The Legal Landscape

ATAC Annual Meeting 2026

Tue Jan 20, 2026, 8:00 AM - 5:00 PM PST

Marriott Long Beach Airport
4700 Airport Plaza Drive Long Beach, CA 90815

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Introduction: Framing the Issue

The SUD, Opioid, and MH Crises

- 110,000+ U.S. overdose deaths in 2022
- Rising anxiety and concern about Fentanyl and other synthetics
- COVID isolation, social media algorithms, and world events
- Access to treatment and meaningful coverage are essential

Systemic Insurer Practices

- Ghost networks, restrictive criteria, prior authorizations
- AI-driven denials, cost-containment, recoupment
- Profits prioritized over patient care

Patient & Provider Perspective

- **Patients:** Limited access, wrongful denials, relapse risk
- **Providers:** Unfair pay, red tape, audits, financial strain

Litigation as a Tool

- Precision, advocacy, and persistence are key
- Engage regulators, officials, nonprofits, and media
- Insurers have deep resources — counsel must be prepared

Trilogy of Governing Federal Laws

1

Mental Health Parity and Addiction Equity Act (MHPAEA, 2008)

- Prohibits discrimination between MH/SUD and medical coverage
- **Quantitative limits ("QTLs"):** Visits, copays
- **Non-quantitative limits ("NQTLs"):** Utilization review, medical necessity

2

Affordable Care Act (ACA, 2010)

- Parity compliance required in all qualified health plans
- Essential Health Benefits (EHBs) include MH, SUD, and lab services

3

Employee Retirement Income Security Act (ERISA, 1974)

- Majority of private health plans
- **Key provisions:** § 502(a)(1)(B), § 502(a)(3), § 502(c)(1)
- **Standard of review:** De novo vs. abuse of discretion
- **Issues:** Administrative record, financial conflicts, procedural irregularities, anti-assignment, exhaustion, preemption

State Law Claims

- **Breach of Contract** (Written and Oral
  - Primarily but not exclusively asserted for breach of non-ERISA health plans
  - Prior authorization and verification of benefits calls with insurer may create a contract.
- **Promissory Estoppel** (Implied Contract)
  - A provider who admits a patient in reliance on an insurer's statements regarding payment
- **Quantum Meruit** (Equity)
  - The services provided were beneficial to the insurer (i.e., its plan member received covered services)
  - The services should be reimbursed at a reasonable and customary rate
- **Unfair Competition Laws**
  - Injunctive relief to discontinue institutional practices
- **Consumer Protection Statutes**
  - Potential for attorney fees

DOL Says Mental Health Parity Law Compliance Still Lacking

- DOL, Treasury, and HHS report **widespread ongoing noncompliance** with the Mental Health Parity and Addiction Equity Act ("MHPAEA")
- Primary issue: health plans **cannot adequately demonstrate parity**, particularly for **nonquantitative treatment limits ("NQTLs")**
- Enforcement since 2021 has produced results:
  - Prohibited limitations removed for **7.6 million participants**
  - Affecting **72,000+ health plans**
- Agencies signal **continued scrutiny and heightened expectations**, not a pause in enforcement

Key takeaway: Parity enforcement has matured from theory to practice—and regulators are not satisfied with paper compliance.

Core Compliance Failures

- **Deficient NQTL analyses**
  - General justifications (industry practice, provider shortages)
  - Lack of comparable processes, standards, or evidentiary support

- **Access and network disparities**
  - Fewer mental health providers than medical/surgical providers
  - Outdated or inaccurate mental health directories

- **Unequal reimbursement and exclusions**
  - Lower payment rates for mental health services
  - Exclusion of key mental health or substance use disorder treatments

*Regulatory message: Unsupported rationales and legacy practices **do not satisfy MHPAEA**.*

Enforcement & What's Next

Increasing Scrutiny Despite Limited Resources

- Recent EBSA activity (Aug. 2022–July 2023):
  - Requests, insufficiency letters, and initial violation determinations
  - Most issues corrected only **after regulator intervention**

- **September 2024 final rule**
  - Raises the bar for comparative analyses
  - Shifts focus toward **data and real-world outcomes**

- Enforcement risk remains high, even as EBSA warns:
  - One investigator per ~13,900 plans
  - **Parity enforcement funding officially expired Sept. 30, 2025**

*Bottom line: Expect **more prescriptive standards, continued investigations, and growing litigation risk** — especially around NQTLs and network adequacy.*

MultiPlan MDL

MultiPlan’s sole function is to pay providers less than what they’re owed

MultiPlan’s revenue is based on the difference between a provider’s billed amount and the insurer's payment amount

MultiPlan Implement its Price-Fixing Scheme?

10 of Top 10 Payer Customers

United Healthcare · aetna · Anthem · Humana · HCSC Health Care Service Corporation · CENTENE Corporation · Cigna · KAISER PERMANENTE · WellCare · MOLINA HEALTHCARE

MultiPlan has agreements to reprice the out-of-network claims of the 15 largest commercial health insurance companies in the United States.

