14-20-cv

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

NEW YORK STATE PSYCHIATRIC ASSOCIATION, INC., in a representational capacity on behalf of its members and their patients; MICHAEL A. KAMINS, on his own behalf and behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers; JONATHAN DENBO, on his own behalf and on behalf of all other similarly situated health insurance subscribers; and SHELLY MENOLASCINO, M.D., on her own behalf and in a representational capacity on behalf of her beneficiary patients and on behalf of all other similarly situated providers and their patients,

Plaintiffs-Appellants,

v.

UNITEDHEALTH GROUP; UHC INSURANCE COMPANY; UNITED HEALTH-CARE INSURANCE COMPANY OF NEW YORK; and UNITED BEHAVIORAL HEALTH,

Defendants-Appellees.

(Caption Continued On Inside Cover)

On Appeal from the United States District Court
for the Southern District of New York, No. 1:13-cv-01559-CM

BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE PARITY IMPLEMENTATION COALITION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS AND REVERSAL

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April 21, 2014

(Caption Continued From Cover)

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Plaintiffs.

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amicus American Psychiatric Association ("APA"), with more than 36,000 members, is the Nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus* in many cases involving mental health issues, including *Indiana v. Edwards*, 554 U.S. 164 (2008); *Sell v. United States*, 539 U.S. 166 (2003); *Kansas v. Crane*, 534 U.S. 407 (2002); *Penry v. Johnson*, 532 U.S. 782 (2001); *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); *Kansas v. Hendricks*, 521 U.S. 346 (1997); *Riggins v. Nevada*, 504 U.S. 127 (1992); *Foucha v. Louisiana*, 504 U.S. 71 (1992); *Washington v. Harper*, 494 U.S. 210 (1990); and *Addington v. Texas*, 441 U.S. 418 (1979).

The members of the APA are physicians engaged in the treatment of mental health and substance use disorders. The organization and its member psychiatrists have substantial knowledge and experience relevant to the issues in this case. The APA seeks to ensure that the Court is well-informed about the nature of the relationship between psychiatrists and their patients, the stigma associated with mental health and substance use disorders, and the legal relevance of these facts

[1] Pursuant to Federal Rule of Appellate Procedure 29(c)(5), counsel for *amici* represents that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amici* or their counsel, made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief.

to the standing of professional associations of psychiatrists to seek legal relief on behalf of their members' patients.

Amicus the Parity Implementation Coalition ("PIC") is comprised of addiction and mental health consumer and provider organizations. PIC members have diligently worked for 15 years to enact a law and implementing regulations that provide access to non-discriminatory health care for individuals and families with mental health and substance use disorders.

INTRODUCTION AND SUMMMARY OF ARGUMENT

Amici APA and PIC file this brief to address the district court's holding that the New York State Psychiatric Association ("NYSPA") lacked standing to pursue claims in the case below.[2] Psychiatrists and professional associations of psychiatrists, like appellant NYSPA and *amicus* APA, play a crucial role in advocating for the legal rights of their patients with mental health and substance use disorders, including litigating on those patients' behalf. The standing of psychiatrists to assert claims on behalf of their patients and of professional associations of psychiatrists to assert claims on behalf of their members' patients is supported by well-established precedent. This litigating role is vital in light of the

[2] The district court made clear – by dismissing the NYSPA's claims with prejudice, slip op. 42 (JA 248) – that its ruling was based on prudential, not constitutional, standing. The court indicated that, if the NYSPA had standing, its claims would nevertheless have been subject to dismissal under Federal Rule of Civil Procedure 12(b)(6), suggesting that its standing ruling was dicta. This Court should expressly disapprove the lower court's ruling on third-party standing.

unique features and social context of mental health and substance use disorders and is particularly important to the effective enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, Div. C, Tit. V, Subtit. B, 122 Stat. 3765, 3881 ("Parity Act").

