Nos. 20-17363(L), 20-17364, 21-15193, 21-15194 (CON)

In The United States Court of Appeals for The Ninth Circuit

DAVID WIT, et al.,
Plaintiffs-Appellees,

LINDA TILLITT, et al.,
Intervenor-Plaintiffs-Appellees,

– v. –

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, et al.,
Plaintiffs-Appellees,

MICHAEL DRISCOLL,
Intervenor-Plaintiff-Appellee,

– v. –

UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

On Appeal from the United States District Court for the Northern District of California
Nos. 3:14-cv-2346, 3:14-cv-5337 (Hon. Judge Spero)

[PROPOSED] BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, ET AL., IN SUPPORT OF EN BANC REVIEW

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CORPORATE DISCLOSURE STATEMENT

The undersigned counsel certifies that the *amici curiae* the National Health Law Program; Center for Health Law and Policy Innovation of Harvard Law School; 2020 Mom; Alabama Disabilities Advocacy Program; American Foundation for Suicide Prevention; American Lung Association; Assistive Technology Law Center; Autism Legal Resource Center LLC; Bazelon Center for Mental Health Law; Center for Public Representation; Charlotte Center for Legal Advocacy; Community Service Society of New York; Depression and Bipolar Support Alliance; Disability Rights California; Disability Rights Education and Defense Fund (DREDF); Disability Rights New Jersey; Families USA; Florida Health Justice Project; Health Law Advocates; Inseparable; Legal Action Center; Mental Health Advocacy Services; Mental Health America; National Alliance on Mental Illness (NAMI); National Autism Law Center; National Center for Law and Economic Justice; National Disability Rights Network; National Women's Law Center; Northwest Health Law Advocates; Partnership to End Addiction; Public Justice Center; Recovery Advocacy Project; The Arizona Center for Law in the Public Interest; The Kennedy Forum; The Trevor Project; United States Society for Augmentative & Alternative Communication; Well Being Trust; and William E. Morris Institute for Justice are not subsidiaries of any other

corporation and no publicly held corporation owns 10 percent or more of any *amici curiae* organization's stock.

Dated: May 13, 2022

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INTEREST OF *AMICI*

Thirty-eight non-profit organizations representing the interests of people with behavioral health conditions have come together to submit this *amicus curiae* brief in support of the Plaintiffs-Appellees. Fed. R. App. P. 29(b).[1] *Amici curiae* are the National Health Law Program; Center for Health Law and Policy Innovation of Harvard Law School; 2020 Mom; Alabama Disabilities Advocacy Program; American Foundation for Suicide Prevention; American Lung Association; Assistive Technology Law Center; Autism Legal Resource Center LLC; Bazelon Center for Mental Health Law; Center for Public Representation; Charlotte Center for Legal Advocacy; Community Service Society of New York; Depression and Bipolar Support Alliance; Disability Rights California; Disability Rights Education and Defense Fund (DREDF); Disability Rights New Jersey; Families USA; Florida Health Justice Project; Health Law Advocates; Inseparable; Legal Action Center; Mental Health Advocacy Services; Mental Health America; National Alliance on Mental Illness (NAMI); National Autism Law Center; National Center for Law and Economic Justice; National Disability Rights Network; National Women's Law Center; Northwest Health Law Advocates; Partnership to End Addiction; Public Justice Center; Recovery Advocacy

[1] Pursuant to Fed. R. App. P. 29(b)(4) and 29(a)(4)(e), counsel for *amici curiae* states that no counsel for a party authored the brief in whole or in part, and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

Project; The Arizona Center for Law in the Public Interest; The Kennedy Forum; The Trevor Project; United States Society for Augmentative & Alternative Communication; Well Being Trust; and William E. Morris Institute for Justice ("National Health Law Program et al.").

While each *amicus* has particular interests, together they share the goal of advancing access to behavioral health services and removing barriers to care. *Amici* all work on behalf of people with behavioral health conditions throughout the country to remove barriers to care using tools such as direct legal services, policy advocacy, education, and litigation. Their *amicus* brief will provide the Court with additional information about the importance of this case.