MultiPlan reprices 81.5% of out-of-network claims submitted in the United States through its proprietary pricing algorithms.

MultiPlan generates approximately $19 billion in underpayments (compared to billed charges) for out-of-network claims on an annual basis.

The Consequences of MultiPlan's Price-Fixing Practices

The **anticompetitive results** of MultiPlan Pricing:

- MultiPlan and insurers receive a windfall of billions in annual profits
- Healthcare providers are forced to accept reimbursement rates that equal pennies on the dollar of actual costs incurred
- Healthcare plan administrative fees skyrocket and health insurers simply increase premiums

In sum: healthcare providers receive less, patients pay more, and MultiPlan and the health insurers take home billions in "administration fees"

DOJ Statement of Interest

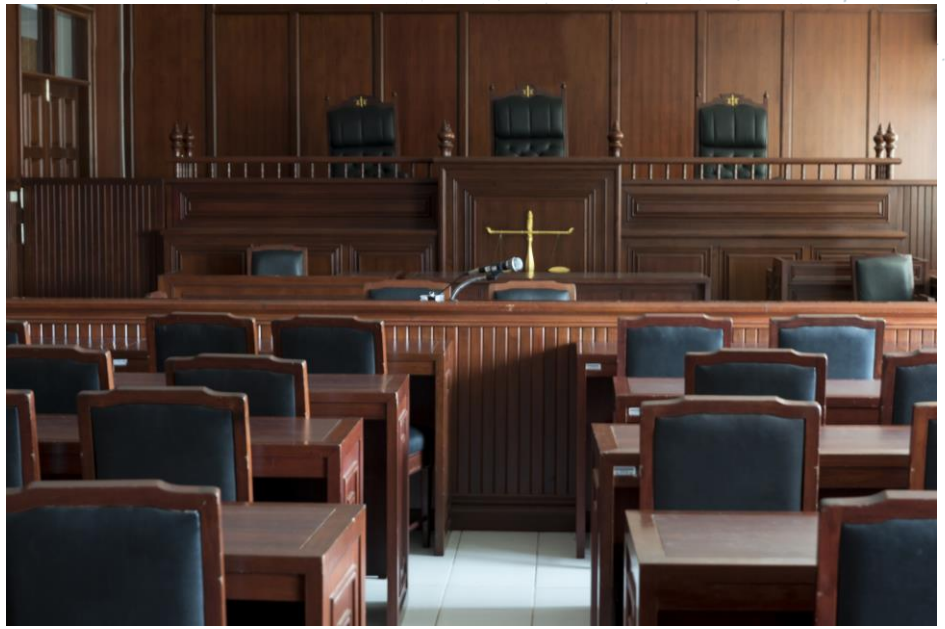
- This past March, the DOJ Antitrust Division filed a **Statement of Interest** in support of the providers:
  - Using a **pricing algorithm to set benchmark** pricing may violate the Sherman Act
  - **Exchanging competitively sensitive information** through an intermediary like MultiPlan may violate the Sherman Act
- DOJ Antitrust Division has only filed a Statement of Interest an average of **7 times per year for the last 5 years**

Order Denying Motion to Dismiss

- In June, the **Court denied MultiPlan and the health insurers' motion to dismiss**
  - Defendants tried to argue that there was no fixable price for out-of-network services; that the dispute is over insurance plan benefits, not provider reimbursements
  - Judge Kennelly: **"the defendants' argument amounts to sleight of hand;"** plaintiffs adequately alleged a fixable price and a functioning competitive market
- MultiPlan's rate-setting tools and negotiation framework support the existence of a **"hub-and-spoke conspiracy"** to depress reimbursement rates for out-of-network healthcare services through

Why It's Important to Join the MDL

- Courts need to realize the number of providers impacted.
- Becoming a Direct-Action Plaintiff (DAP) consolidates similar claims, creating a united front against powerful defendants.
- There is no certainty that this will be a class action.
- The MDL allows providers to negotiate settlements based on their unique financial harm, leading to potentially higher payouts.
- The MDL will influence future regulations and reforms to prevent price-fixing abuses.



Case Study: *TML Recovery v. Cigna*

- Eight OON SUD providers sued for underpayment (<20% billed)
- Discovery revealed financial conflict of interest: Cigna kept ~30% of delta, MultiPlan 7-10%
- Court compelled fee data and C-suite emails
- Documents unsealed in public interest
- ***New York Times* exposé:**
  "Insurers Reap Hidden Fees by Slashing Payments — You May Get the Bill"
- DOJ, DOL, and Congress launched investigations

Lesson:
Transparency + Media + Regulators = Leverage

How It Works . . .

The New York Times

- “Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill”
- “Health Insurers’ Lucrative, Little-Known Alliance: 5 Takeways”
- “In Battle Over Health Care Costs, Private Equity Plays Both Sides”
- “Collusion in Health Care Pricing? Regulators Are Asked to Investigate”

The New York Times https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html

Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill.

A little-known data firm helps health insurers make more when less of an out-of-network claim gets paid. Patients can be on the hook for the difference.