Psychiatrists have third-party standing to assert claims on behalf of their patients because: (1) they suffer injury themselves; (2) they stand in a "close relationship" with the patients on whose behalf they seek to litigate; and (3) those patients face "some hindrance to . . . asserting their own rights." *Campbell v. Louisiana*, 523 U.S. 392, 397-98 (1998). The district court held otherwise in part because it determined that mental health and substance use disorder patients face "no hindrance to [their] ability to bring suit themselves." Slip op. 39 (JA 245). That determination fails to recognize that social stigma and the inherent incapacities associated with mental health and substance use disorders constitute a substantial and often insurmountable obstacle to patients' efforts to vindicate their own rights through litigation. These deterrent effects are supported by the scientific literature and have long been recognized by the courts. As a result, just as courts have recognized the third-party standing of non-psychiatric doctors to litigate on behalf of patients, courts also have recognized the standing of psychiatrists to do the same. *See Pennsylvania Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 291 (3d Cir. 2002).

Professional associations of psychiatrists like appellant NYSPA and *amicus* APA in turn have associational standing on the basis of the standing of their psychiatrist members because "(a) [their] members would otherwise have standing to sue in their own right; (b) the interests [they] seek[ ] to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt v. Washington State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977). The members of these associations themselves have third-party standing to bring the claims in this suit; those claims further the associations' aims of protecting the rights of the psychiatric profession and mental health and substance use disorder patients; and the declaratory and injunctive relief sought to remedy unlawful and generally applied policies of insurers would not require the participation of any individual association members.

Recognition of the associational standing of professional associations of psychiatrists is essential in the context of the Parity Act. The Act seeks to end discrimination by insurers against those who suffer from mental health and substance use disorders by prohibiting insurers from imposing disparate financial requirements and treatment limitations on these types of medical conditions. Psychiatrists and their professional organizations, as well as other mental health providers, often are best situated to pursue legal remedies to vindicate the rights

the Act was designed to protect. A failure to recognize the associational standing of professional associations of psychiatrists would therefore frustrate the purpose of the Act.

For these reasons, this Court should recognize that associations of professional psychiatrists like the NYSPA and the APA have associational standing to assert claims on behalf of their members' patients for violations of the Parity Act.

ARGUMENT

A. Stigma Obstructs Patients with Mental Health and Substance Use Disorders from Vindicating Their Legal Rights Through Litigation

The court below rejected the associational standing of the NYSPA to bring claims on behalf of its members' patients in part on the ground that "there is no hindrance to the primary victims' ability to bring suit themselves." Slip op. 39 (JA 245). That finding reflects a misunderstanding of the nature of mental health and substance use disorders. Furthermore, that misunderstanding threatens to undermine the rights of those suffering from such disorders by denying legal standing to those best positioned to litigate on their behalf – their doctors. Mental health and substance use disorder patients face significant and often insurmountable obstacles to vindicating their own rights through litigation. The social stigma associated with mental health and substance use disorders and the functional disabilities inherent in those disorders, long recognized by the courts and firmly established in the scientific literature, constitute precisely the sort of "genuine

obstacle[s] to [the] assertion" of "their own rights," *Singleton v. Wulff*, 428 U.S. 106, 116 (1976) (plurality opinion), that give rise to third-party standing. As explained in Part B, *infra*, the third-party standing of patients' physicians in turn forms a basis for the standing of professional associations of psychiatrists to bring those claims. *See Pennsylvania Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 291 (3d Cir. 2002) (holding that association of psychiatrists has standing to bring claims under the Employee Retirement Income Security Act of 1974 ("ERISA") on behalf of its members' patients).

1. The social stigma associated with mental health and substance use disorders creates a powerful impediment to patients asserting their legal claims in court. As the Supreme Court has explained, those with mental disabilities suffer from "prejudice from at least part of the public at large." *Board of Trustees of Univ. of Alabama v. Garrett*, 531 U.S. 356, 366 (2001) (internal quotation marks omitted); *see also id.* at 375 ("[P]ersons with mental or physical impairments are confronted with prejudice which can stem from indifference or insecurity as well as from malicious ill will.") (Kennedy, J., concurring). The scientific literature confirms this conclusion and documents its harmful consequences. The Surgeon General's report on mental health explained that "[s]tigmatization of people with mental disorders . . . is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance," and, "[i]n its most overt and egregious

form, stigma results in outright discrimination and abuse." U.S. Dep't of Health & Human Services, *Mental Health: A Report of the Surgeon General* 6 (1999), *available at* http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf; *see generally* Jennifer Crocker et al., *Social Stigma*, *in* 2 *The Handbook of Social Psychology* 504 (Daniel T. Gilbert et al. eds., 4th ed. 1998). Recent peer-reviewed studies demonstrate that "[p]ublic stigma of mental illness in the U.S. continues to be widespread." Angela M. Parcesepe & Leopoldo J. Cabassa, *Public Stigma of Mental Illness in the United States: A Systematic Literature Review*, 40 Admin. & Pol'y in Mental Health & Mental Health Servs. Res. 384, 397 (2013). Those with mental health and substance use disorders continue to face social stigma due to their condition and continue to suffer from the consequences of that bias.