INTRODUCTION

The worsening mental health and opioid crises have heightened the need to remove illegal barriers to treatment for mental health and substance use disorders (collectively "behavioral health"). The COVID-19 pandemic has exponentially increased the need for these services. For years, legislators and regulators have attempted to bridge the gap between need and treatment by ensuring fair and equitable access to coverage of behavioral health services. Unfortunately, with each new bridge, insurers dig a new—but often illegal—trench, finding new ways to deny critically needed behavioral health services ostensibly covered under their plan. Appealing the denials is usually futile since the administrative appeals system largely

reflects the insurers' flawed and conflict-ridden rationale for denying care. And fighting the denial on an individual basis through litigation typically demands substantial resources for experts and advocacy. The District Court in this case found that United Behavioral Health ("UBH"), "one of the nation's largest managed healthcare organizations," 2-ER-336, developed and applied improper, overly restrictive medical necessity guidelines contrary to the generally accepted standards of care ("GASC") that define the coverage promised in their contracts. The Circuit Court reversed. According to the Panel, "UBH's interpretation—that the Plans do not require consistency with the GASC—was not unreasonable." *Wit v. United Behav. Health*, No. 20-17363, 2022 WL 850647, at *2 (9th Cir. Mar. 22, 2022).

The Panel's opinion is flatly contradicted by the record below, misconstrues Plaintiffs' claims, and precipitates great harm. Moreover, the question presented is one of exceptional importance—allowing the Circuit Panel's decision to stand would allow insurers to deny care arbitrarily based on their own plan-conflicting standards that can be clinically unsound and often tainted by significant conflicts of interest. Safeguarding the few guardrails that Congress has enacted to govern private health insurance plans is of profound importance, both because of the nature of our national behavioral health crisis, and because of the inevitable suffering for class members and those like them when such guardrails are undermined. *Amici* urge this Court to accept this case for rehearing en banc to address these critically important issues.

ARGUMENT

I. Restrictive Insurance Practices Wrongfully Block People from Obtaining Medically Necessary Behavioral Health Treatment.

A. Many Individuals Do Not Receive the Behavioral Health Services That They Need.

Millions of people in the U.S. need behavioral health care but do not get it. An estimated 40 million U.S. adolescents and adults have a substance use disorder ("SUD"). Substance Abuse & Mental Health Servs. Admin., *2020 National Survey on Drug Use and Health* 5 (2021), https://perma.cc/C5NX-Y7GD. Over 52 million (or one in five) U.S. adults live with a mental health condition. *Id.* at 5. The COVID-19 pandemic has had significant impacts on behavioral health, with sharp increases in prevalence of conditions and specific populations, such as young adults, people of color, essential workers and unpaid caregivers, experiencing a disproportionate impact. Mark E. Czeisler, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – US, June 24-30, 2020*, CDC Morbidity & Mortality Wkly. Rpt. (2020), https://perma.cc/7V2Q-4SLU; U.S. Dep't of Labor, *2022 MHPAEA Report to Congress* 6 (2022), https://perma.cc/4KHN-46U3. Since 2019 overdose deaths increased by nearly 50 percent to reach a record high of nearly 108,000 in 2021. FB Ahmad et al., Ctrs. for Disease Control, *Provisional Drug Overdose Death Counts* (2021), https://perma.cc/G4GP-QV2R.

Despite the ubiquity of behavioral health conditions, people often have trouble accessing the care they need. The National Institute of Mental Health reports that 56.2% of people with mental health conditions did not receive any mental health services over the course of a year. Nat'l Inst. of Mental Health, *Mental Health Information: Statistics* (last updated Jan. 2021), https://perma.cc/Z5YC-Z4Z5. The unmet need for mental health services is particularly serious among groups that have historically experienced discrimination. Azza Altiraifi & Nicole Rapfogel, Ctr. Am. Prog., *Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis* (Sept. 10, 2020), https://perma.cc/SH9R-DBRM; Ctrs. for Disease Control & Prevention (CDC), *The Mental Health of People with Disabilities* (2020), https://perma.cc/3QRV-874K.