By Chris Hamby
Chris Hamby reviewed more than 50,000 pages of documents and interviewed more than 100 people for this article. The New York Times also petitioned two federal courts for materials under seal.

April 7, 2024

Weeks after undergoing heart surgery, Gail Lawson found herself back in an operating room. Her incision wasn’t healing, and an infection was spreading.

At a hospital in Ridgewood, N.J., Dr. Sidney Rabinowitz performed a complex, hourslong procedure to repair tissue and close the wound. While recuperating, Ms. Lawson phoned the doctor’s office in a panic. He returned the call himself and squeezed her in for an appointment the next day.

“He was just so good with me, so patient, so kind,” she said.

But the doctor was not in her insurance plan’s network of providers, leaving his bill open to negotiation by her insurer. Once back on her feet, Ms. Lawson received a letter from the insurer, UnitedHealthcare, advising that Dr. Rabinowitz would be paid $5,449.27 — a small fraction of what he had billed the insurance company. That left Ms. Lawson with a bill of more than $100,000.

“I’m thinking to myself, ‘But this is why I had insurance,’” said Ms. Lawson, who is fighting UnitedHealthcare over the balance. “They take out, what, $300 or $400 a month? Well, why aren’t you people paying these bills?”

When AI Denies, Insurance Bad Faith Claims May Follow

AI in Insurance Claims: Emerging Legal Risk

- Insurers increasingly use AI to improve claims efficiency
- Recent court decisions show **AI-driven denials can trigger bad faith and contract claims**
- Key risk is not AI itself — but **lack of disclosure, oversight, and alignment with policyholder expectations**
- Courts are willing to examine:
  - Marketing and plan documents
  - Promises about clinician involvement
  - Whether AI replaced individualized judgment

Key takeaway: AI may accelerate claims handling — but also litigation exposure.

Litigation Developments

Courts Allow AI-Related Claims to Proceed

- **Estate of Lokken v. UnitedHealth Group (D. Minn.)**
  - Claims allowed for breach of contract and good faith
  - Focused on alleged failure to disclose AI use in claims review
- **Estate of Barrows v. Humana (W.D. Ky.)**
  - Unjust enrichment claim allowed to proceed
  - Court emphasized nondisclosure — not coverage correctness
- **Key Judicial Holding**
  - The issue is not whether AI use is permitted, but whether undisclosed AI decision-making violates contractual and equitable duties.

Implication: Preemption defenses may not shield insurers from AI-based bad faith claims.

What This Means for Healthcare Providers

- Increased Denials Risk
  - AI-driven claim determinations may accelerate denials
  - Providers may face higher volumes of **formulaic or opaque medical necessity denials**
- Leverage for Appeals & Litigation
  - Claims were denied **without reasonable investigation**
  - Decisions did not reflect **clinical judgment**
- Documentation & Advocacy Opportunities
  - Disclosure of AI tools used in utilization review
  - Identification of human decision-makers involved
- Anticipate AI-based denials and **build appeal strategies around transparency, clinical judgment, and good-faith review obligations**

EviCore and the Prior Authorization Ecosystem

- EviCore reviews prior authorization requests for **~100 million insured patients**
- Owned by **Cigna**; contracts with major national and regional insurers
- Operates at the intersection of:
  - Utilization management
  - Cost containment
  - Clinical decision-making
- Marketed to insurers as delivering **significant cost savings** (often cited as 3-to-1 ROI)

Key theme: Coverage decisions are frequently outsourced — away from treating physicians and patients.

Algorithms, Incentives, and Guidelines

- **“The Dial”**
  - Proprietary algorithm determines which requests get manual review
  - Adjustable thresholds can increase review volume — and denials

- **Financial Incentives**
  - Some contracts reward EviCore for reducing medical spend
  - Risk-based models allow EviCore to keep or share “savings”

- **Medical Guidelines**
  - Criticized as outdated, rigid, or misaligned with specialty standards
  - Academic studies and audits found deficiencies in some programs

Core concern: Cost incentives may influence how “medical necessity” is evaluated.

Consequences for Patients, Providers, and Oversight

- **For Patients**
  - Delays or denials of diagnostic tests and treatment
  - Potential for worsened outcomes when care is postponed
- **For Providers**
  - Administrative burden and appeal fatigue
  - “Sentinel effect” discouraging legitimate requests
- **For Policymakers & Litigators**
  - Limited regulatory enforcement to date
  - Heightened scrutiny of AI-assisted utilization management
  - Growing focus on transparency, bias, and contractual incentives

*Bottom line: EviCore’s model highlights how **delegated utilization review and algorithmic triage** can quietly reshape access to care—with limited public visibility or accountability.*

