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)

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, ET AL., IN SUPPORT OF AFFIRMANCE
FILED WITH CONSENT OF ALL PARTIES (Cir. R. 29-2(a))

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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; The Kennedy Forum; 2020 Mom; American Foundation for Suicide Prevention; Autism Legal Resource Center; Bazelon Center for Mental Health Law; Center for Public Representation; Community Service Society of New York; Depression and Bipolar Support Alliance; Disability Rights California; Disability Rights Education and Defense Fund (DREDF); Health Law Advocates; Legal Action Center; Legal Aid at Work; Mental Health Advocacy Services, Inc.; Mental Health America; National Alliance on Mental Illness; National Autism Law Center; National Disability Rights Network; Northwest Health Law Advocates; Partnership to End Addiction; Public Justice Center; Recovery Advocacy Project; Southwest Women's Law Center; The Arizona Center for Law in the Public Interest; The Trevor Project; and Well Being Trust 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 19, 2021

/s/ Abigail K. Coursolle
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INTEREST OF *AMICI*

Twenty-eight non-profit organizations that represent 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(a).[1] The *amici curiae* are the National Health Law Program; Center for Health Law and Policy Innovation of Harvard Law School; The Kennedy Forum; 2020 Mom; American Foundation for Suicide Prevention; Autism Legal Resource Center; Bazelon Center for Mental Health Law; Center for Public Representation; Community Service Society of New York; Depression and Bipolar Support Alliance; Disability Rights California; Disability Rights Education and Defense Fund (DREDF); Health Law Advocates; Legal Action Center; Legal Aid at Work; Mental Health Advocacy Services, Inc.; Mental Health America; National Alliance on Mental Illness; National Autism Law Center; National Disability Rights Network; Northwest Health Law Advocates; Partnership to End Addiction; Public Justice Center; Recovery Advocacy Project; Southwest Women's Law Center; The Arizona Center for Law in the Public Interest; The Trevor Project; and Well Being Trust (collectively, "NHeLP et al.").

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[1] All parties consented to the filing of this brief. Pursuant to Fed. R. App. P. 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.

While each *amicus* has particular interests, together they share the goal of advancing access to behavioral health services and removing barriers to health care for all people. *Amici* NHeLP et al. work on behalf of people with behavioral health conditions throughout the country to remove barriers to behavioral health care using various tools such as direct legal services, policy advocacy, education, and litigation. *Amici* submit this brief to provide the Court with additional information about the serious need for behavioral health services in this country, and the importance of the holdings below to ensure that people with insurance receive the behavioral health services their insurers promised to provide.

INTRODUCTION

The worsening mental health and opioid crises have sharpened the focus on the importance of removing illegal barriers to treatment for mental health and substance use disorders (collectively "behavioral health"). For years, legislators and regulators have attempted to bridge the gaps to ensure fair and equitable access to these important services. Unfortunately, with each new bridge, insurers dig a new—but often illegal—trench, finding new ways to deny people behavioral health services that they need, and that are covered by their insurance.[2] As a result of these illegal denials, millions go without the behavioral health care they need and are

[2] Under ERISA, several parties can team up to offer a health insurance policy, including an employer-sponsor, a health plan and a third party administrator. In this brief we collectively refer to these entities as "insurers."

promised. Appealing the denials is futile since the administrative appeals system largely reflects the insurers' flawed rationale for denying care. And fighting the denial on an individual basis through litigation demands resources for experts and advocacy typically far out of proportion with the specific coverage benefit at stake. The District Court in this case found that one large insurer, United Behavioral Health ("UBH"), developed and applied improper, overly restrictive medical necessity guidelines contrary to generally-accepted standards of care to deny needed behavioral health care to people enrolled in its insurance products, and ordered appropriate remedies to right this wrong. *Amici* urge this Court to uphold the District Court's decision and affirm that people with UBH insurance receive the full coverage they were promised.

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. Over 50 million (or one in five) U.S. adults live with a mental health condition, with more than a quarter—over 13 million people—not receiving the mental health services they report needing. Substance Abuse & Mental Health Servs. Admin., *2019 National Survey on Drug Use and Health* 5 (2020), https://perma.cc/Y8SC-GEX2.