B. Insurers Often Deny Needed Behavioral Health Services for Fiscal Reasons.

Contractual obligations require insurers to cover the non-excluded services described in their plan terms. The UBH plans at issue here are typical of private health insurance contracts by defining these services with reference to GASC. *See* 2-ER-253 (finding of fact that "[e]very class member's health benefit plan includes, as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care."). Behavioral health services are disproportionately denied coverage, an issue that Congress has tried to ameliorate. *See infra* Section II. Improper service denials—such as those at the heart of this

litigation—create a major barrier to accessing behavioral health care. A 2015 survey found that mental health claims were denied at double the rate of physical health claims. Nat'l Alliance for Mental Illness (NAMI), *A Long Road Ahead* 4 (2015), https://perma.cc/9VWC-S4UV (hereafter NAMI, *A Long Road Ahead*). Insurers are often overly impacted by market forces to "cherry-pick" they care they deemed medically necessary out of services covered by a given plan, to the detriment of the health and welfare of their covered lives. *See* Neiloy Sircar, *Your Claim Has Been Denied: Mental Health and Medical Necessity*, 11 Health L. & Pol'y Brief 1, 10-11 (2017), https://perma.cc/68RS-6CW6.

Financial incentives are often at the heart of behavioral health service denials.[2] The Panel Opinion discounted any conflict of interest in this case, citing *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008). *Wit*, 2022 WL 850647, at *3. The *Saffon* Court ruled that where the defendant bore the financial risk of its own decisions, it would weigh the conflict more or less heavily depending on what other evidence was available. *Saffon*, 522 F.3d at 868. Whereas the conflict would be viewed with a low level of skepticism if "there's no evidence "of malice, of self-dealing, or of a parsimonious claims-granting history," it should weigh more heavily

[2] *See, e.g.*, 60 Minutes: Denied (CBS television broadcast Dec. 14, 2014), https://perma.cc/RV7T-KHX8 (text), https://perma.cc/ZWA5-Z6SR (video) (chronicling multiple examples of systematic denials of coverage for treatment of chronic mental health needs tragically leading directly to needless deaths).

"if there's evidence that the administrator . . . has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly." *Id.* (cleaned up). Parsimonious claims processes that misinterpret plan terms are precisely what the District Court found here. 2-ER-320 ("[F]inancial incentives . . . infected the Guideline development process."); 2-ER-331-332 (describing UBH's structural conflict of interest and concluding that UBH breached its "duty to comply with plan terms . . . .").

Wrongful denials of care have far-reaching consequences. Often, insurers focus on acute care to the detriment of the various facets of people's lives and societal costs, even though focusing on acute care is inconsistent with GASC that recognize the importance of long-term stabilization and relapse prevention. Susan G. Lazar et al., *Clinical Necessity Guidelines for Psychotherapy, Insurance Medical Necessity and Utilization Review Protocols, and Mental Health Parity*, Psychiatric Prac. (May 2018), https://perma.cc/37SJ-99TT; Paul S. Applebaum & Joseph Parks, *Holding Insurers Accountable for Parity in Coverage of Mental Health Treatment*, 71 Psychiatric Servs. 202, 203 (Nov. 14, 2019), https://perma.cc/7D3D-833Y. A lack of chronic care can lead to an "overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care." Substance Abuse & Mental Health Servs. Admin., *National Guidelines for Behavioral Health Crisis Care* 8 (2020), https://perma.cc/KGX5-29LD. When individuals

experience behavioral health crises, often the only option available to these individuals and their family members is to contact law enforcement for help, leading to arrest, criminal charges, or bodily harm. *Id.* at 68-69. These barriers to routine care and correlated reliance on intensive crisis care create significant costs for health care systems. One national review of behavioral health emergency department visits estimated that, in 2017, such visits totaled more than $5.6 billion (7% of all emergency department costs) with the frequency and costs of the visits and hospitalizations increasing over time. Zeynal Karaca & Brian J. Moore, *Costs of Emergency Department Visits for Mental and Substance Use Disorders in the United States, 2017* 1, 3 (2020), https://perma.cc/6YT6-V8D4.