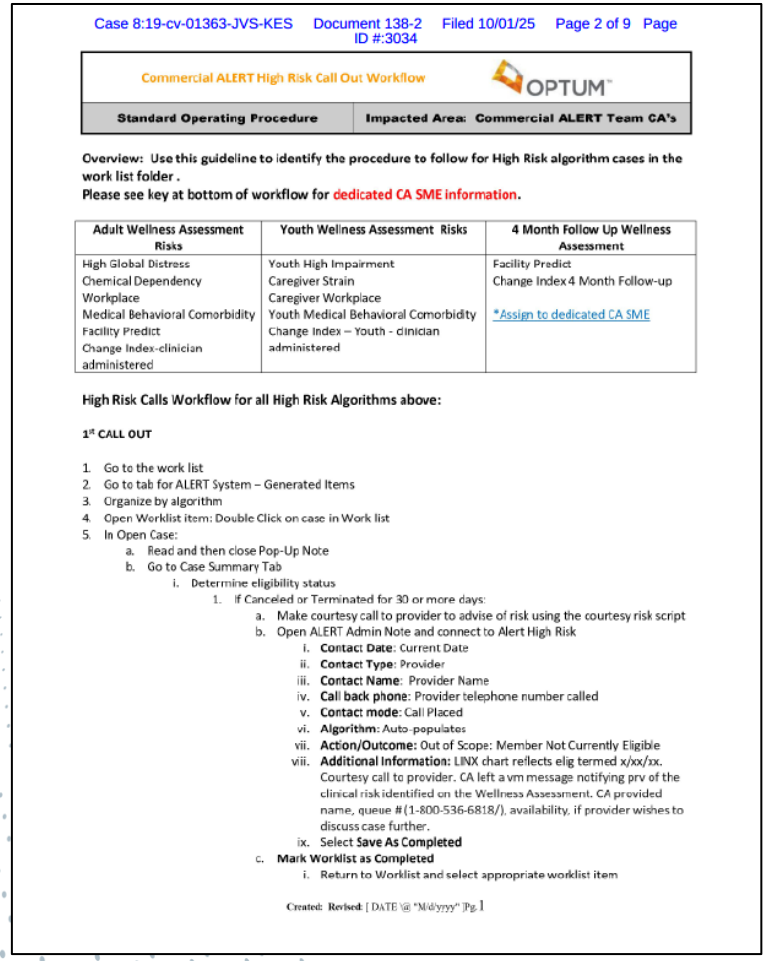
Case Study:
Ryan S. v. UnitedHealthcare

- ERISA fiduciary class action over AI-driven ALERT denial system and per diem parity violations
- Twice dismissed with prejudice, twice reversed on appeal
- **Ninth Circuit (98 F.4th 965) upheld parity & fiduciary claims**
- Court ordered public filing of United's ALERT and per-diem guidelines
- Class certification briefing set for 2026; trial in 2027

Lesson:
Persistence builds precedence and transparency

Guidelines

United's ALERT Guidelines



Commercial ALERT High Risk Call Out Workflow

OPTUM

Standard Operating Procedure	Impacted Area: Commercial ALERT Team CA's

Overview: Use this guideline to identify the procedure to follow for High Risk algorithm cases in the work list folder .
Please see key at bottom of workflow for dedicated CA SME information.

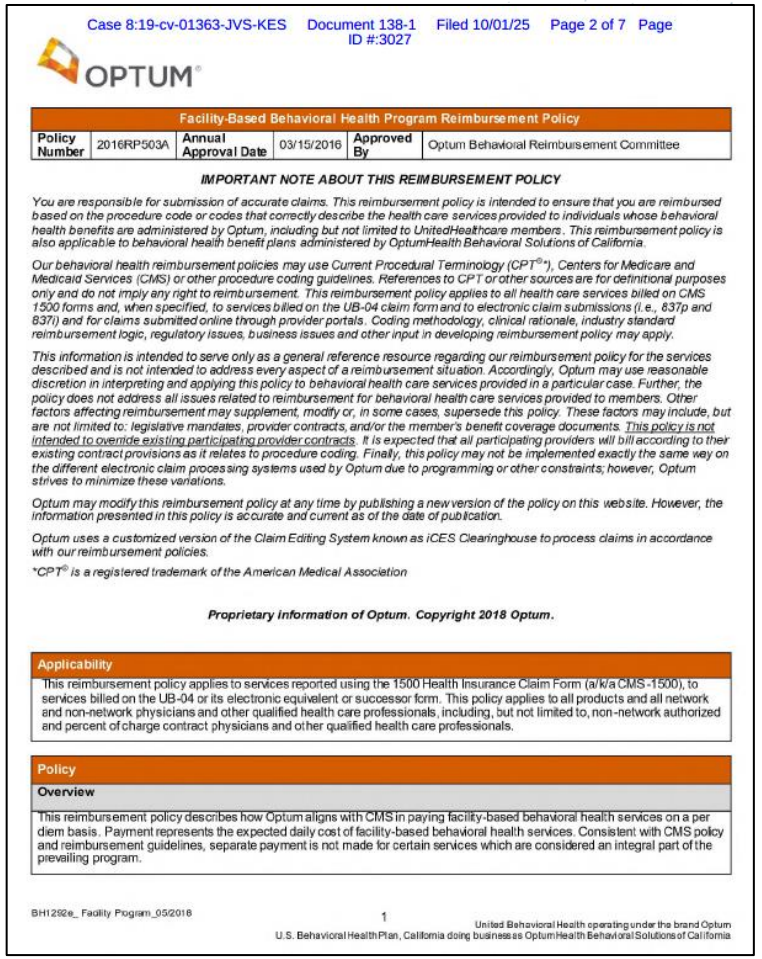
Adult Wellness Assessment Risks	Youth Wellness Assessment Risks	4 Month Follow Up Wellness Assessment
High Global Distress Chemical Dependency Workplace Medical Behavioral Comorbidity Facility Predict Change Index-clinician administered	Youth High Impairment Caregiver Strain Caregiver Workplace Youth Medical Behavioral Comorbidity Change Index – Youth - clinician administered	Facility Predict Change Index 4 Month Follow-up *Assign to dedicated CA SME