This stigma manifests both in private interactions among individuals and in the "policies of private and governmental institutions." Patrick W. Corrigan et al., *Structural Levels of Mental Illness Stigma and Discrimination*, 30 Schizophrenia Bull. 481, 481 (2004). Insurers' discriminatory treatment of mental health/substance use benefits as compared with other medical benefits, as alleged here and in other similar cases, suggests that unlawful bias persists within the health care industry. Such discriminatory policies and attitudes are precisely what the Parity Act was designed to remedy. Moreover, those policies and attitudes demonstrate that the stigma against mental health and substance use disorders is

imbedded in the public and private institutions with which mental health and substance use disorder patients must interact in order to secure medically necessary treatment.

As a result, stigma often presents those suffering from mental health and substance use disorders an insurmountable obstacle to the vindication of their legal rights through litigation. The stigma of mental health disorders frequently deters those most in need from seeking the treatment they require. *See* Patrick Corrigan, *How Stigma Interferes With Mental Health Care*, 59 Am. Psychol. 614, 617 (2004). Stigma constitutes an even greater impediment to proceeding with complicated and adversarial litigation than it does to seeking treatment. Bringing suit risks public exposure and publicity. *See Singleton*, 428 U.S. at 117 (plurality opinion) ("the woman's assertion of her own rights [faces] several obstacles," including that "she may be chilled from such assertion by a desire to protect the very privacy of her decision from the publicity of a court suit"). This is especially true where, as is often the case, the patient's employer must be involved in the case as the group health insurance provider. Moreover, "[b]esides the stigmatization that may blunt mental health patients' incentive to pursue litigation, their impaired condition may prevent them from being able to assert their claims." *Green Spring*, 280 F.3d at 290*; cf. City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 442 (1985) ("[I]t is undeniable . . . that those who are mentally [disabled] have a reduced

ability to cope with and function in the everyday world."). This functional impairment both undermines mental health and substance use disorder patients' ability to navigate complicated health insurance schemes and impedes their ability to litigate to remedy violations of federal law.

In sum, the stigma associated with mental health and substance use disorders and the functional constraints inherent in certain such disorders constitute a "hindrance to the third party's ability to protect his or her [own] interests" sufficient to ground psychiatrists' third-party standing. *Powers v. Ohio*, 499 U.S. 400, 411 (1991) (citing *Singleton*, 428 U.S. at 115-16 (plurality opinion)).

2. The district court suggested that the mere fact that the complaint in this case "raises claims by several patients to enforce their own rights under ERISA" indicates that "there is no hindrance to the primary victims' ability to bring suit themselves." Slip op. 39 (JA 245). This reasoning is flawed for two reasons. *First*, three of those four named plaintiffs are parents of unnamed, beneficiary children. *See id.* at 7-10, 33 (JA 213-16, 239). The anonymity afforded to these juvenile "primary victims" through their parents' litigation on their behalf serves as partial protection from the stigma that mental health and substance use disorder patients would typically risk in litigation. Because many mental health and substance use disorder patients are adults, however, this provides no solution

for the millions of adult Americans who suffer from mental health and substance use disorders.

Second, the fact that a single named plaintiff is an adult mental health patient who brought suit on his own behalf cannot disturb the conclusion, based on scientific evidence, that mental health and substance use disorder patients face stigma that impedes their ability to seek treatment and to litigate a case in open court. The existence of a single litigant who is able to overcome the "genuine obstacle," *Singleton*, 428 U.S. at 116 (plurality opinion), of stigma against mental health and substance use disorders does not disprove the existence of that obstacle. *See*, *e.g.*, *Hodgson v. Minnesota*, 497 U.S. 417, 429 (1990) (simultaneously recognizing standing of six women seeking abortions, the mother of a minor child seeking an abortion, two doctors who perform abortions, and four clinics providing abortion services). Accordingly, this Court should reject the district court's contrary reasoning.