Inpatient behavioral health services also leave patients with unnecessarily large medical bills and debt. Patients in such circumstances also frequently find themselves with worsening mental health, and deterred from seeking care in the future. *See, e.g.*, Laura Ungar, *Grief Grew into A Mental Health Crisis and A $21,634 Hospital Bill*, Kaiser Health News (Oct.31, 2019), https://perma.cc/3U7S-PVGM; Nathaniel P. Morris & Robert A. Kleinman, *Involuntary Commitments: Billing Patients for Forced Psychiatric Care*, 117 Am. J. Psychiatry 1115, 1115 (Dec. 1, 2020), https://perma.cc/39F4-9BYR. People who are unable to access needed mental health services, including continuation of care, not only experience a deterioration in their mental health condition, but also may face physical health complications. One review of data from

2001 to 2003 concluded that 68% of adults with mental disorders also had separate medical conditions. S. Goodell et al., *Mental Disorders and Medical Comorbidity*, The Synthesis Project 1 (Feb. 1, 2011), https://perma.cc/GFP5-6PB6. Physical illnesses, in turn, can exacerbate or create additional mental health symptoms, creating a cyclical relationship in which conditions worsen each other. Martin Prince et al., *No Health Without Mental Health*, The Lancet (Sept. 4, 2007), https://perma.cc/95GB-MUDG. The lack of mental health treatment also creates employment costs, with an estimated annual cost of reduced efficacy in the workplace to be $78.7 billion in 2010, with absenteeism accounting for $23.3 billion in lost productivity. Paul E. Greenberg et al., *The Economic Burden of Adults With Major Depressive Disorder in the United States (2005 and 2010)*, J. Clinical Psychiatry (Feb. 2015), https://perma.cc/G3KP-F4U6.

The lack of behavioral health care can also lead to death. *See, e.g.*, RAND Corp., *The Relationship Between Mental Health Care Access and Suicide* (Mar. 2, 2018), https://perma.cc/48HE-G4JC (finding that studies suggest mental parity laws and improved access to care may reduce suicide rates); *see also* Wit First Amended Complaint ECF 39 ¶¶ 130-32 (Lauralee Pfiefer paid nearly $54,000 for behavioral health treatment, was deterred by UBH denials from seeking further treatment, and died approximately 6 months after UBH's last denial); Wit Intervenor Complaint ECF 123 ¶¶ 69-73 (after an abrupt coverage termination of residential treatment for substance use and mental health citing lack of acute need, Max Tillittt was discharged

without a discharge plan in place, soon relapsed, and died roughly 10 weeks after UBH's denials of his claims at the age of 21).

When people with private insurance are not able to access the behavioral health services they need, they are more likely to turn to taxpayer-funded public programs to access care. "[P]ayers continue to shift the cost of [mental health] care to state and local governments and deny many consumers health care benefits that they pay for in private health plans or are entitled to receive through their Medicaid managed care plan." Ellen Weber & Abigail Woodworth, Legal Action Ctr., *Parity Tracking Project: Making Parity a Reality* 4 (2017), https://perma.cc/TL4K-5TST; *see also* Tami L. Mark et al., *Insurance Financing Increased for Mental Health Conditions but Not for Substance Use Disorders, 1984-2014*, 35 Health Affairs 958, 963 (2016), https://perma.cc/DD66-XFQL. Medicaid, the federally-and-state-funded health coverage program for low-income people, is currently the single largest payer for mental health services in the U.S., and also pays for a high proportion of substance use disorder services. *See* Ctrs. for Medicare & Medicaid Servs., *Behavioral Health Services*, https://perma.cc/B6FS-QMBV (last accessed May 5, 2022). Others scramble to pay for needed care out-of-pocket, including some of the *Wit* plaintiffs for treatment that was included as a service under the terms of their plans. *See, e.g.*, Wit First Amended Complaint ECF 39 at ¶¶ 50 & 153 (David and Natasha Wit and Brian Muir each paid out-of-pocket nearly $30,000 out-of-pocket for residential treatment), 90 (Cecilia

