keep from getting worse. If coming directly out of a higher level of care (hospital or residential treatment), the person must need residential treatment to continue to improve or to keep from getting worse. The information we have indicates that you have made progress and are no longer actively suicidal. You no longer need this much supervision and structured care and you may be treated at a lower level of care. For this reason, the request is denied as not medically necessary. There may be

other treatment options to help you, such as the partial hospitalization services you were approved to receive prior to your admission to Lifeline. You may want to discuss these with your doctor.

You have the right to appeal
You can appeal our decision if you or your doctor disagree with it. Please read the **Rights Available to Members** guide we've included with this letter. It explains your options, tells you how much time you have to appeal and lists the information you'll need to send us.

Sincerely,

James Matzer, M.D.

Appeals Coordinator
Universal Health Insurance Company

Your Rights as a Member
We've told your doctor about our decision. Your doctor can provide more information about your case by calling our clinical reviewer at (800) 555-4444.

What you owe
Health-care professionals and facilities in your plan should only bill you for care that we've decided isn't medically necessary when you've signed a form in advance stating that you'd pay for care your plan wouldn't cover.

If you get a bill from a health-care professional or facility in your plan for care that isn't medically necessary, give Universal Health Insurance Company a call at the number on your ID card. We will work with you to figure out who's responsible for paying which portions of what's owed.

If the health-care professional or facility isn't on your plan, then you may have to pay for any care that Universal Health Insurance Company has decided isn't medically necessary - even if the professional or facility participates in another Blue Cross plan.

Questions? Give us a call at the Member Services number on your ID card.

If you don't agree with this decision, you can file an appeal. You have 180 calendar days from the date that you get this letter.

How do I file an appeal?
Send a written request to Grievances and Appeals, P.O. Box 2100, North Haven, CT 06473 or call 1-800-555-8989 and ask for your G&A Analyst. If they're not available, don't worry. Anyone who answers the phone can help you.

How long does an appeal review take?
We'll do a review and give you a written decision within 30 calendar days from the date we get your appeal. If you're covered under a group policy that offers two levels of appeal, we'll do a review and give you a written decision within 15 calendar days from the date we get your appeal if your appeal relates to a pre-service request. If your appeal relates to a post-service request, we'll do a review and make a decision within 30 calendar days from the date we get your appeal.

If you file an appeal for a decision we make about a step therapy requirement, we'll do a review and give you a written decision within 72 hours of getting the information we need to support the request. Step therapy simply means you may need to use one type of prescription drug before we'll cover another.

What if my situation is urgent?
You'll need to file an expedited appeal. Your situation is urgent if:

- Your life, health or ability to regain maximum function is in jeopardy (danger); or
- In your doctor's opinion, your pain can't be controlled while you wait for a standard appeal review to be finished.

We'll handle your appeal urgently if:

- You're receiving continued or extended health care services;
- You're receiving additional services rendered in the course of continued treatment;
- You're receiving home health care services following an inpatient hospital admission;
- You're receiving mental health or substance use disorder services subject to court order; or
- Your doctor feels an expedited review is necessary.

An expedited appeal must be filed before services are provided or while services are ongoing. This means you can't file an expedited appeal after services have already been provided.

How do I file an expedited appeal?
You can mail your request but it's best if you call 1-800-555-8989 so we can handle it fast.

How long does an expedited appeal review take?
Generally, we'll do a review and give you a decision within two business days of receiving all information necessary to make a decision for an expedited appeal (but no later than 72 hours) by phone. We'll also send you the decision in writing. For inpatient substance abuse disorder treatment, we'll do a review and give you a decision within 24 hours of receiving all information necessary to make a decision if the appeal is received at least 24 hours before you are discharged from an inpatient stay.

If your appeal involves an urgent step therapy issue for prescription drugs, we'll do a review and give you a decision within 24 hours of getting the information we need to support the request.

What if I don't agree with an expedited appeal decision?
You have two options:

1) If you are enrolled through a group, you can file a standard appeal with us within 180 calendar days from the date you get the expedited appeal decision; or
2) You can file an external appeal within four months from the date of the expedited appeal decision (see *External Appeal* below).

If you choose to file a standard appeal instead of an external appeal, you'll get new external appeal rights if the standard appeal is denied. This means you'll have four months from the date of the standard appeal decision to file an external appeal.

Can I get copies of documents for my records?
Of course! You can call 1-800-555-8989 or send a letter to ask for free copies of all documents, including the actual benefit provision, guideline, protocol or other similar criterion this decision was based on.