B. Professional Associations of Psychiatrists Have Associational Standing To Assert the Claims of Their Members' Patients

Professional associations of psychiatrists dedicated to advocating for the interests of the psychiatric profession and to protecting the rights of mental health and substance use disorder patients, like appellant NYSPA and *amicus* APA, have associational standing to assert claims on behalf of their members' patients for declaratory and injunctive relief. An association has standing to litigate claims

on behalf of its members when: "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt v. Washington State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977). Professional associations of psychiatrists like appellant NYSPA and *amicus* APA satisfy each of these elements.

First, the members of these professional associations themselves have standing to assert claims like those asserted in this case. For a litigant to assert the rights of a third party, the litigant must show that: (1) he suffered injury himself; (2) he stands in a "'close relationship'" with the third party; and (3) the third party faces "some hindrance to . . . asserting [its] own rights." *Campbell v. Louisiana*, 523 U.S. 392, 397 (1998) (quoting *Powers*, 499 U.S. at 411). Psychiatrists themselves suffer a cognizable injury where, as here and in similar cases, unlawful conduct reduces the reimbursement rates a health insurance company sets for psychiatric services or prevents their patients from receiving treatment. *See Singleton*, 428 U.S. at 112-13 ("there is no doubt . . . that the respondent-physicians suffer concrete injury from the operation of the challenged statute" because "[i]f the physicians prevail in their suit . . . they will benefit, for they will then receive

payment for" procedures they perform).[3] Moreover, psychiatrists stand in a close relationship with their patients that grounds their assertion of those patients' rights. As the Third Circuit has explained, "[p]sychiatrists clearly have the kind of relationship with their patients which lends itself to advancing claims on their behalf. This intimate relationship and the resulting mental health treatment ensures psychiatrists can effectively assert their patients' rights." *Green Spring*, 280 F.3d at 289; *see Jaffee v. Redmond*, 518 U.S. 1, 10 (1996) ("Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.");[4]

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[3] Contrary to the district court's holding, *see* slip op. 39 (JA 245), professional organizations of psychiatrists also may satisfy the first *Hunt* factor when their members receive proper assignments of claims from those members' patients. The district court misread *Hunt*'s requirement that an association's members have standing "in their own right" to preclude associational standing predicated on such assignments. That phrase simply means that at least one of the association's members must have constitutional standing *himself or herself*. *See Alliance for Open Soc'y Int'l, Inc. v. United States Agency for Int'l Dev.*, 651 F.3d 218, 228 (2d Cir. 2011) (a plaintiff "establish[es] associational standing by demonstrating that . . . at least one of the association's members would otherwise have standing to sue in its own right – i.e., has constitutional standing"), *aff'd*, 133 S.Ct. 2321 (2013). This requirement may be satisfied either by third-party standing, *see Green Spring*, 280 F.3d at 293, or by an assignment of claims, *see Sprint Communications Co. v. APCC Servs., Inc.*, 554 U.S. 269, 285 (2008).

[4] In addition to psychiatrists, similar arguments support the third-party standing of other mental health care providers. *Cf. Jaffee*, 518 U.S. at 17 (holding that evidentiary privilege of psychiatrists extends to social workers in the course of psychotherapy on ground that "[d]rawing a distinction between the counseling provided by costly psychotherapists and the counseling provided by more readily accessible social workers serves no discernible public purpose") (internal quotation marks omitted; alteration in original).

see also Singleton, 428 U.S. at 117-18 (plurality opinion) (finding requisite close relationship and therefore third-party standing for doctors on behalf of their patients); *Caplin & Drysdale, Chartered v. United States*, 491 U.S. 617, 623 n.3 (1989) (same for lawyers on behalf of their clients); *Secretary of State v. Joseph H. Munson Co.*, 467 U.S. 947, 954-55 (1984) (same for political fundraisers on behalf of their donors); *Craig v. Boren*, 429 U.S. 190, 193-95 (1976) (same for beer vendors on behalf of their customers). And, as explained above, the social stigma of mental health and substance use disorders and the incapacities inherent in those disorders present frequently insurmountable obstacles to patients seeking to assert their own rights. *See* Part A, *supra.*