Holdnak paid over $100,000 out-of-pocket), 130 (Lauralee Pfeifer spent about $54,000 out-of-pocket and was deterred from seeking more treatment due to denials) & 180 (Lori Flanzraich paid nearly $90,000 out-of-pocket).

Put simply, when insurers do not meet their legal obligations to provide behavioral health services, these shortcomings lead to poorer clinical outcomes and even death, negative impacts on people's lives including significant medical debt, higher population health costs, and increased costs to public programs.

C. Insurers Often Hide Behind Internal Guidelines to Deny Necessary Behavioral Health Services.

The *Wit* case is particularly important because it highlights how insurers skirt scrutiny. Insurers can inappropriately rely on internally-developed clinical guidelines, the terms and criteria for which are opaque and purposefully ambiguous for insureds, to restrict coverage and ration behavioral health care in ways that are inconsistent with GASC. Although there are insurer duties under ERISA to disclose guidelines used in denials of care, *see* 29 C.F.R. § 2560.503-1(g)(1)(v), there are few guardrails that meaningfully prescribe how clinical guidelines are used by insurers to ensure that GASC are properly followed. *See* Am. Health Lawyers Assoc., *Medical Necessity: Current Concerns and Future Challenges* 43 (2005), https://www.yumpu.com/en/document/read/21768262/medical-necessity-american-health-lawyers-association. The existing legal scheme does not ensure that regulators

scrutinize the quality and empirical underpinnings of insurers' internal medical necessity guidelines, with disastrous results. *Id.* at 28-29. The contradiction of an insurer's medical necessity denial in circumstances where the care is clearly supported under the GASC is hard to understand and difficult to rebut, leading many people to forego needed treatment. *Id.* at 3.

D. The Right to Administrative Appeal Does Not Remedy the Problem of Improper Medical Necessity Guidelines.

When insurers like UBH manipulate how medical necessity determinations are made and deny care that is necessary according to GASC, peoples' options to obtain the care they need are limited. While insurers must offer ways for their covered lives to appeal denials of care, often these administrative appeal processes are both time-consuming and ineffective at addressing insurer medical necessity standards that do not comport with GASC. Putting aside the fact that many people do not understand their appeal rights, filing an appeal to challenge their insurer's denial of treatment is challenging, complicated, expensive, and time-consuming. Consumer Reports Nat'l Res. Ctr. at 3 (2015); *see generally* The Kennedy Forum & NAMI, *The Health Insurance Appeals Guide* (2021), https://perma.cc/Q3WN-RGA6.

Further, the administrative process does not readily allow approval for needed services, despite the language promising coverage in their plan. Individuals must typically prevail based on the insurer's self-selected medical necessity criteria, and often cannot meaningfully challenge that criteria through an appeal, even when those

criteria are pervasively flawed and inconsistent with GASC. *See* NAMI, *A Long Road Ahead* at 5. Most individuals also cannot readily take on appeals involving conflicts between their provider and their insurer over whether the behavioral health services they are seeking are medically necessary, as such battles require costly experts and the help of a professional advocate. The Kennedy Forum & NAMI at 49, 67; *see also* Sircar at 15-16. Too often, instead of attempting to fight their insurers' denials of care, people simply go without behavioral health services, no matter how critically important they are.

II. Despite Attempts by Congress and Regulators to Improve Access to Behavioral Health Care, Privately Insured Individuals Continue to Encounter Barriers to Care.