Can I get diagnosis and treatment codes?
You can and it's free! Just call 1-800-555-8989 to ask for them. You can also ask for descriptions of the codes, if they are available.

What should my appeal include?

- Include if you can:
- Your name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree; and
- The specific reason(s) why you don't agree with the decision.

You have the right, and we encourage you, to give us written comments, documents and other relevant information with your appeal.

If you are filing an appeal because we denied an out-of-network health service or out-of-network provider, there are some other things you'll need to include.

<u>Out-of-network health service</u>
An out-of-network health service is a service provided by a doctor, or other provider, who does not participate with your health plan. You can file an appeal if we deny coverage for an out-of-network health service because it is not materially different from an available in-network health service. You must send the following details with your appeal:

- A written statement from your treating doctor, who must be a licensed, board certified or eligible doctor qualified to practice in the specialty area of practice

appropriate to treat your health condition, that the requested out-of-network health service is not materially different from an approved health service available in-network;
- Two documents from the available medical and scientific evidence, that the out-of-network service is likely to be more clinically beneficial to you than the in network service and that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

You won't be eligible for an appeal or external appeal if the service you request is available from a provider who participates with your health plan, even if the non-participating provider has more experience in diagnosing or treating your condition. Your request will be handled as a grievance.

Out-of-network authorization

An out-of-network authorization is a request to see a doctor, or other provider, who doesn't participate with your health plan. If we deny an out-of-network authorization because there are providers who participate with your health plan available with the right training and experience to meet your health care needs, you can also file an appeal. You must send a written statement from your treating doctor, who must be a licensed, board certified or board-eligible doctor qualified to practice in the specialty area to treat your health condition that the network provider we recommend doesn't have the right training and experience to meet your particular health care needs.

Without this information your request will be handled as a grievance and you will not be eligible for an external appeal.

Can other people help file my appeal or act on my behalf?

Yes! You can choose someone to act for you or help you during the appeal process. We call this a member (or authorized) representative. They can be anyone-your doctor, friend, relative, spouse, neighbor, attorney, etc. You must let us know in writing if you choose a member representative.

Need to let us know who your member representative is for an appeal? Send a letter that includes the following details to the address above (a form is also available - just contact customer service):

- Your name, ID number, date of birth and full address;
- The full name of the person you've chosen to act for you;
- That you are giving us permission to share protected health information (PHI) with this person;
- The purpose for disclosing PHI to this person;
- A description of the specific information we can share;
- The date your authorization expires;
- That you understand that you have the right to withdraw your authorization at any time in writing;
- That you understand we aren't responsible if your member representative shares your PHI with others; and

- That you understand you aren't required to provide authorization in order to receive treatment, payment, for enrollment or to be eligible for benefits.

You must also sign and date the letter.

How will my appeal be handled?
We'll make sure your appeal is reviewed by an appropriate reviewer. The reviewer will not have been involved in the initial adverse determination. We'll also make sure they don't work for the person who made that decision. Any information you share with us will be considered. If we need more information, we may get in touch with you. We may also contact your doctor or any other provider who may be able to help.

External appeal
You can file an external appeal with the Department of Financial Services (DFS) if we deny health care services as not medically necessary, experimental/investigational or out-of-network. Just be sure you do within four months from the date that you get a final adverse determination from us (unless your situation is urgent). An independent external appeal agent arranged by the DFS will look at the request. We aren't involved in the review. We'll give you more details if your appeal is denied.

If your health plan offers two levels of internal appeal, the timeframe to ask for external appeal begins when you receive our final adverse determination of the first level appeal. It's important for you to know that by choosing to request a second level internal appeal, the time to request an external appeal may expire.

We don't charge a fee for an external appeal. There aren't any filing fees either.

Is an expedited external appeal available if my situation is urgent?
Yes. You can file an expedited external appeal with the DFS instead of, or at the same time as, filing an expedited internal appeal with us. If you have any questions, or to learn more, please contact the DFS by phone or email.

Can I file an external appeal if my situation isn't urgent and I haven't received a final adverse determination?
You may be able to file an external appeal without getting a final adverse deternination from us even if your situation isn't urgent. You'll need to ask for a waiver and give us details about why you need one. To ask for a waiver, call 1-800-555-8989 or write to Grievances and Appeals at the address above. We aren't required to approve your request. If we do, you'll have four months from the date we let you know your request is approved to file an external appeal.

ERISA plan members
If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA within one year,

unless your plan provides for a longer period. Check your benefits booklet or plan documents to see if you have more time.