High Risk Calls Workflow for all High Risk Algorithms above:

1st CALL OUT

1. Go to the work list
2. Go to tab for ALERT System – Generated Items
3. Organize by algorithm
4. Open Worklist item: Double Click on case in Work list
5. In Open Case:
   a. Read and then close Pop-Up Note
   b. Go to Case Summary Tab
      i. Determine eligibility status
         1. If Canceled or Terminated for 30 or more days:
            a. Make courtesy call to provider to advise of risk using the courtesy risk script
            b. Open ALERT Admin Note and connect to Alert High Risk
               i. **Contact Date**: Current Date
               ii. **Contact Type**: Provider
               iii. **Contact Name**: Provider Name
               iv. **Call back phone**: Provider telephone number called
               v. **Contact mode**: Call Placed
               vi. **Algorithm**: Auto-populates
               vii. **Action/Outcome:** Out of Scope: Member Not Currently Eligible
               viii. **Additional Information:** LINX chart reflects elig termed x/xx/xx. Courtesy call to provider. CA left a vm message notifying prv of the clinical risk identified on the Wellness Assessment. CA provided name, queue # (1-800-536-6818/), availability, if provider wishes to discuss case further.
               ix. Select **Save As Completed**
            c. **Mark Worklist as Completed**
               i. Return to Worklist and select appropriate worklist item

United's Facility Per Diem Guidelines



OPTUM

Facility-Based Behavioral Health Program Reimbursement Policy

Policy Number	2016RP503A	Annual Approval Date	03/15/2016	Approved By	Optum Behavioral Reimbursement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, clinical rationale, industry standard reimbursement logic, regulatory issues, business issues and other input in developing reimbursement policy may apply.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, provider contracts, and/or the member's benefit coverage documents. This policy is not intended to override existing participating provider contracts. It is expected that all participating providers will bill according to their existing contract provisions as it relates to procedure coding. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

Optum uses a customized version of the Claim Editing System known as iCES Clearinghouse to process claims in accordance with our reimbursement policies.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500), to services billed on the UB-04 or its electronic equivalent or successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This reimbursement policy describes how Optum aligns with CMS in paying facility-based behavioral health services on a per diem basis. Payment represents the expected daily cost of facility-based behavioral health services. Consistent with CMS policy and reimbursement guidelines, separate payment is not made for certain services which are considered an integral part of the prevailing program.

Case Study: *Collins v. Anthem*

Class Action Settlement – Anthem Residential Treatment Denials

Lawsuit challenged Anthem's denial of **residential mental health and SUD treatment**

Alleged violations:

- **ERISA fiduciary duties**
- **Mental Health Parity and Addiction Equity Act**

Focused on **system-wide medical necessity criteria**, not individual claim errors

Certified class covering denials from **2017–2025**

Key takeaway: Courts are closely examining **behavioral health coverage standards** under parity law.

Settlement Terms at a Glance

$12.875 Million Class-Wide Resolution

- Up to **70–75% reimbursement** for members who paid out-of-pocket after RTC denials
- **$100 minimum payment** to all remaining class members
- Streamlined claims process—no re-litigation of medical necessity
- Minimal opposition:
  - <0.2% opt-out rate
  - Single objection

Why it matters: This is an **exceptional recovery** in an ERISA parity case.

Practical Implications

What Healthcare Providers Should Take Away

- **Utilization management guidelines matter**
  - Courts will compare behavioral health criteria to medical/surgical standards
- **Document parity violations**
  - Systemic guideline challenges can drive class-wide relief
- **Growing enforcement risk**
  - Settlements like this reinforce national scrutiny of behavioral health denials
- **Financial and operational signal**
  - Payers face real exposure where RTC access is restricted by rigid criteria

Bottom line: Residential treatment parity enforcement is no longer theoretical—it carries **significant financial consequences**.

Case Study: *Wit v. UBH*

Where the Case Stands

- *Wit v. United Behavioral Health*: Post-Mandate Status
  - Ninth Circuit **eliminated all denial-of-benefits claims**
  - District court authority limited to **systemic fiduciary misconduct**
  - **December 5, 2025, Permanent Injunction**

Fiduciary Duties & Injunctive Relief

What UBH Is Legally Prohibited From Doing

- ✅ Surviving violations:
  - Breach of **duty of loyalty**
  - Breach of **duty of care**
- ❌ Dismissed:
  - Claims tied to **plan-term application or individual benefit denials**
- **Permanent injunction**:
  - UBH may not use its invalidated guidelines to implement the **Generally Accepted Standards of Care (GASC)** requirement in ERISA-governed plans.
- **Five-year mandate**:
  - Any future GASC-implementing criteria must **accurately reflect GASC**

Court focus: **Prospective fiduciary conduct**—not retroactive claim correction.