(hereafter *SAMHSA 2019 Survey*) In addition, an estimated 20.4 million U.S. adolescents and adults have a substance use disorder ("SUD"). *Id.* at 3. The relationship between mental health needs and substance use creates complex co-occurring behavioral health conditions for many in the United States, with about one-half of people with a SUD also having a mental health diagnosis. *Id.* at 46. Meanwhile, related complications, including suicide and overdose, continue to drive down U.S. life expectancy, with 2010 marking the first time in six decades that life expectancy decreased. Anne Case & Angus Deaton, *Rising Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 49 Proc. Nat'l Acad. Sci. 15078, 15078 (2015), https://perma.cc/XY9Y-YYQ5 (the change in life expectancy "was largely accounted for by increasing death rates from drug and alcohol [overdose]s, suicide, and chronic liver diseases and cirrhosis").

Despite the prevalence of behavioral health conditions, people often have trouble accessing the care they need. UnitedHealth Group reports that only 42% of U.S. residents receive the mental health and SUD care they need. UnitedHealth Group, *Improving Access to Behavioral Health Care* (Aug. 30, 2019), https://perma.cc/EKH2-KGFQ. In line with this stark statistic, 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. Another recent nationwide survey reported that roughly 11.8 million U.S. residents had an unmet need for mental health services in 2016, with 6.3 million (53%) reporting they received only a limited amount of care and the remaining 5.5 million (47%) reporting they received no care at all. Peggy Christidis et al., Am. Psych. Association, *An Unmet Need for Mental Health Services* (Apr. 2018), https://perma.cc/YZ43-R98Q. The unmet need for mental health services is particularly serious among groups that have historically experienced discrimination. For example, African Americans, American Indians, and Alaska Natives access mental health services at substantially lower rates than white Americans. 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. Likewise, people with a range of disabilities experience co-occurring mental distress at rates five times higher than people without disabilities, yet these individuals report twice as much difficulty in accessing appropriate mental health care. Ctrs. for Disease Control & Prevention (CDC), *The Mental Health of People with Disabilities* (2020), https://perma.cc/3QRV-874K; CDC, *Delayed or Forgone Medical Care Because of Cost Concerns Among Adults Aged 18-64 Years, by Disability and Health Insurance Coverage Status*, 59 Morbidity & Mortality Wkly. Rpt. 44, 44 (Nov. 12, 2010), https://perma.cc/2FUW-QCG5.

B. Insurers Often Fail to Provide Needed Behavioral Health Services.

Improper service denials – such as those at the heart of this litigation – create a major barrier to accessing behavioral health care. In one survey, 29% of respondents said they or their family member had been denied mental health care and 18% had been denied substance use care, while in comparison only 14% had been denied general medical care. Nat'l Alliance for Mental Illness (NAMI), *A Long Road Ahead* 4 (2015), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead (hereafter NAMI, *A Long Road Ahead*). Health insurers often do this to save costs. *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. In 2015, a National Alliance for Mental Illness survey found that mental health claims were denied at double the rate of physical health claims. NAMI, *A Long Road Ahead* at 4. As the District Court found, financial incentives are often at the heart of behavioral health service denials. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2020 WL 6479273, at *42 (N.D. Cal. Nov. 3, 2020) ("[T]he evidence showed that UBH executives put in place business practices that ensured that financial considerations would take precedence over faithful administration of class members' plans.") The *Wit* court's conclusions are buttressed by independent accounts of health insurers prioritizing financial concerns over medically necessary treatment for chronic mental health

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

Despite the high need for behavioral health services, health insurers still spend disproportionately few dollars on that necessary care. For example, non-public insurers account for only a small portion of SUD treatment coverage, which has been attributed to the rise of managed care practices that make it difficult for people with insurance to obtain SUD services from an in-network provider. *See* Steve Melek et al., Milliman, *Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* 6 (2019), https://perma.cc/ZB92-HF9J (hereafter Melek et al. 2019). The failure of private insurers to provide access to behavioral health services, particularly SUD services, has a stark impact on public insurance programs and state-funded services, drawing funds away from other necessary services. *See, e.g.*, 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.