For nearly 30 years, Congress has repeatedly recognized the critical unmet need for behavioral health services in this country, amending ERISA to address barriers to those services. Efforts to expand access to behavioral health coverage began decades earlier, but Congress first amended ERISA to address the disparities in coverage of behavioral health benefits perpetuated by insurers via the Mental Health Parity Act of 1996 (MHPA).[3] 104 Pub. L. 204, 110 Stat. 2945 (1996). Despite this effort, in 2000, the GAO found that, about 87% of insurers adopted restrictive mental health benefit design features to offset the impact of complying with MHPA,

[3] *See* Caroline V. Lawrence & Blake N. Shultz, *Divide and Conquer? Lessons on Cooperative Federalism from A Decade of Mental-Health Parity Enforcement*, 130 Yale L.J. 2216, 2219, 2224-25 (2021) (describing history of mental health parity law in Congress).

while about 14% remained non-compliant. U.S. Gov't Accountability Office, GAO/HEHS-00-95, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* 5 (2000), https://perma.cc/P373-59Y9. Subsequent changes in 2002 to the claims procedure attempted to rein in misuse of medical necessity guidelines. 29 C.F.R. § 2560.503-1. In 2008, Congress again amended ERISA to explicitly address access to behavioral health services, and expand parity to substance use disorder treatment, with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). Pub. L. 110-343, Div. C, 122 Stat. 3765 (2008). In 2016, in the 21st Century Cures Act, Congress again amended ERISA to increase transparency generally, but especially around medical necessity. Pub. L. 114-255, 130 Stat. 1033 (2016). Congress also amended the law in December 2020, to ensure that insurers' criteria and methods for approving behavioral health care, written and unwritten, were appropriate. Consolidated Appropriations Act, 2021, Pub. L. 116-260, 134 Stat. 2900, § 203 (2020); *see also* Substance Abuse & Mental Health Servs. Admin, *The Essential Aspects of Parity: A Training Tool for Policymakers* 2-3 (2022), https://perma.cc/9HV5-TALN (listing the evolution of parity enforcement).

Even in light of these important protections enshrined in federal law, there is widespread recognition that health insurers continue to flout government efforts to reform their policies and practices. *See, e.g.*, NAMI, *A Long Road Ahead* at 4 (finding that while insurers subject to the Affordable Care Act have a lower reported rate of denial

for mental health care, that denial rate is still twice the denial rate for general medical care); Gov't Accountability Office (GAO), *Mental Health and Substance Abuse: State and Federal Oversight of Compliance with Parity Requirements Varies* (2019), https://perma.cc/32NS-K3QC ("GAO 2019 Report") (identifying need for more compliance oversight of employer-sponsored plans); *2022 MHPAEA Report to Congress*, at 15 (all of insurers' parity analyses that DOL "reviewed between April 10, 2021, and October 31, 2021, were initially insufficient regarding the[] statutory requirements"). At the same time, many states have passed laws requiring insurers in their states to provide covered behavioral health benefits consistent with GASC. *See, e.g.*, Ellen Weber, Legal Action Ctr., *Spotlight on Medical Necessity Criteria for Substance Use Disorders* 9-10 (2020), https://perma.cc/V4PE-GZNN. As Congress and other regulators have scrutinized insurance coverage of behavioral health benefits more closely, insurers have responded by finding ways to hide and obscure their illegal actions to avoid the consequences of their illegal denials.

III. En Banc Review is Warranted Because the Question Whether Arbitrary Insurer Conduct Should Be Sanctioned Is of Exceptional Importance.