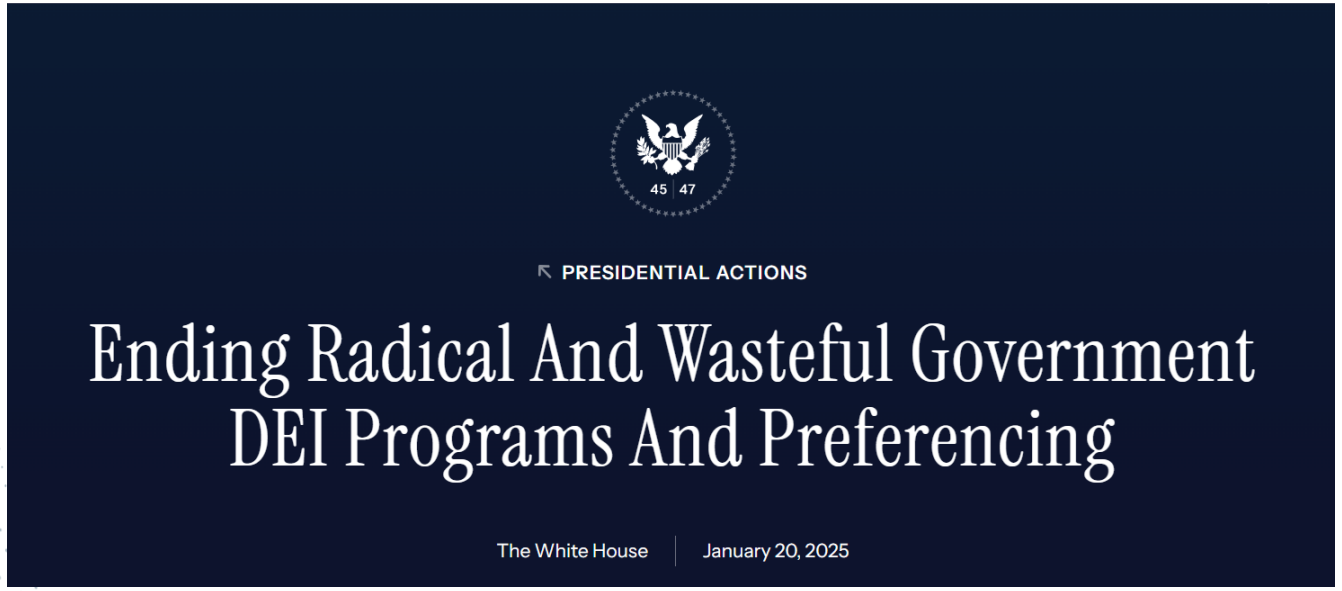
Employment Law Developments

Legal Developments in 2025

- Adding to the myriad of employer legal issues **new DEI scrutiny under the new administration**.
  - Executive Orders
  - EEOC and DOJ Guidance
  - U.S. Attorney General Memo

Executive Order 14151

- Orders the termination of DEI and DEIA programs in federal agencies
- Mandates removal of related positions and policies review of federal employment practices and requires agencies to report on DEI activities.

