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Spotlight on Litigation: Wilderness Therapy Programs

Once considered an extreme therapeutic option, “wilderness therapy” programs are becoming more commonly recommended to treat a variety of mental and substance abuse issues. Coverage under employer group health plans, however, has not caught up with the trend, and the issue has been increasingly litigated. Employer-sponsored plans have generally excluded or limited coverage for this type of therapy, which involves a residential element as well as outdoor adventure therapy. Several federal district courts recently allowed plaintiffs to move forward with their claims for coverage. Employer group health plans should be aware of this trend and consider associated risks with any limitations imposed on coverage for these programs.

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Background

Generally, wilderness therapy is a form of residential mental and behavioral health treatment involving therapy provided in a non-traditional outdoor or natural setting. Over the past decade, it has become an increasingly popular treatment option for adolescents with physical health challenges such as traumatic brain injury, mental and behavioral health conditions and/or substance use disorders. Wilderness therapy programs generally combine traditional therapy methods with outdoor activities. Programs often last several weeks and costs typically include a hefty enrollment fee of approximately \$1,500 - \$3,000, plus daily fees that average over \$500.

“Wilderness programs” generally tend to fall into three categories — wilderness adventure camps (e.g., summer camp), wilderness expeditions/courses (e.g., those that focus on teaching coping skills “for struggling teens and young adults”) and wilderness therapy programs. Wilderness camp and expedition programs offer experiential learning and personal growth opportunities through outdoor and adventure-based curricula, which may ultimately have some therapeutic results. However, these types of programs typically do not deliver mental/behavioral health treatment provided by a medical professional and would not qualify under the Internal Revenue Code as medical expenses — and,

therefore, could not be covered by an employer group health plan that is subject to the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). On the other hand, many wilderness *therapy* programs meet state law criteria and involve licensed medical experts providing mental/behavioral health services. Staffing for many wilderness therapy programs (including those that are the subjects of some of the recent litigation discussed below) include multidisciplinary teams, including psychologists, psychiatrists, pediatricians, and licensed therapists (i.e., licensed mental health professionals) who are consistently involved in the care of the participant.

Employer-sponsored health plans have generally excluded or limited coverage for these programs. In recent years, however, there has been an uptick in employee demand for coverage of wilderness therapy — followed by a wave of lawsuits alleging that failure to cover it violates ERISA and/or the MHPAEA.

Statutory and regulatory guidance

ERISA requires a fiduciary to follow the terms of the plan and allows participants and beneficiaries to sue to recover benefits due under those terms.

MHPAEA generally prohibits group health plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable conditions or more stringent limits on those benefits than they do on the same classification of medical and surgical benefits. It requires parity in (1) financial requirements (like deductibles or copayments) and quantitative treatment limitations (like number of covered visits) and (2) nonquantitative treatment limitations (NQTLs) — meaning, non-numerical limits on the scope or duration of benefits, for example a pre-authorization requirement or a medical management technique. (See our [January 14, 2014 For Your Information.](#))

The Departments of Labor, Treasury, and Health & Human Services issued guidance last year focusing on NQTLs, providing specific examples of parity standards in the context of experimental or investigative treatment limitations and provider networks. They also revised a disclosure template to help participants and beneficiaries request information on limitations that may affect their MH/SUD benefits, as well as a self-compliance tool that plans can use to review coverage terms and policies and to monitor those of plan vendors. (See our [May 14, 2018 For Your Information.](#))

Compliance considerations

Plans that do not cover or limit coverage for wilderness therapy programs may be subject to lawsuits under ERISA and/or MHPAEA. Given the uptick in wilderness therapy-related litigation (described below), plan sponsors may want to consider how their plans approach this coverage and assess the risk associated with coverage exclusions or limitations.

Assessing Risk

For self-funded plans that exclude or limit coverage for wilderness therapy, the concern is the possibility of being sued under ERISA and/or MHPAEA. For insured plans, courts continuing to assess liability against insurers for failing to cover wilderness therapy means that carriers may adjust their standard coverage offering — and associated plan sponsor costs — in response.