Rights available to Providers:
If you don't agree with this decision, you can file an appeal. You have 45 calendar days from the date that you get this letter. Providers also have the right to file an external appeal within 60 days for concurrent and retrospective denials.

EXHIBIT C

Universal Health Insurance Company
Grievances and Appeals
P.O. Box 5678
Los Angeles, CA 90022

May 13, 2022

K[redacted] D[redacted]
1234 Main Street
Los Angeles, CA 90012

Reference #: 20224978-64287
Member Name: K[redacted] D[redacted]
Member ID: JD1234567

Dear Ms. D[redacted],

We received your request for appeal of the adverse benefit determination. The appeal letter, along with all submitted clinical information, was reviewed against the plan document and the applicable utilization criteria adopted by the plan. The original decision was upheld.

The reason for our determination is:

Although review typically involves a telephone conversation with your provider, Universal's attempts to reach your provider by phone were unsuccessful. Nevertheless. after medical review of the records submitted, it was determined the requested residential treatment after May 9, 2022, is denied. Under Universal Standard of Care Guidelines, residential treatment is no longer medically necessary because you could receive care at a lower level partial hospitalization level of care.

Therefore, we are unable, according to the plan terms, to approve your request as a covered benefit under the plan. Please be advised that your health benefit plan excludes coverage for the requested service. You may refer to the plan document which outlines this topic.

If any internal rule, guideline or protocol or similar criteria was relied upon in making the appeal decision, a copy will be provided to you at no cost upon request by calling your Care Coordinators. If the appeal decision was based on an exclusion or limitation due to medical necessity or experimental treatment, an explanation of the scientific or clinical judgment, applying the terms of the plan to your circumstances, will be provided to you in writing at no cost upon request by calling your Care Coordinators. You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. You will be provided with the meaning of the diagnosis and/or treatment codes, if requested.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

You have exhausted the internal appeal process for this plan. Because your claim is considered to involve the exercise of medical judgment, you have a right to file a request for an external appeal within four (4) months from the date of this letter. The written request for an external appeal must be submitted to the following address:

Universal Health Insurance Company
P.O. Box 4567
Los Angeles, CA 90022

If you require additional information regarding your appeal rights, you can contact the Employee Benefit Security Administration (EBSA) at the toll-free number 1-866-444-EBSA [3272].

You have the right to bring a civil action under ERISA § 502(a) if you file an appeal and your request for coverage or benefits is denied following review. Any such action must be filed not later than one (1) year after the completion of the Plan's claims review process.

If we can provide any information or assistance regarding your healthcare needs, please contact the Care Coordinators at 1-800-555-8888.

Sincerely,

Jennifer Lawrence, M.D.

Appeals Coordinator
Universal Health Insurance Company

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

J.D. and K.D.,	)	
	)	
Plaintiffs,	)	
	)	**CIVIL ACTION NO. 23-CV-499**
v.	)	
	)	
UNIVERSAL HEALTH INSURANCE CO.,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF DR. EVELYN SMITH

I, Dr. Evelyn Smith, declare and state:

1. I am a Board certified psychiatrist with a specialty in addiction medicine. I make this declaration of my own personal knowledge and, if called as a witness, could and would competently testify to the following.
2. I received my medical degree in 1983 from Columbia University Vagelos College of Physicians and Surgeons, where I also did my residency in psychiatry. I received my Board certification in addiction psychiatry in 1989. I have worked as a staff psychiatrist at Lifeline since 2010.
3. I treated K.D. at Lifeline for over a year at Lifeline starting in April of 2022. After she entered Lifeline's residential treatment center following a suicide attempt and heroin/fentanyl overdose. I have continued to see her monthly since her discharge on a private, outpatient basis.
4. K.D. has a complicated history of trauma and substance use disorder, with co-morbid mental health issues, including major depressive disorder and generalized anxiety.
5. During her time at Lifeline, I saw K.D. at least once a week. Through medication,

intensive group and individual therapy and applied neuroscience modalities, K.D. was able to make steady progress toward remission and recovery while at Lifeline.