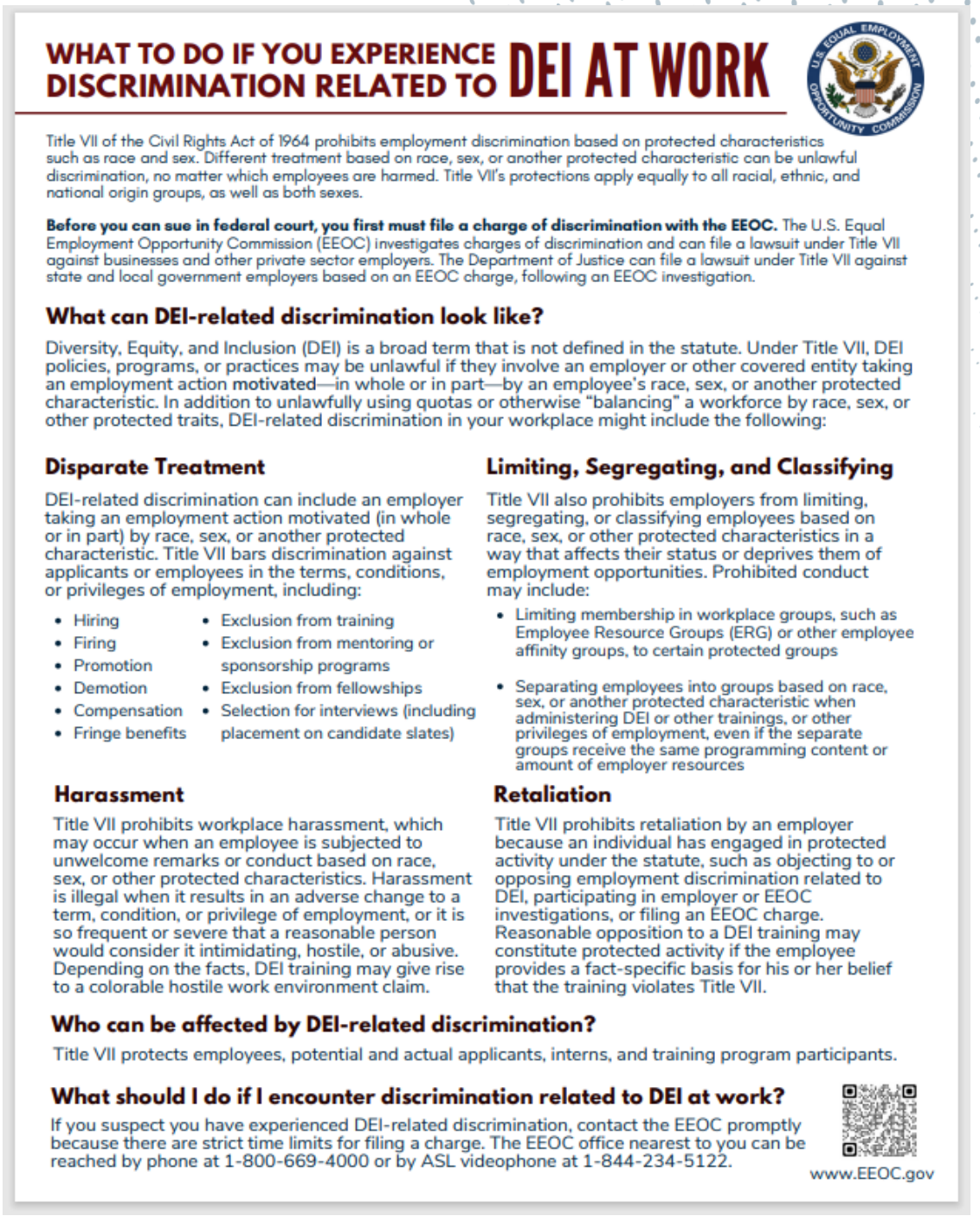


Executive Order 14173

- Ends affirmative action in federal contracting
- Directs agencies to eliminate race, sex, and identity-based workforce balancing
- Shifts enforcement toward existing civil rights laws without changing underlying statutes

Joint EEOC-DOJ Guidance

On March 19, 2025, the EEOC and DOJ issued two technical assistance documents addressing DEI in the workplace.



WHAT TO DO IF YOU EXPERIENCE DISCRIMINATION RELATED TO DEI AT WORK

Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on protected characteristics such as race and sex. Different treatment based on race, sex, or another protected characteristic can be unlawful discrimination, no matter which employees are harmed. Title VII's protections apply equally to all racial, ethnic, and national origin groups, as well as both sexes.

Before you can sue in federal court, you first must file a charge of discrimination with the EEOC. The U.S. Equal Employment Opportunity Commission (EEOC) investigates charges of discrimination and can file a lawsuit under Title VII against businesses and other private sector employers. The Department of Justice can file a lawsuit under Title VII against state and local government employers based on an EEOC charge, following an EEOC investigation.

What can DEI-related discrimination look like?

Diversity, Equity, and Inclusion (DEI) is a broad term that is not defined in the statute. Under Title VII, DEI policies, programs, or practices may be unlawful if they involve an employer or other covered entity taking an employment action **motivated**—in whole or in part—by an employee's race, sex, or another protected characteristic. In addition to unlawfully using quotas or otherwise "balancing" a workforce by race, sex, or other protected traits, DEI-related discrimination in your workplace might include the following:

Disparate Treatment

DEI-related discrimination can include an employer taking an employment action motivated (in whole or in part) by race, sex, or another protected characteristic. Title VII bars discrimination against applicants or employees in the terms, conditions, or privileges of employment, including:

- Hiring
- Firing
- Promotion
- Demotion
- Compensation
- Fringe benefits
- Exclusion from training
- Exclusion from mentoring or sponsorship programs
- Exclusion from fellowships
- Selection for interviews (including placement on candidate slates)

Limiting, Segregating, and Classifying

Title VII also prohibits employers from limiting, segregating, or classifying employees based on race, sex, or other protected characteristics in a way that affects their status or deprives them of employment opportunities. Prohibited conduct may include:

- Limiting membership in workplace groups, such as Employee Resource Groups (ERG) or other employee affinity groups, to certain protected groups
- Separating employees into groups based on race, sex, or another protected characteristic when administering DEI or other trainings, or other privileges of employment, even if the separate groups receive the same programming content or amount of employer resources

Harassment

Title VII prohibits workplace harassment, which may occur when an employee is subjected to unwelcome remarks or conduct based on race, sex, or other protected characteristics. Harassment is illegal when it results in an adverse change to a term, condition, or privilege of employment, or it is so frequent or severe that a reasonable person would consider it intimidating, hostile, or abusive. Depending on the facts, DEI training may give rise to a colorable hostile work environment claim.