In a 2019 report, an analysis of preferred provider organization ("PPO") claims data, which included claims from over 37 million U.S. residents, found that only 1% of health care spending went to SUD treatment and only 4.3% went to mental health

treatment. Melek et al. 2019 at 17. These percentages remained fairly constant over a five-year period, despite a sharp increase in deaths from overdose and by suicide during that same period. *Id.*; *SAMHSA 2019 Survey* at 25, 42-43 (overdose and suicide rates).

This same report revealed that insurers demonstrate significant deficiencies in network adequacy and provider reimbursement for behavioral health services compared to physical health services, leading to significant delays and deterrent effects on accessing care. Melek et al. 2019 at 12. This aligns with an earlier national study that found stark disparities comparing access to behavioral office visits to access to physical health primary care and specialty care office visits. Stephen P. Melek et al., *Addiction and Mental Health vs. Physical Health* 3 (2017), https://perma.cc/VDE7-KZ8W ("Nationally in 2015 the proportion of behavioral care that was provided out-of-network was 3.6 to 5.8 times higher than medical/surgical care, varying by care setting.").

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

Insurers often rely on internally-developed coverage guidelines, the terms and criteria for which are opaque and purposefully ambiguous for insureds, and which are not consistent with generally-accepted standards of care, to restrict coverage and ration behavioral health care. When insurers adopt their own guidelines for authorizing behavioral health services, those guidelines frequently

serve as gatekeeping mechanisms that limit coverage through overly restrictive medical necessity, admission, or level of care criteria. Under ERISA the insurer has a duty to disclose the "internal rule, guideline, protocol, or other similar criterion" that was used in making the denial of care and provide "an explanation of the scientific or clinical judgement for the determination, applying the terms of the plan to the (patient's) medical circumstances." 29 C.F.R. § 2560.503-1(g)(1)(v). Other existing utilization management protections offer basic "process" measures such as establishing staffing and professional oversight standards in terms of who oversees medical necessity decisions and who can make a denial of care. *See, e.g., id.* § 2560.503-1(b). But there are few guardrails that meaningfully prescribe how clinical guidelines are used by insurers to ensure that generally-accepted standards of care 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. Nor does the existing legal scheme ensure that regulators scrutinize the quality and empirical underpinnings of insurers' internal medical necessity guidelines to ensure they were properly developed, maintained, and implemented. *Id.* at 28-29.

This lack of regulatory scrutiny too often allows insurers to manipulate the guidelines illegally to deny reimbursement for needed behavioral health services by

deeming the care as not "medically necessary." *See id.* at 29. Conversely, individuals seeking care, family members, and clinicians frequently cite behavioral health denials citing "not medically necessary" as a target of frustration, especially because it is often hard to understand how the criteria was used to make a decision that appears arbitrary and without reasonable explanation. *Id.* at 3; NAMI, *A Long Road Ahead* at 4-5. When the medical necessity determination of an individual's clinician is at odds with the insurer's own internal medical necessity guidelines that are not consistent with generally-accepted standards of care, the individual is left at a loss. As a result, many people simply accept their insurers' denials and forego the care they need. *See, e.g.*, Consumer Reports Nat'l Research. Ctr., *Surprise Medical Bills Survey* 3 (2015), https://perma.cc/7Q3B-QUHS.

D. When Insurers Deny Ongoing and Routine Behavioral Health Care, People are Likely to Go Without Care Until They Experience a Crisis.

Insurers' coverage determinations frequently focus primarily on "acute" episodes of care, to the detriment of individuals with "chronic" behavioral health conditions. Insurers' failure to cover medically necessary behavioral health care also shows up in their coverage of acute and incidental care rather than ongoing routine and preventative behavioral health services. This coverage structure can lead to the repeated and avoidable use of emergency departments, both increasing costs for the health care entity and insurer, and leaving individuals with large and unplanned medical bills.