6. By the time of her discharge in May 2023, she was in recovery from her addiction, had her depression and anxiety under control and once again had hope for the future. In fact, she continues to do well from a psychiatric standpoint, and has just enrolled in college. She has also begun to reconnect to her peers.
7. But as with all patients suffering from substance use disorder and mental illness, her recovery is precarious and she could easily suffer a big set-back.
8. She is very sensitive, even ashamed, about her past drug use and about having spent a year in a residential treatment facility. She has expressed her fears that if anyone learns of this, she will be shunned.
9. I believe it is possible that she could again become depressed and anxious and suffer a recurrence of substance use disorder if she were forced to proceed in this matter under her name. I strongly recommend against this.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed this 20th day of July, 2023 at Washington, District of Columbia

/s/ Dr. Evelyn Smith
Evelyn Smith, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

J.D. and K.D.,	)	
	)	
Plaintiffs,	)	
	)	**CIVIL ACTION NO. 23-CV-499**
v.	)	
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UNIVERSAL HEALTH INSURANCE CO.,	)	
	)	
	)	
Defendant.	)	
_____	)	

MEMORANDUM OPINION AND ORDER

Before the Court is the "Motion of Plaintiffs to Proceed Anonymously" (Doc. 25), as well as the "Motion of Defendant Universal Health Insurance Co. to Dismiss Count II." Doc. 27. As set forth below, Plaintiffs' motion is **DENIED**, Defendant's motion is **GRANTED**. Furthermore, because Plaintiffs have indicated that they will not proceed with their claim for benefits if they must reveal their names, this matter is **DISMISSED.**

I. Background and Procedural History.

Plaintiff J.D. is a participant in a health insurance plan sponsored by her employer. Her daughter K.D. is a Plan beneficiary and a young adult. The Plan is both insured and administered by Universal Health Insurance Co. ("Universal") and is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

The plan covers medically necessary treatment of mental illness and substance use disorders. Doc. 12 (Admin. Rec. 200). Universal has developed guidelines that it applies in deciding whether a particular claim for benefits is medically necessary. *Id.* (Admin. Rec. 300). These guidelines cover five increasing levels of care ranging from "outpatient," to "intensive outpatient" (normally 2-3 times a week), to "partial hospitalization" (defined, counterintuitively, as outpatient day treatment 5 days a week), to "residential treatment," to inpatient "hospitalization." *Id.*

According to the Complaint, K.D. suffers from numerous mental health issues and substance use disorder.[1] After being hospitalized for a month in 2022 because of these disorders, she was admitted to Lifeline, Inc., an inpatient treatment facility in Virginia. K.D. was 18 years old at that time.

After authorizing and paying for three weeks of treatment, Universal determined that residential treatment was no longer medically necessary for K.D. because her symptoms had abated to some degree and she could, according to Universal's reviewing doctors, be treated at a lower level of outpatient care, such as "partial hospitalization" five days a week. Plaintiffs appealed the denial of benefits, and Universal affirmed its denial.

[1] Except where otherwise noted, the facts are taken from the Complaint (Doc. 1).

Because K.D.'s doctors advised that K.D. continued to be at high risk of relapse and mortality, J.D. paid out-of-pocket for K.D.'s continued treatment at Lifeline. In fact, J.D. took out a second mortgage on her home to pay for this treatment. K.D. remained in residential treatment for an additional twelve months.

J.D. and K.D. then filed suit in this court, using only their initials in order to protect K.D.'s privacy. The complaint asserts two counts. Count I is a claim for benefits under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Count II seeks equitable relief under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a), in the form of an injunction and equitable surcharge to remedy a violation of ERISA's mental health parity provision, 29 U.S.C. § 1185a. In Count II, Plaintiffs assert that the clinical criteria applied by Universal for coverage of mental health and substance abuse residential programs are more stringent than their criteria for analogous medical or surgical benefits because they require patients to "fail first" at lower levels of care.

Because K.D. is an adult – she was 18 at the time of the treatment in question and 19 when she and her mother filed suit – this Court directed the Plaintiffs to show cause why they should be permitted to proceed using initials. In response, the Plaintiffs filed a motion asking to be allowed to proceed anonymously. Universal filed a response opposing the Plaintiffs' motion. In

addition, Defendant filed its own motion to dismiss J.D. as a plaintiff and to dismiss Count II (the "Parity Act claim").

II. DISCUSSION

The Plaintiffs argue that they should be allowed to proceed anonymously in order to protect the privacy interests of K.D. Universal, on the other hand, opposes the Plaintiffs' motion, arguing that plaintiffs should not be allowed to proceed anonymously because of the strong public interest in open court proceedings.

In its motion, Universal argues that that this Court should dismiss the Parity Act claim, Count II, because it is duplicative of Count I, the claim for benefits. In opposition to this motion, the plaintiffs argue that they should be able to proceed on both their claim for benefits and their claim for equitable relief, including injunctive relief, to remedy the asserted Parity Act violation.