Retaliation

Title VII prohibits retaliation by an employer because an individual has engaged in protected activity under the statute, such as objecting to or opposing employment discrimination related to DEI, participating in employer or EEOC investigations, or filing an EEOC charge. Reasonable opposition to a DEI training may constitute protected activity if the employee provides a fact-specific basis for his or her belief that the training violates Title VII.

Who can be affected by DEI-related discrimination?

Title VII protects employees, potential and actual applicants, interns, and training program participants.

What should I do if I encounter discrimination related to DEI at work?

If you suspect you have experienced DEI-related discrimination, contact the EEOC promptly because there are strict time limits for filing a charge. The EEOC office nearest to you can be reached by phone at 1-800-669-4000 or by ASL videophone at 1-844-234-5122.

www.EEOC.gov

EEOC-DOJ Guidance

DEI-related discrimination **may arise** where workplace policies or practices

- Consider **race, sex, or other protected traits** in employment decisions
- Including through **quotas, preference systems, or workforce "balancing"**

Federal enforcement agencies reiterate that **DEI initiatives may violate Title VII** when they:

- Influence employment decisions based on **protected characteristics**
- Rather than individualized, **merit-based criteria**

What HAS Changed

- Employers can anticipate significantly more scrutiny of their DEI programs.
- Enforcement priorities have dramatically shifted despite no change in underlying law.

What Has NOT Changed

- Existing discrimination statutes have not been amended.
- Private employer DEI programs are not banned or prohibited altogether.
- Expressly permitted are **educational, cultural, or historical observances** that celebrate diversity, recognize historical contributions, or promote awareness without engaging in exclusion or discrimination.
  - Black History Month
  - International Holocaust Remembrance Day
  - Women's History Month

What Is EPLI & Why It Matters in Healthcare

- **Employment Practices Liability Insurance (EPLI)** protects employers against employee **claims of wrongful employment practices**
  - Wrongful termination or retaliation
  - Discrimination (ADA, Title VII, age, gender, disability)
  - Harassment and hostile work environment
  - Failure to hire, promote, or accommodate
- **Why It Matters in Healthcare**
  - Employment claims are **rising across healthcare**
  - Defense costs alone can **exceed six figures** — even when employers prevail
  - Most standard **liability policies exclude employment-related claims**
  - Responds to HR-driven claims outside workers' comp, professional liability, and general liability — precisely where most treatment centers are exposed

“Wrongful Employment Act”

- A **wrongful employment act** includes any actual or alleged **violation of employment law** tied to hiring, supervision, discipline, or termination.
- **Examples in Treatment Centers**
  - Terminating an employee shortly after requesting ADA or FMLA accommodations
  - Retaliating against staff who raise patient safety or compliance concerns
  - Inconsistent discipline due to staffing shortages or burnout
  - Failure to address harassment between clinical or support staff
- **Key Takeaway→ Intent does not matter** — allegations alone trigger defense obligations
- Most EPLI claims arise from **operational stress points, not bad actors** — understaffing, documentation gaps, and rapid growth create risk long before litigation appears.

Why Substance Use Disorder Treatment Providers Are High-Risk

- **SUD treatment providers face elevated EPLI exposure** due to structural realities of the industry
- **Risk Factors:**
  - High staff turnover and burnout
  - Whistleblower activity tied to safety, medication, or restraint practices
  - Younger or rapidly scaling organizations with informal HR controls
  - Emotionally charged work environments
- **Result:**
  - More frequent employment claims
  - Higher defense costs
  - Increased scrutiny during renewals, diligence, and exits

EPLI Exclusions Every Employer Should Understand

- EPLI provides critical protection — **but it is not all-inclusive**
- **Common EPLI Exclusions**
  - **Bodily injury or medical injury claims**→ Covered under professional, general, or workers' compensation policies
  - **Intentional, fraudulent, or criminal acts**→ Final adjudication usually required before exclusion applies
  - **Wage & hour violations**→ Many policies exclude or severely limit coverage for overtime, misclassification, or pay claims
  - **Workers' compensation and unemployment claims**→ Statutory systems, always excluded
  - **ERISA fiduciary breaches**→ Requires separate fiduciary liability coverage
  - **Prior or known circumstances**→ Claims or complaints known before policy inception may be excluded
- **Gaps between policies are where coverage disputes arise**
  - Align EPLI, HR practices, and companion coverages

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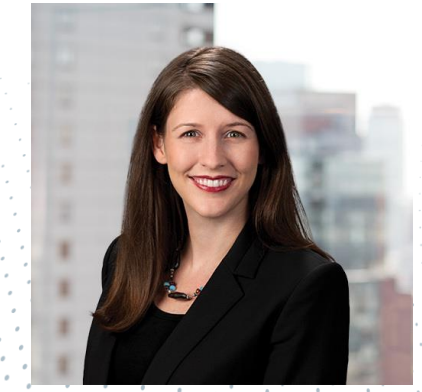

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