Plan language addressing wilderness therapy programs varies greatly, with some plans not explicitly referencing this treatment at all. While litigation is developing, court rulings to date offer some insight on how different types of plan designs may fare concerning wilderness therapy coverage. Blanket exclusions for wilderness therapy may be problematic, for example, because it can be difficult to identify analogous medical/surgical services for purposes of a MHPAEA analysis. The difficulty in this analysis has led two courts to allow MHPAEA claims involving blanket coverage exclusions to move forward — though another court opted to dismiss the claim precisely because the plaintiff did not proffer an analogous service. Courts have also allowed claims to proceed where plan terms demanded that the treatment be medically necessary to treat an illness and plaintiffs' allegations met those standards.

In at least one case, the plan had a blanket exclusion for wilderness therapy, but plan language permitted coverage for intermediate residential programs to treat mental illnesses. The plan rejected a claim for a wilderness therapy program which it admitted was a form of intermediate-level care. Not reaching a conclusion on parity, the court commented that excluding mental health treatment merely because it occurs outdoors appears to place a limitation on mental health that does not apply to medical/surgical treatments. On the other hand, courts have dismissed lawsuits where the plan language excluded treatments taking place in camp or ranch settings or without specific types of on-site providers, and the plaintiffs could not sufficiently distinguish the substance of their programs from these exclusions.

Buck comment. Plan documents may have exclusions that lump camp-like and wilderness therapy programs into the same category. It's important for plan sponsors to understand the differences and it may be necessary for a plan to distinguish these different types of programs, or more specifically and consistently define permissible versus impermissible coverage. Imprecise or vague wording can lead to ambiguity and a conflict amongst the terms of the plan, leaving an employer or group health plan open to litigation risk.

In thinking about potential risks and lessons learned so far from the case law, plan sponsors may want to consider:

- Whether the plan documents explicitly address coverage – or exclusions/limitations on coverage — for wilderness therapy programs (using that term or a term like adventure therapy, wilderness camp, or ranch therapy)
- Whether plan documents clearly define what the term entails for purposes of coverage, coverage limitations, or exclusions
- Where a plan excludes or limits coverage for these programs, how the plan would explain the rationale for the exclusion/limit
- Where a plan does not explicitly reference this treatment, how the plan would treat a claim for this service. For example, where a plan covers intermediate-level care to treat mental health conditions, would a wilderness therapy program (that meets the criteria of intermediate-level care)

be considered an in-patient residential treatment facility? Would it be excluded from coverage because there is no plan language specifically covering it?

The DOL's self-compliance tool and draft NQTL disclosure form may provide a helpful framework for assessing how any restrictions or exclusions square up with parity rules — though, as noted above, it can be difficult to identify services on the medical/surgical side that are analogous to wilderness therapy programs. Reviewing these issues may help plan sponsors weigh any risks involved with current coverage and think about possible changes to future coverage. Plans may want to think about working with trusted advisors to consider any financial and clinical impact of wilderness therapy-related coverage on the plan.

Relevant case law

Coverage for wilderness therapy programs in employer-sponsored plans has become an increasingly litigated issue — sometimes, but not always, in the form of a class action lawsuit. These cases typically involve the denial of an employee's claim for coverage of wilderness therapy program fees on behalf of the employee's adolescent child who has been diagnosed with a mental health condition and/or substance use disorder, and the case law is still developing — currently with mixed results. The cases described below are currently pending unless otherwise noted.

The following federal district court rulings have allowed plaintiffs to move forward with some or all their wilderness therapy-related claims.

- *Michael D. v. Anthem Health Plans of Ky., Inc.* (D. Utah 2019): Court found that denial of coverage for wilderness therapy program was arbitrary and plan's exclusion for "wilderness camps" was ambiguous/not clearly defined; suggested that a blanket exclusion for wilderness therapy programs may violate MHPAEA because it effectively imposed a limit on mental health treatment that did not also apply to medical/surgical treatments.
- *A.Z. v. Regence BlueShield* (W.D. Wash. 2018): With the allegation of a depression diagnosis, court refused to dismiss a claim for wilderness therapy benefits where the plan's exclusion for such coverage applied only "in the absence of illness."; found that the plan's definition of residential care for mental health conditions was not limited to a "brick and mortar" structure; settled in January 2019 for an undisclosed amount.
- *Vorpahl v. Harvard Pilgrim Health Insurance Co.*, (D. Mass. 2018): Allowed claim for wilderness therapy benefits to proceed despite a plan exclusion for "health resorts, recreational programs, camps, wilderness programs, outdoor skill programs, relaxation or lifestyle programs, and services provided in connection with these programs"; court found it was not clear at the preliminary stage of litigation how a categorical (blanket) wilderness therapy exclusion would apply to medical/surgical benefits for purposes of MHPAEA analysis; settled in December 2018 for an undisclosed amount.
- *A.H. v. Microsoft Corp. Welfare Plan* (W.D. Wash. 2018): Plan excluded coverage for educational or recreational programs such as wilderness programs, but covered medically necessary