A. The Plaintiffs' Motion to Proceed Anonymously

Federal Rule of Civil Procedure 10(a) provides that "every pleading" in federal court must "name all the parties." This Rule has been read to create a "strong," but not irrebuttable, "presumption in favor of parties' proceeding in their own names." *Plaintiff B v. Francis*, 631 F.3d 1310, 1315 (11th Cir. 2011); *see also Doe v. Blue Cross & Blue Shield United of Wisconsin,* 112 F.3d 869, 872 (7th Cir. 1997) ("The people have a right to know who is using their courts.").

Thus, before allowing a party to proceed under a pseudonym, courts must ensure that "*extraordinary* circumstances support such a request by balancing the party's stated interest in anonymity against the public's interest in openness and any prejudice that anonymity would pose to the opposing party." *Doe v. Pub. Citizen*, 749 F.3d 246, 274 (4th Cir. 2014) (emphasis added). "The courts that have considered this issue have framed the relevant inquiry as a balancing test that weighs the plaintiff's need for anonymity against countervailing interests in full disclosure." *Sealed Plaintiff v. Sealed Defendant*, 537 F.3d 185, 189 (2d Cir. 2008) (citing cases). They do so by looking to numerous factors, including, as relevant here, whether the case involves matters of a "highly sensitive and personal nature," *M.M. v. Zavaras*, 139 F.3d 798, 803 (10th Cir. 1998), whether in light of the plaintiff's age or other circumstances, she is particularly vulnerable to the possible harms of disclosure, *Does I thru XXIII v. Advanced Textile Corp.*, 214 F.3d 1058, 1068 (9th Cir. 2000), whether the public's interest in the litigation is furthered by requiring the plaintiff to disclose her identity, *id.*, and whether there are any alternative mechanisms for protecting privacy interests, *Roe v. Aware Woman Ctr. for Choice, Inc.*, 253 F.3d 678, 685 (11th Cir. 2001).

Under a totality-of-the-circumstances, consideration of these relevant factors does not support allowing the plaintiffs to proceed under pseudonyms in this case. First, although the Plaintiffs argue that K.D.'s mental health struggles and

treatment are highly sensitive and personal, the same is true in all medical cases, particularly those involving mental illness and drug addiction. But this fact cannot, by itself, justify allowing plaintiff (and her mother) to use pseudonyms to shield K.D.'s identity. Otherwise, there would essentially be a presumption in favor or pseudonyms in all cases involving mental health or drug addiction treatment, instead of a presumption against them as demanded by Rule 10(a) and the Constitution. And although the Plaintiffs assert that there will be a chilling effect if ERISA participants and beneficiaries are forced to proceed in court in their own names, this possibility is ameliorated by the ability of Plaintiffs to file their medical records and social history and even part or all of their Complaint in redacted form or under seal, as discussed below.

Second, although K.D. is quite young, she is not a minor and thus cannot show that she is in need of special protection. While her treating physician from Lifeline, Dr. Smith, has provided a declaration stating that K.D. could be harmed in her recovery by having to reveal her identity in this matter, the court finds this of limited persuasive value considering the equivocal nature of this declaration. Doc. 25-1. Moreover, Dr. Smith stands to benefit at least indirectly if Universal is determined to be on the hook for the cost of K.D.'s treatment.

Third, this Court concludes that the public's interest in open court proceedings is always furthered by knowing the identity of the litigants, and this

case is no exception. Indeed, this is the very premise upon which Rule 10(a) rests and a fundamental principle embedded in the American constitution.

Finally, and importantly, K.D.'s interest in protecting private and sensitive details of her treatment can be protected by redacting private information or sealing the medical and court records to the extent that they contain or would reveal this information. The Plaintiffs counter that the public has at least as strong an interest in the details of her treatment and recovery as in knowing her name. Rule 10(a), however, requires that the parties to litigation ordinarily have a duty to make themselves known. It does not demand that they reveal their medical histories. The Plaintiffs also protest that the complaint in this case has already revealed much of this sensitive personal and medical information. Be that as it may, this is a problem of Plaintiffs' own making since they could have sought to redact or omit this information at the outset or filed the complaint provisionally under seal. Moreover, the Court will allow them to refile the complaint under seal now, thereby ameliorating any such harm.