Second, professional associations of psychiatrists satisfy the second *Hunt* factor because the relief that this suit and other suits like it seek – that is, enjoining insurers' unlawful discrimination against mental health and substance use disorder patients in their health insurance coverage – directly implicates the purpose of these professional organizations: to protect the rights and interests of mental health professionals and their patients. *See Building & Constr. Trades Council of Buffalo v. Downtown Dev., Inc.*, 448 F.3d 138, 149 (2d Cir. 2006) ("The proper inquiry at the pleading stage is thus a limited one: A court must determine whether an association's lawsuit would, if successful, reasonably tend to further the general interests that individual members sought to vindicate in joining the association and

whether the lawsuit bears a reasonable connection to the association's knowledge and experience."). The interests that this suit and others like it seek to vindicate are "germane to the . . . purpose," *Hunt*, 432 U.S. at 343, of professional organizations of psychiatrists like appellant NYSPA and *amicus* APA.

Third, neither the claims asserted nor the relief requested here by the NYSPA or by other associations in similar suits would require the individual participation of members. The central allegation in many such lawsuits is that a defendant's policies regarding mental health and substance use disorder benefits, set at a corporate level and applied across its health insurance plans, violate the Parity Act. Suits for declaratory and injunctive relief seeking to remedy unlawful corporate or other institutional policies do not require the participation of an association's members and therefore associational standing is proper in such cases. *See Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 184-85 (2000) (holding that association had standing in suit alleging that company violated federal Clean Water Act of 1977); *Hunt*, 432 U.S. at 343-44 (holding that association had standing to challenge constitutionality of state statute); *Building & Constr. Trades Council*, 448 F.3d at 144-45 (holding that association had standing in suit alleging that companies violated federal environmental statute). Establishing claims under the Parity Act on the merits would not require the participation of the individual members of a professional association of psychiatrists like appellant NYSPA and

amicus APA where the unlawful policies apply across the insurer's health plans and thus no individualized proof from individual psychiatrists is necessary.

Moreover, like other professional associations of psychiatrists in other similar cases, the NYSPA seeks only declaratory and injunctive relief. As the Supreme Court explained in *Hunt*, "'[i]f in a proper case the association seeks a declaration, injunction, or some other form of prospective relief, it can reasonably be supposed that the remedy, if granted, will inure to the benefit of those members of the association actually injured.'" 432 U.S. at 343 (quoting *Warth v. Seldin*, 422 U.S. 490, 515 (1975)); *see Alliance for Open Soc'y Int'l*, 651 F.3d at 229 ("[T]he 'relief requested' component of the third *Hunt* prong has been satisfied because the Associations seek an injunction barring enforcement of the Policy Requirement, which will not necessitate the participation of individual members in the lawsuit.") (citation omitted). The relief sought by the NYSPA here and by other professional associations of psychiatrists in similar cases – that a health insurer cease its unlawful discrimination against mental health and substance use disorder patients and benefits – will not require the participation of their members.[5]

[5] The district court also suggested that establishing associational standing of the NYSPA would require the individual participation of its members because "the members would need to establish each patient's valid assignment in order to have standing." Slip op. 40 (JA 246). This conclusion is incorrect for three reasons. *First*, as explained above, the associational standing of professional associations of psychiatrists may be grounded in the third-party standing of psychiatrists to bring claims on behalf of their patients. *Second*, *Hunt* requires only that a single member

In comparable situations, courts have found that other professional organizations of psychiatrists and other physicians satisfy the test for associational standing. *See Green Spring*, 280 F.3d at 293 ("So long as the association's members have or will suffer sufficient injury to merit standing and their members possess standing to represent the interests of third-parties, then [psychiatric] associations can advance the third-party claims of their members without suffering injuries themselves."); *see also New York State Nat'l Org. for Women*, 886 F.2d at 1348 n.3 (finding associational standing for organizations, including organization of physicians, to assert rights on behalf of those physicians' patients). This Court should accordingly reverse that aspect of the district court's judgment.

C. Recognition of the Standing of Psychiatrists and Their Professional Organizations Is Essential to the Effective Enforcement of the Parity Act

The standing of professional organizations of psychiatrists to bring claims on behalf of their members' patients is particularly important in the context of the

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of an association have standing. *See United Food & Commercial Workers Union Local 751 v. Brown Group, Inc.*, 517 U.S. 544, 555 (1996) (explaining that *Hunt* requires only that "an organization suing as representative to include at least one member with standing"); *Alliance for Open Soc'y Int'l*, 651 F.3d at 228 (same). As a result, establishing associational standing on the basis of an assignment would require the participation of only one member. Such limited participation is no bar to associational standing. *See Warth*, 422 U.S. at 511; *New York State Nat'l Org. for Women v. Terry*, 886 F.2d 1339, 1349 (2d Cir. 1989). *Third*, even if the law required that more than one member of an association have individual standing in order for the association to have standing, many assignments by patients to their psychiatrists are standard forms and so individualized inquiry would be unnecessary.