While people sometimes experience acute crises that require intensive care for a brief period of time, or behavioral health episodes that can be resolved with treatment in the short term, many behavioral health conditions are chronic and last throughout much of individuals' lives. As with chronic physical conditions, managing a chronic behavioral health condition requires treatment and interventions over an extended period, sometimes for a lifetime. Susan G. Lazar et al., *Clinical Necessity Guidelines for Psychotherapy, Insurance Medical Necessity and Utilization Review Protocols, and Mental Health Parity*, 24 (3) J. Psychiatric Practice 179, 181-82 (May 2018), https://perma.cc/7Q3B-QUHS. Focusing on addressing acute symptoms while ignoring routine care that individuals need to maintain stability and prevent acute episodes is inconsistent with generally-accepted standards of care that recognize the importance of long-term stabilization and relapse prevention. *Id.*; 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. Prevention and early intervention are also important to the successful management of behavioral health conditions and to avoid trauma and disruption in individuals' lives. Nat'l Assoc. of State Mental Health Program Dirs., *Reducing the Burden of Mental Illness* 6 (2014), https://perma.cc/9YE3-ZEXX.

Because of the lack of access to routine care, people with chronic behavioral health needs are often only able to obtain care when their condition has reached a

crisis point, making them far more likely to use the emergency department, to be hospitalized, and to experience readmission after an initial hospitalization. Laura N. Medford-Davis et al., *The Role of Mental Health Disease in Potentially Preventable Hospitalizations: Findings From a Large State*, 56 Medical Care 31, 31 (Jan. 2018), https://perma.cc/2XFZ-ZFQL. These episodes, often involving involuntary detention and treatment, are traumatic and disruptive to people's lives. Often they result in loss of employment, housing, and relationships, contributing to further deterioration of individuals' health and mental health.

Adding to the problem, the type of care received in a hospital setting rarely meets the full, complex needs of a person with a chronic condition. For example, individuals using emergency departments for crisis care often face complicated authorization procedures set up by insurers—which have been called "rationing by hassle"—that act as "false hurdles" to care such that people will not get even the treatment they need in an emergency or crisis situation. Chloe Reichel, *Obstacles Prevent Access to Mental Health Care, Even Among Insured*, The Journalist's Resource (July 10, 2019), https://perma.cc/R7JT-7GD2. The failure to provide ongoing, chronic care. The lack of chronic care leads 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. People who do not have access to routine care end up in emergency departments and jails when they are in crisis; neither of which are suited to provide needed treatment. *Id.* at 27, 41.

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. The results of police involvement can be particularly harmful, as it may lead 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). Zeynal Karaca & Brian J. Moore, *Costs of Emergency Department Visits for Mental and Substance Use Disorders in the United States, 2017*, Healthcare Cost & Utilization Project Statistical Briefs 1, 3 (May 12, 2020), https://perma.cc/6YT6-V8D4. The frequency and cost of these visits and hospitalizations have been increasing over time, especially those related to SUD. *Id.*

Inpatient behavioral health services also leave patients with unnecessarily large medical bills and debt. *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. Perversely, this financial crisis can then trigger or exacerbate mental health symptoms, including depression and anxiety. Jacqueline C Wiltshire et al., *Problems*

Paying Medical Bills and Mental Health Symptoms Post-Affordable Care Act, 7 AIMS Pub. Health 274, 275 (May 6, 2020), https://perma.cc/QGQ3-8VQ6. Patients seeking psychiatric care are "particularly vulnerable to harms from surprise medical bills," not least of which is the potential consequence of "discouraging patients from seeking care" for fear of incurring further financial burdens. 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. Where coverage of necessary services is lacking, and when patients are funneled unnecessarily into acute care settings rather than receiving appropriate ongoing care for chronic conditions, the effect may be to ultimately worsen a person's condition, introducing new financial and emotional burdens, as well as deterring many from seeking care in the future.

E. Insurer Practices That Deny Needed Behavioral Health Care Lead to Worse Patient Outcomes and Shift Costs to Families, Employers and Governments.