For these reasons, the Court concludes that, on balance, no extraordinary circumstances support allowing K.D. or her mother J.D. to proceed in this matter under their initials. This ruling is in line with several other recent rulings in which district courts have not allowed the use of pseudonyms by ERISA healthcare claimants in similar circumstances. *See*, *e.g.*, *L.R. v. Cigna Health & Life Ins. Co.*,

No. 6:22-cv-1819-RBD-DCI, 2023 WL 4532672, at *1 (M.D. Fla. July 11, 2023); *L.L. v. MedCost Benefit Servs.*, No. 1:21-cv-00265-MR, 2023 WL 362391, at *1 (W.D.N.C. Jan. 23, 2023); *Doe v. UNUM Life Ins. Co.*, 164 F. Supp. 3d 1140, 1145 (N.D. Cal. 2016) (collecting cases).

B. Universal's Motion to Dismiss Count II

The Mental Health Parity and Addiction Equity Act of 2008, codified in part at 29 U.S.C. § 1185a, is an amendment to ERISA. Among other things, this provision requires that plans providing for "both medical and surgical benefits and mental health or substance use disorder benefits" must not impose more coverage restrictions on the latter than it imposes on the former. 29 U.S.C. § 1185a(a)(3)(A). This prohibits plan administrators from applying treatment limitations to mental health benefits that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits," and it also prohibits plan administrators from applying "separate treatment limitations" only to mental health benefits. 29 U.S.C. § 1185a(a)(3)(A)(ii).

Universal argues that Count II fails because the language in its mental health level-of-care guidelines does not expressly require that a claimant fail at a lower level of care in order to obtain benefits at the higher level, and it is not applied in that manner. The Plaintiffs on the other hand contend that, in practice, this language is applied as a "fail first" policy. And, they say, because Universal has

no such policy for a person claiming medical or surgical benefits, this violates ERISA's mental health parity requirements. This is a merits argument and, as such, is inappropriate for resolution on a motion to dismiss.

Universal also argues, however, that this Count for equitable relief under ERISA Section 502(a)(3) is duplicative of the claim for benefits asserted under ERISA Section 502(a)(1)(B) in Count I. This point is well taken.

Although federal pleading rules generally permit alternative and even inconsistent claims, ERISA presents a special case. The Supreme Court has pointed out that equitable relief under ERISA Section 502(a)(3) normally is not "appropriate" where a plaintiff's injury can be adequately addressed elsewhere, cautioning against allowing a plaintiff to simply "repackage [a] 'denial of benefits' claim as a claim for 'breach of fiduciary duty[.]'" *Varity v. Howe*, 516 U.S. 489, 512-14 (1996). Since that time, courts have generally recognized that ERISA plaintiffs may not seek "a duplicative or redundant remedy ... to redress the same injury." *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 373 (6th Cir. 2015) (en banc). While some courts have permitted plaintiffs to simultaneously plead claims under both Section 502(a)(1)(B) and 502(a)(3), they have also recognized that plaintiffs may not seek "duplicate *recoveries* when a more specific section of the statute, such as § 1132(a)(1)(B), provides a remedy similar to what the plaintiff

seeks under the equitable catchall provision, § 1132(a)(3)." *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 726 (8th Cir. 2014).

Universal argues that Count II seeks just that: the payment of benefits to remedy the perceived Parity Act violation. Plaintiffs claim, however, that in addition to seeking declaratory and injunctive relief requiring that Universal pay the cost K.D.'s treatment at Lifeline without application of the asserted "fail first" policy, they also seek an injunction requiring Universal to do so in the future should K.D. have a relapse and again require residential care. However, even this remedy is encompassed within ERISA Section 502(a)(1)(B), since that provision permits not just a suit "to recover benefits due," it also permits a claim "to clarify [a claimant's] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Thus, Count I, if successful, will allow this Court to impose precisely the relief sought by Plaintiffs in Count II.

Because the Plaintiffs Parity Act claim brought under ERISA Section 502(a)(3) could have been brought as part of their 502(a)(1)(B) claim for benefits, and their injury, if proven, can be adequately redressed through the benefit claim, Count II must be dismissed.

C. Dismissal of the Entire Case

Plaintiffs have made it clear in their briefs and argument before this Court that they will not file an amended complaint with their full names as ordered

herein. Instead, they request that if they lose on the issue of pseudonyms, as has happened, judgment be entered against them so that they may appeal this ruling. The Court will do so.

IT IS, THEREFORE, ORDERED that Plaintiffs' motion (Doc. 25) is **DENIED**, Defendant's motion (Doc. 27) is **GRANTED**, and this case is **DISMISSED.**

IT IS SO ORDERED.

Hon. Jacob K. Javits
Hon. Jacob K. Javits
United States District Court Judge