This case presents a question of exceptional importance. The Panel's flawed analysis will sanction significant barriers for people with behavioral health needs in the form of health insurance policies and practices that violate plan requirements

regarding GASC. Without review, the fundamental error in the Panel Opinion will license arbitrary, harmful insurer conduct going forward.[4]

First, the Opinion's cardinal conclusion is that "UBH's interpretation—that the Plans do not require consistency with the GASC—was not unreasonable." *Wit*, 2022 WL 850647, at *2. That conclusion is flatly contradicted by the record below. "Plaintiffs here have demonstrated, as a factual matter, that the insurance plans for the putative class members . . . require as a condition of coverage adherence to generally accepted standards and/or state law." 2-ER-367. The Panel Opinion's conclusion to the contrary usurps the fact-finding role of the District Court, and has no basis in the record.

Second, the Panel bases its conclusion on faulty rationale expressed in a single sentence: "The Plans exclude coverage for treatment inconsistent with the GASC; Plaintiffs did not show that the Plans mandate coverage for all treatment that is consistent with the GASC." *Wit*, 2022 WL 850647, at *2. At every opportunity, the Plaintiff-Appellees made clear that they did not claim that the plan terms mandate coverage for every service within the umbrella of GASC, and the District Court did not understand them to make that argument.[5] Instead, as the record below makes

[4] Generally, that plans must be administered according to their terms does not foreclose plans from covering additional benefits beyond what GASC currently recognize; in any event plans must comply with anti-discrimination laws that may require inclusion of benefits beyond existing GASC standards.

[5] In their opening statement at trial, among other places, counsel for Plaintiffs made

abundantly clear, the nature of Plaintiffs' argument is that UBH is forbidden by the plan terms from employing criteria that are inconsistent with GASC to adjudicate the relevant behavioral health coverage claims at issue. *See, e.g.*, 2-ER-238. Taken to its logical conclusion, the Panel Opinion's logic would permit a health insurer to utilize internal coverage guidelines wholly untethered from GASC. Such a practice would be the very definition of arbitrary.[6]

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this clear. "For every one of th[e] plans, a precondition of coverage is that the treatment must be consistent with generally accepted standards of care. *This is not the same thing as saying that the plans provide coverage for all services that are consistent with generally accepted standards. That's not plaintiffs' argument.*" 3-ER-464-65 (emphasis added). The District Court plainly understood this aspect of the claims, memorializing its understanding in its February 28, 2019 findings of fact. "Every class member's health benefit plan includes, as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care. . . . On the other hand, *Plaintiffs do not dispute that a service that is consistent with generally accepted standards of care may, nonetheless, be excluded from coverage under a particular class member's plan*." 2-ER-253 (emphasis added) (citations omitted).

[6] This possibility is not as far-fetched as it may seem. *See, e.g., Charles W. v. Regence BlueCross BlueShield of Oregon*, No. 2:17-CV-00824-TC, 2019 WL 4736932, at *7 (D. Utah Sept. 27, 2019), (finding that the plaintiffs' requested treatment fell within the generally accepted standards of medical practice, while the position advanced by the defendant's medical experts "cabined, as they were," by internal guidelines, do not) *order clarified*, No. 2:17-CV-00824-TC, 2020 WL 1812372 (D. Utah Apr. 9, 2020); *H.N. v. Regence BlueShield*, No. 15-CV-1374 RAJ, 2016 WL 7426496, at *10 (W.D. Wash. Dec. 23, 2016) ("Though [insurer] places the highest value on the [internal guidelines], it provides no authority to show that these are only guidelines by which Plaintiffs must prove their right to benefits. Indeed, Plaintiffs provided evidence by several physicians who can attest to the accepted medical standards that were met when deciding on the treatment options for H.N.").

IV. CONCLUSION

This case presents questions of exceptional importance arising from the promises made to insurance plan members regarding the process by which their behavioral health claims will be determined. For the foregoing reasons, and those in the Appellees' brief, *amici* respectfully request that this Court accept this case for rehearing en banc.

Dated: May 13, 2022

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 20-17363(L), 20-17364, 21-15193, 21-15194 (CON)

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Signature /s/ Abigail K . Coursolle **Date** May 13, 2022

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I certify that on May 13, 2022, I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Date: May 13, 2022

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