People who are unable to access needed mental health services not only experience a deterioration in their mental health condition, but also may experience physical health complications. For example, the presence of several mental health conditions significantly increase an individual's risk of cardiovascular disease. Melanie Arenson & Beth Cohen, Nat'l Ctr. for PTSD, *Posttraumatic Stress Disorder and Cardiovascular Disease*, 28 PTSD Res. Q. 1 (2017), https://perma.cc/PJW6-4SYM (PTSD); Miriam Weiner et al., Annals of Psychiatry, *Cardiovascular Morbidity and*

Mortality in Bipolar Disorder, 23 Ann. Clin. Psychiatry 40 (Oct. 11, 2011), https://perma.cc/TFJ7-CGQT (bipolar); Marc De Hert et al., *The Intriguing Relationship Between Coronary Heart Disease and Mental Disorders*, 20 Dialogues Clin. Neuroscience 31 (Mar. 2018), https://perma.cc/2536-5RFN (depression, schizophrenia, anxiety disorders). 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, 1 (Feb. 1, 2011), https://perma.cc/GFP5-6PB6. People with mental health diagnoses, particularly those that are clinically classified as "severe," have dramatically higher mortality rates, owing largely to these comorbid conditions. Marc De Hert et al., *Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications and Disparities in Health Care*, 10 World Psychiatry 52 (Feb. 2011), https://perma.cc/E2EB-BQFD. 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. Moreover, "comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis." *Id.* A lack of mental health treatment can therefore be deleterious to physical health, and vice versa. Coverage of behavioral health services thus has significant implications for physical well-being.

Inadequate behavioral health treatment can also interfere with individuals' employment. Significant manifestations of this are seen in both absenteeism and presenteeism—defined as missing work entirely or being present at work while being prevented from fully performing work tasks, respectively. One study, tracking changes in the economic costs of various untreated mood disorders including depression and bipolar disorder from 2005 to 2010, estimated the annual cost of presenteeism to be $78.7 billion by 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)*, Clinical Psychiatry (Feb. 2015), https://perma.cc/G3KP-F4U6.

Moreover, when people with 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 et al., *Parity Tracking Project: Making Parity a Reality* 4 (2017), https://perma.cc/TL4K-5TST. 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. Medicare & Medicaid Servs., *Behavioral*

Health Services, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html (last accessed May 14, 2021).

Put simply, when insurers do not meet their legal obligations to provide behavioral health services, these shortcomings lead to poorer clinical outcomes and higher population health costs.

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

A. Congress Has Repeatedly Recognized the Unmet Need for Behavioral Health Services and Legislated to Improve Access.

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. Despite Congress's enactment of multiple protections to ensure access to behavioral health services, insurers have attempted to thwart those protections and have continued to illegally restrict care. 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.

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 1996

Mental Health Parity Act (MHPA). At the time, when insurers offered mental health benefits, they were often so severely restricted that an individual would quickly exhaust the available benefits. Despite this effort, in 2000, the GAO found that, about 87% of insurers who adopted restrictive mental health benefit design features to offset the impact of the reforms to dollar limit requirements they made to comply with MHPA, 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.

In 2002, the U.S. Department of Labor's (DOL) adopted a claims procedure regulation under ERISA to promote fair decision making, transparency and due process rights when an insurer or third party administrator is assessing whether a recommended treatment is medically necessary. 29 C.F.R. § 2560.503-1. While these regulations apply to the broad range of services covered by insurers under ERISA, the procedures they set forth are particularly important in the context of behavioral health denials or when there is no "medical necessity" determination made at all. In such cases, individuals must rely on the insurer's internal appeals process (and external review) to have their denials re-considered. Yet, as discussed in more detail below, these appeal processes rarely ensure that people get the behavioral health services they need.

In 2008, Congress again amended ERISA to explicitly address access to behavioral health services, with the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA was intended to address the range of discriminatory treatment limitations that persisted after enactment of the MHPA and to apply protections to the treatment of substance use disorders for the first time. P.L. 110-343, Div. C, 122 Stat. 3765 (2008). Under the subsequent rulemaking, regulators worked to ensure that there was parity between medical/surgical and behavioral services provided, and that the underlying processes for approving and denying those services were developed with parity. *See generally* MHPAEA Final Rules, 78 Fed. Reg. 68240 (Nov. 13, 2013), https://perma.cc/X4AJ-XQ3J; *see, e.g.*, 29 C.F.R. § 2590.712(c)(4)(iii)(ex. 8).