treatments received in these settings if furnished by an eligible provider; court dismissed the MHPAEA claim on the basis that the exclusion applied generally and not only to mental health treatment, but nevertheless found that plaintiff had sufficiently alleged under ERISA that the wilderness therapy provider was an eligible provider of a medically necessary treatment; dismissed in December 2018 pending a settlement agreement.

- *Buchanan v. Magellan Health, Inc.* (E.D. Mo. 2018): Court dismissed claims against the employer since it did not administer the plan but allowed the lawsuit to proceed against the plan's third-party administrator that determined that wilderness programs were not covered as behavioral services under the plan and denied a request for post-service authorization.

Other courts have recently dismissed plaintiffs' wilderness therapy coverage claims.

- *Alice F. v. Health Care Serv. Corp* (N.D. Ill. 2017): Court determined that wilderness therapy program did not meet the plan's definition for covered residential treatment services, and that this definition did not violate MHPAEA where the plan also excludes coverage for medical/surgical services that are "primarily supportive in nature."
- *A.G. v. Community Insurance Company, d/b/a/ Anthem Blue Cross and Blue Shield* (S.D. Ohio 2018): Court determined that the plan "equally covers mental health services and medical/surgical services at residential treatment centers," and that blanket exclusion of services as "wilderness camps" does not violate MHPAEA; website for the wilderness therapy program at issue referred to the program as a "camp."
- *H.H. v. Aetna Life Insurance Co.* (S.D. Fla. 2018): Plan definition of covered "residential treatment facility" required admission by a physician and a licensed behavioral health provider on site at all times — neither of which the wilderness therapy program provided; plaintiffs failed to allege facts to support claim that the carrier uses different processes, strategies, and evidentiary standards to assess medically necessary services for MH/SUD conditions at residential treatment center programs, on the one hand, and medical/surgical conditions at skilled nursing facilities, on the other; case closed in January 2019.
- *Meyers v. Kaiser Found. Health Plan Inc.* (N.D. Ca. 2017): Where the plan allowed for service area exceptions only in certain circumstances, including for "emergency services," court held that a wilderness treatment program did not constitute an emergency service.
- *Cotten v. Blue Cross and Blue Shield of Massachusetts* (D. Mass. 2016): Court dismissed claim for wilderness therapy program coverage based on the plan's "unambiguous exclusionary language" for coverage of "wilderness," "camp," or "ranch" programs.
- *Roy C. v. Aetna Life Insurance Co.* (D. Utah 2017): Plan excluded coverage for wilderness treatment programs whether or not they are part of a licensed residential treatment facility or otherwise licensed institution, and the court determined that the plaintiff failed to identify a medical/surgical comparison or analog for purposes of a MHPAEA analysis; notice of settlement filed in the district court.

- Welp v. Cigna Health and Life Ins. Co. (S.D. Fla. 2017): Court found that criteria for denying coverage — including the wilderness therapy program’s lack of multidisciplinary team or consistent supervision of professionals — were legitimate given plan’s exclusion for mental health services rendered in a wilderness therapy program; case closed in March 2018.

There are several other lawsuits currently pending in district courts nationwide that involve denied claims for wilderness therapy programs with respect to which the court has not yet issued a decision on the merits.

Conclusion

Employer-sponsored group health plan coverage for wilderness therapy is a complex and evolving compliance area. Plan sponsors should be attuned to this ongoing litigation and any plan exclusions for or limitations placed on coverage for mental health services provided through a wilderness program — with an eye toward legal risk. Now is the time to examine plan terms and language in light of mental health services and wilderness therapy coverage. Adjusting terminology or definitions may not be enough; it is important to look at the plan’s language as a whole to ensure that any limitations are clear, unambiguous, and comply with ERISA and MHPAEA requirements.

DOL Enforcement

In addition to litigation brought by participants and beneficiaries, it is possible that plans may face DOL enforcement actions relating to coverage for wilderness therapy programs. In 2018, DOL identified MHPAEA enforcement as an agency priority.

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