Parity Act. Congress enacted the Parity Act to end discrimination in health care coverage against those with mental health and substance use disorders. *See Coalition for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010) (Parity Act is "designed to end discrimination in the provision of coverage for mental health and substance use disorders as compared to medical and surgical conditions"). Due to the social stigma and the inherent incapacities associated with these disorders, as detailed above, patients themselves often will be unable or unwilling to litigate to secure the rights the Act was designed to protect. Moreover, the substantive requirements of the Parity Act impose system-wide obligations on insurers, and as a result violations of the Act may be hidden from the patients while evident to their psychiatrists. A failure to recognize the standing of professional associations of psychiatrists to bring such claims would undermine effective enforcement of the Act.

The passage of the Parity Act followed more than a decade of advocacy on behalf of mental health and substance use disorder patients highlighting the inadequacy of the Act's predecessor statute. In the spring of 1996, a bill was introduced in the Senate that proposed a comprehensive mental health parity bill that would have required full parity between mental health and medical/surgical benefits. *See* Health Insurance Reform Act of 1996, S. 1698, 104th Cong. § 305 (1996). Debates over the potential cost of parity resulted in passage of the Mental

Health Parity Act of 1996, Pub. L. No. 104-204, Tit. VII, 110 Stat. 2874, 2944 ("1996 Act"), a watered-down version of the original proposed bill. The 1996 Act prohibited health insurance plans from imposing annual and lifetime limits for mental health benefits that were not comparable to corresponding limits on medical/surgical benefits. However, the law that Congress ultimately enacted in 1996 contained exceptions and restrictions limiting its scope, no provision mandating access to out-of-network mental health benefits, and no protections for substance use disorder benefits. *See* Aviv Shamash, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. Health & Biomedical L. 273, 280-82 (2011), *available at* http://suffolk.edu/documents/Law%20Journal%20of%20H%20and%20B/d_Shamash_273-324.pdf.

Insurers took advantage of these loopholes and found alternative strategies to discriminate against mental health patients that violated the principle of parity but did not violate the terms of the 1996 Act. These strategies included covering lower percentages of mental health costs than medical and surgical costs; imposing higher coinsurance rates on mental health benefits; and restricting the number of outpatient visits and inpatient hospital days for mental health patients but not for medical/surgical patients. Eighty-seven percent of plans reported imposing some restrictions on mental health coverage that were not imposed on medical/surgical benefits. *See* U.S. Gen. Accounting Office, *Mental Health Parity Act: Despite*

New Federal Standards, Mental Health Benefits Remain Limited 5 (May 2000), *available at* http://www.gao.gov/assets/240/230309.pdf. As a result, mental health patients were forced either to pay higher health care costs or to forgo treatment altogether. *See id*. As Representative Barbara Lee explained, under the 1996 Act, "companies [could] limit both the number of visits that a person makes to a mental health professional in a year and the network of doctors a patient can see, even when no such limit exists for medical or surgical benefits. That is ridiculous." 154 Cong. Rec. E1915 (daily ed. Sept. 25, 2008).

The Parity Act, through its anti-discrimination provisions, closed many of the loopholes left open under the 1996 Act. The Parity Act is first and foremost an anti-discrimination statute. It represents a major step forward in ending discrimination against those with mental health and substance use disorders by eliminating differences in insurance coverage between mental health/substance use disorders and medical/surgical conditions, reflecting the recognition that mental illnesses and substance use disorders are just as serious and requiring of treatment as medical conditions such as heart disease and cancer.

The legislative history of the Parity Act confirms its manifest purpose. As Representative Patrick Kennedy explained in support of the passage of the Parity Act, "[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with

mental disorders have suffered discriminatory treatment at all levels of society." 153 Cong. Rec. S1864 (daily ed. Feb. 12, 2007). Representative James Ramstad elaborated that "[i]t's time to end the discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory barriers on treatment." 154 Cong. Rec. H8619 (daily ed. Sept 23, 2008). Representative Bill Pascrell called mental health parity "a civil rights issue. Parity removes the discrimination against a population that has been discriminated against and stigmatized. This is a humanitarian issue. Without parity, we allow those with illnesses to continue to suffer." *Id*. at H8622.