Just two years later, in 2010, the Affordable Care Act (ACA) applied MHPAEA to other types of insurance plans. Patient Protection and Affordable Care Act, P.L. 111-148, 124 Stat. 119 (2010), as amended in the Health Care and Education Reconciliation Act, P.L. 111-152, 124 Stat. 1029 (2010), as amended in the Health Care and Education Reconciliation Act, modified by P.L. 111-152 (2010). The ACA also contained numerous provisions aimed at improving access to behavioral health services, including in ERISA plans. For example, the ACA requires most insurers, including ERISA-covered small group

employer plans, to provide ten Essential Health Benefits, including mental health and substance use disorder benefits. *See* 42 U.S.C. § 18022.

In 2016, in the 21st Century Cures Act, Congress again amended ERISA to improve meaningful access to behavioral health services – recognizing that restrictive policies around those services remained a significant issue and that existing parity provisions were insufficient to ensure access to these critically important services. P.L. 114-255, 130 Stat. 1033 (2016). The 21st Century Cures Act contained several provisions to enhance the enforcement of parity by increasing transparency, including requiring the Secretary of Health and Human Services to develop a parity action plan, the Department of Labor (DOL) to issue a report on parity investigations in ERISA plans, and the GAO to produce a study on parity that would detail how covered insurers were complying with the requirements, including those related to medical necessity transparency. *Id.* §§ 13002-13007); *see* Gov't Accountability Office, GAO-20-150, *Mental Health and Substance Abuse: State and Federal Oversight of Compliance with Parity Requirements Varies* (2019), https://perma.cc/32NS-K3QC.

Finally, as recently as December 2020, Congress yet again amended ERISA to improve access to mental health and substance use disorder benefits. Consolidated Appropriations Act ("CAA"), 2021, P.L. 116-260 § 203 (2020). These amendments require ERISA plans to provide to DOL, upon

request, certain information and analysis about their compliance with ERISA. *See id.* The CAA specifically required that the insurers' comparative analyses demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limitations as written and in operation for behavioral health services are no more stringent than those for medical/surgical benefits. *Id.* The CAA demonstrated congressional concern that insurers' criteria and methods, written and unwritten, were being used to deny services. Thus, it also required investigation of these analyses and a compliance report from the Secretary. *Id.*

Despite Congressional protections, illegal practices by insurers continue and people are routinely denied behavioral health services to which they should have access under their plans. *See, e.g.*, NAMI, *A Long Road Ahead* at 4 (finding that while insurers subject to the ACA have a lower reported rate of denial for mental health care, that denial rate is still twice the denial rate for general medical care).

B. 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 generally-accepted standards of care, 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 generally-accepted standards of care. 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) (noting that 72% of Americans "are unsure if they have the right to appeal to the state/independent medical expert if their health plan refuses coverage for medical services they think they need" and 87% "don't know the state agency/department tasked with handling health insurance complaints"); *see generally* The Kennedy Forum & NAMI, *The Health Insurance Appeals Guide* (2021), https://perma.cc/Q3WN-RGA6 (detailing how to navigate the appeals processes and highlighting how medical necessity may be used to deny care). The uncertainty and futility of the appeals process can in turn cause stress and anxiety that exacerbates the very behavioral health condition for which the person is seeking treatment. *See* Sircar at 16.

If they appeal, individuals typically must prevail based on insurer's self-selected medical necessity criteria, and cannot meaningfully challenge them through an appeal, even when those criteria are pervasively flawed and inconsistent with generally-accepted standards of care. *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. As a result, people with behavioral health conditions are often left high and dry because they cannot afford to obtain the behavioral health services they need if their insurer is not covering the expense. *See* 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.

III. For the Insured, Class Certification and the Relief It Facilitates Are Particularly Well Matched to Resolution of the Systemic, Difficult to Fight Denials of Necessary Care at Issue in *Wit*.

The individuals seeking behavioral health services at the center of this appeal face a difficult road in accessing the coverage benefits promised by their insurer. In line with a long line of similar class litigation, the District Court's certification below is an indispensable component of the relief in this case. Since its modern iteration was enacted in 1966, Rule 23 has been employed as an instrument to effect meaningful advancement of civil rights. Applied properly, Rule 23 allows groups of litigants subjected to common harm to band together in a single, efficient, and effective process to seek redress for past harm and achieve court-ordered reform of ongoing malignant policies and practices. The District Court below certified and ordered relief

under each of the forms permitted by Rule 23(b). This was not just appropriate; it was wholly consistent with the highest and best use of the class action device.

At the core of *Wit* are more than 67,000 coverage denials for behavioral health treatment. It would simply not be feasible for each of the individuals on the wrong end of these denials to challenge UBH's standards acting alone in court. Even for those claimants able to overcome the overwhelming confusion, distress, and stigma that attend challenging a denial of behavioral health coverage, a stark economic reality remains. Individual claimants faced with the need to support properly any coverage denial challenge, including the costs of counsel, litigation fees, and the limited potential recovery, face insurmountable impediments. The type of challenge necessary to show that the UBH breached its fiduciary duty by designing and using pervasively flawed guidelines necessarily requires retention of an expert witness. This is a significant investment beyond the reach of the average individual. *See* Sircar at 16 (discussing that pursuing relief through the courts for access to behavioral health services is often a function of a valid cause of action, one's social standing, and access to resources). That such claimants are simultaneously struggling to overcome an uncovered or untreated mental health diagnosis underscores the difficulties. By recognizing a single vehicle to resolve

numerous claims in which common issues predominate over individual variations, the District Court's class certification aggregates the economic power of insureds, making it possible for an attorney to commit to the matter, and for costs—including the cost of experts—to be advanced. Without it, UBH might face no meaningful consequence for systemic misbehavior. "Economic reality dictates that petitioner's suit proceed as a class action or not at all." *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 161 (1974). This is precisely the type of factual landscape for which Rule 23 was designed.

The roots of modern Rule 23 as a tool to realize civil rights for marginalized communities are well documented. *See, e.g.*, Suzette M. Malveaux, *The Modern Class Action Rule: Its Civil Rights Roots and Relevance Today*, 66 U. Kan. L. Rev. 325, 393–94 (2017) ("The modern class action rule's civil rights provision was one answer to [ ] societal turmoil and a concrete embodiment of how historically marginalized people could seek justice and efficiency in the federal courts. This very same rule remains today and continues to play a critical role in American democracy."). "Civil rights cases against parties charged with unlawful, class-based discrimination are prime examples" of the use of Rule 23(b)(2). *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591, 614 (1997); *see also* Jack Greenberg, *Civil Rights Class Actions: Procedural Means of Obtaining Justice*, 39 Ariz. L. Rev. 575, 577 (1997) ("Civil rights and class actions have an historic

partnership."). Likewise, the Supreme Court has observed that in creating Rule 23(b)(3), "the Advisory Committee had dominantly in mind vindication of 'the rights of groups of people who individually would be without effective strength to bring their opponents into court at all.'" *Amchem Prod.*, 521 U.S. at 617 (internal citations omitted). This matter, attacking a set of unjustified procedures applied uniformly to a large group of people, who by definition have a behavioral health condition, and aggregating their litigating strength, fits squarely within the traditions associated with Rule 23 certification for at least three reasons. *Cf.* Robert L. Carter, *The Federal Rules of Civil Procedure As A Vindicator of Civil Rights*, 137 U. Pa. L. Rev. 2179, 2185 (1989) (noting that in the struggle for school desegregation "[i]n some of those cases, full relief would have been impossible were it not for plaintiffs' ability to proceed as a class.").

First, a "classic example" of Rule 23's utility is a case "charging a breach of trust by an indenture trustee or other fiduciary similarly affecting the members of a large class of beneficiaries . . . ." *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 833-34 (1999) (cleaned up). ERISA cases attacking the employment of wrongful criteria plan-wide typify the form. *See, e.g., K.M. v. Regence Blueshield*, No. C13-1214 RAJ, 2014 WL 801204, at *15 (W.D. Wash. Feb. 27, 2014) ("[W]ere this Court to find that the Plan requires Defendants to act in a certain fashion, ERISA would require [Defendant] to act in a similar fashion

toward all beneficiaries-the quintessential (b)(1)(B) scenario."). By certifying classes below, the District Court's finding of a breach of fiduciary duty, including the arbitrary and capricious denial of benefits, ensures the ruling will be applied uniformly to all insureds whose interests were at stake, and avoids the possibility of inconsistent rulings from parallel procedures.