In light of the serious obstacles that mental health and substance use disorder patients face in bringing litigation on their own behalf, *see* Part A, *supra*, the principles of parity and anti-discrimination that Congress embodied in the Parity Act would go unrealized if courts denied standing to professional organizations of psychiatrists. The recognition of that standing is therefore crucial to enforcing the Act's requirements and effectuating Congress's aims.

The Parity Act's substantive provisions support the conclusion that psychiatrists are those best positioned to litigate to enforce their requirements. The Act requires that, when a health plan or health insurance coverage "provides both medical and surgical benefits and mental health or substance use disorder benefits," two separate non-discrimination requirements apply:

> (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.

29 U.S.C. § 1185a(a)(3)(A) (emphases added).

The Departments of Labor, Treasury, and Health and Human Services issued detailed regulations implementing the broad mandates of the Parity Act. *See* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 146 (eff. Apr. 5, 2010)) (the "Regulations").[6] The Final Rules provide that "standards for provider admission to participate in a network, including reimbursement rates," and "plan methods for

[6] On November 13, 2013, the Departments issued Final Rules implementing the Parity Act. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240 (Nov. 13, 2013) ("Final Rules"). These Final Rules reflect only minor changes and "clarifications" to the Interim Final Rules, none of which is relevant here. *See id.* at 68,242 ("In general, these final regulations incorporate clarifications issued by the Departments through [frequently asked questions] since the issuance of the interim final regulations, and provide new clarifications on issues such as [nonquantitative treatment limitations] and the increased cost exemption.").

determining usual, customary, and reasonable charges" are "treatment limitations" subject to the non-discrimination requirements of the Parity Act. 78 Fed. Reg. at 68,245. The statute thus prohibits, for example, the use of methodologies for calculating reimbursement rates for mental health and substance use disorder treatment that are not comparable to, or are applied more stringently than, the methodology used to calculate reimbursement rates for medical and surgical treatment. The purpose of this requirement is to ensure that mental health and substance use disorder patients have access to adequate networks of mental health service providers: when the law allowed it, insurers set reimbursement rates for psychiatrists at levels so low that mental health providers could not afford to stay in insurers' networks.

With respect to treatment limitations, including the methodologies for determining reimbursement rates, the Regulations thus provide:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder 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.

29 C.F.R. § 2590.712(c)(4)(i). Accordingly, the Regulations "require that [the] factors [used in determining reimbursement rates] be applied comparably to and no

more stringently than those applied with respect to medical/surgical services." Final Rules, 78 Fed. Reg. at 68,246; *see id.* at 68,283; *see also* 29 C.F.R. § 2590.712(a).

Violations of these core substantive requirements imposed by the Parity Act and articulated in its implementing regulations are unlikely to be apparent to mental health and substance use disorder patients. Patients' experience is typically limited to a single psychiatrist or other mental health provider and typically would provide no insight into "methodologies" that an insurer uses in calculating the reimbursement rates that it sets for that provider or the "standards" that it establishes for admission of that provider to its network. Moreover, the functional incapacities from which certain mental health and substance use disorder patients suffer would further hinder their ability to investigate their insurer's methodologies. By contrast, psychiatrists and other mental health providers are more likely to have insight into the operation and application of insurers' policies and practices across their patient population and bring to bear years of experience in the health care field that informs their understanding of those policies and practices. As a result, psychiatrists and other mental health providers are better positioned to recognize whether an insurer is violating the Act's substantive requirements. Professional associations of psychiatrists are especially well-positioned to discover violations through the experiences of their many members,

which facilitates comparisons that the substantive obligations imposed by the Act may require.

CONCLUSION

Judicial recognition of the standing of psychiatrists and their professional associations to bring claims on behalf of patients is of surpassing importance to the implementation of the Parity Act and to the realization of non-discrimination and fairness embodied in the requirements of the Act. Accordingly, this Court should reverse the district court's determination that the NYSPA lacked associational standing.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

I hereby certify that this brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(d) and 32(a)(7)(B) because:

1. This brief contains 5,822 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii); and

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in 14 point Times New Roman.

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