Second, the District Court's certification for the purpose of facilitating uniform injunctive relief was similarly historically sound. The declaratory and injunctive remedies ordered here respond to the Defendant's "conduct that applies generally to the class." Fed. R. Civ. P. 23(b)(2). For example, the District Court issued a declaratory judgment finding that "each and every adverse benefit determination made by UBH based in whole or in part on any of the [challenged guidelines] between May 22, 2011 and June 1, 2017, was wrongful and made in violation of plan terms and ERISA." *Wit*, 2020 WL 6479273 at *49. Relatedly, the District Court ordered notice to be sent to the various classes and issued an injunction directing "each and every adverse benefit determination meeting the criteria for Class Membership in this case [to be] remanded to UBH to be reprocessed in a manner consistent with the Court's FFCL and this Order." *Id.* at *51. These aspects of the District Court's opinion represent archetypal examples definitive of the value to the Court, and to the public more broadly, of Rule 23.

The benefit of this class certification stems not just from the judicial economy generated by affording appropriate relief to every class member with a single order. There are practical implications as well. Without class certification, insureds are faced with a no-win landscape. On the one hand, to be successful, in such a challenge, an individual litigant must overcome a difficult standard of review, limiting the number of challenges actually brought. On the other hand, in those instances where defense motions for summary judgment are not granted, individual settlements limited to a single beneficiary are the most common immediate result. In either case, insurers are effectively isolated from broad accountability for systemic misconduct. Rule 23 can revoke this "get out of jail free card" from ERISA defendants, allowing all insureds to gain from the litigation efforts of their fellow members, and providing a robust deterrent effect. Courts following the Ninth Circuit's rejection of the so-called "necessity requirement," have particular occasion to identify the ancillary due process benefits of Rule 23 certification beyond the legal effect of classwide relief. *Fernandez v. Dep't of Soc. & Health Servs.*, 232 F.R.D. 642, 646 (E.D. Wash. 2005). "Class certification will ensure that [class] notice and enforcement of the Court's Order is vetted by both parties and the Court rather than unilaterally determined by the [defendant]." *B.E. v. Teeter*, No. C16-0227-JCC, 2016 WL 3939674, at *5 (W.D. Wash. July 21, 2016).

Last, the District Court's Rule 23 certification similarly facilitates quintessential relief associated with common factual and legal questions that predominate over individual variances. "Courts have long recognized the benefits conferred by the class action mechanism over numerous individual actions." *Smith v. Los Angeles Unified Sch. Dist.*, 830 F.3d 843, 863 (9th Cir. 2016). Those benefits are overwhelming here. As detailed herein, there are a host of barriers preventing widespread private enforcement by individual insureds. Beyond the confusion and distress that impede meaningful administrative appeals for behavioral health care denials, more generic difficulties block the courthouse door. Cost to bring suit is at the top of this list. Rule 23(b)(3) changes this dynamic. "[T]he class action is one of the few devices that the American legal system has developed to offset the high cost of legal services." Jed Rakoff, *Why You Won't Get Your Day in Court*, N.Y. Rev. of Books (Nov. 24, 2016), https://perma.cc/G3Z6-D754.

Rule 23 thus makes possible judicial enforcement of the congressionally recognized rights enshrined in ERISA's protections, as well as the promises made to insureds by their own employers and fiduciaries. The relief entered by the District Court was thus appropriate. More than that, it was consistent with a long tradition of important systemic reform facilitated by Rule 23.

IV. CONCLUSION

For the foregoing reasons and those in the Appellees' brief, *amici* respectfully request that this Court affirm the District Court's decision.

Dated: May 19, 2021

Respectfully submitted,

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FOR THE NINTH CIRCUIT

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