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 (ADAP); American Foundation for Suicide Prevention; American Lung Association; Arizona Center for Law in the Public Interest; Assistive Technology Law Center; Autism Legal Resource Center; Center for Public Representation; Legal Action Center; Partnership to End Addiction; Public Justice Center; The Kennedy Forum; The Trevor Project; and William E. Morris Institute for Justice.

Dated: March 17, 2023

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INTEREST OF *AMICI*

Fifteen non-profit organizations representing the interests of people with behavioral health conditions and other disabilities have come together to submit this *amicus curiae* brief in support of the Plaintiffs-Appellees.[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 (ADAP); American Foundation for Suicide Prevention; American Lung Association; Arizona Center for Law in the Public Interest; Assistive Technology Law Center; Autism Legal Resource Center; Center for Public Representation; Legal Action Center; Partnership to End Addiction; Public Justice Center; The Kennedy Forum; The Trevor Project; 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 and other disabilities throughout the country to remove barriers to care using tools such as direct legal services, policy advocacy, education, and litigation. As such, the *amici* have an interest in the outcome of this case.

[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.

INTRODUCTION

Over the last decade, 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). In the last three years, the COVID-19 pandemic has exponentially increased the need for these services. Adults reporting symptoms of anxiety and depressive disorder rose from 11 percent in 2019 to 29-43 percent in 2020-21; 13 percent of adults started or increased their substance use; and drug overdose deaths increased 29 percent. U.S. Gov't Accountability Office, GAO-22-104437, Behavioral Health and Covid-19 (2021), https://perma.cc/c4gn-zs3g. Increases in anxiety and depression were even more pronounced among youth and Black, Indigenous, and Other People of Color, exacerbating existing racial disparities in behavioral health. *See* Sherry Everett Jones et al., Ctrs. Disease Control & Prevention, *Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic*, 71 Morbidity & Mort. Weekly R. 16, 16-17 (2022), https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm; Mieke Beth Thomeer et al., *Racial and Ethnic Disparities in Mental Health and Mental Health Care During The COVID-19 Pandemic*, J. Racial & Ethnic Disp. (2022), https://perma.cc/NR3U-6FNW.

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—often illegal—

trench, finding new ways to deny critically needed behavioral health services ostensibly covered under their plan. Appealing a denial is often futile, as the administrative appeals system largely reflects the insurers' flawed and conflict-ridden rationale for denying care. Fighting the denial on an individual basis through litigation usually 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 in part. According to the Panel, although the plan terms required coverage of treatment be consistent with GASC, nothing in the plan terms "require UBH to develop Guidelines that mirror GASC." *Wit v. United Behav. Health*, 58 F.4th 1080, 1097 (9th Cir. 2023).

The Panel's opinion is flatly contradicted by the record below, misconstrues Plaintiffs' claims, and precipitates great harm. The Plaintiffs did not argue that the plans required coverage of all services consistent with GASC. Instead, the Plaintiffs object to the method that the plans used in evaluating medical necessity. The core of Plaintiffs position is that *in the evaluation of whether requested services are medical necessary*, plans are required to use GASC, rather than restrictive internal guidelines infected by their own financial interests. The Panel's decision would allow plans to make medical

necessity determinations without basis in GASC despite contractual obligations otherwise. It would create a hole in insurance coverage through which plans may drive denials based on reasons far removed from clinical guidelines. And, because appeals rely on the same plan-created criteria, it would allow Plans to continue to deny medically necessary services even when people appeal a denial of coverage.

The Circuit Panel's decision sanctions widespread arbitrary denials of care by insurers and incentivizes insurers to use their own standards, including standards that are clinically unsound and tainted by 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 high level of need for behavioral health care in the United States and because of the inevitable harm to class members when the 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 Necessary Behavioral Health Treatment.

A. Individuals Are Not Receiving Needed Behavioral Health.

Millions of people in the U.S. need behavioral health care but do not get it. An estimated 46 million U.S. adolescents and adults have a substance use disorder (SUD). Substance Abuse & Mental Health Servs. Admin., *2021 National Survey on Drug Use and Health* 5 (2022),

https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf. Over 57 million (one in five) U.S. adults live with a mental health condition. *Id.* The COVID-19 pandemic has had significant impacts on behavioral health, with sharp increases in prevalence of conditions and population groups disproportionately affected, particularly young adults, people of color, essential workers, and unpaid caregivers. 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; while overdose deaths decreased slightly in 2022, they were still over 100,000. FB Ahmad et al., Ctrs. Disease Control & Prevention, *Provisional Drug Overdose Death Counts* (2023), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

Despite the ubiquity of behavioral health conditions, people often have trouble accessing the care they need. The GAO recently identified major barriers to needed treatment that include variation in treatment standards and focus on crisis stabilization rather than ongoing treatment of underlying conditions. U.S. Gov't Accountability Office, GAO-22-104597, Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts 23 (2022), https://perma.cc/DN36-JZXK [hereinafter GAO-22-014597]. The National Institute of Mental Health reports

that 56.2 percent of people with mental health conditions did not receive any mental health services over the course of 2019. 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. Disease Control & Prevention (CDC), *The Mental Health of People with Disabilities* (2020), https://perma.cc/3QRV-874K.

B. Insurers Deny Needed Behavioral Health Care to Serve Their Own Fiscal Interests.

Contractual obligations require insurers to cover the non-excluded services described in their plan terms. The UBH plans at issue here, like most private health insurance contracts, define these services with reference to GASC. *See* 2-ER-253. Yet, private health insurers disproportionately deny coverage of behavioral health services, a problem that Congress has repeatedly tried to address. *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 [hereinafter NAMI, *A Long Road Ahead*]. The basis of denials are often unknown to the insured and

based on market-influenced criteria untethered from clinical standards. *See* Neiloy Sircar, *Your Claim Has Been Denied: Mental Health and Medical Necessity*, 11 Health L. & Pol'y Brief 1, 10-12 (2017), https://perma.cc/68RS-6CW6 (also describing the negative effects of these practices on the health and welfare of covered individuals).

Wrongful denials of care have far-reaching consequences to people's lives and to society more broadly. For example, insurers often focus approved coverage on acute care, even when that focus is inconsistent with GASC that support the need for 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. The lack of coverage for chronic behavioral health conditions 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 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. *See, e.g.*, 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 (estimating behavioral health emergency visits totaled more than $5.6 billion).

Reliance on inpatient behavioral health services leaves people with unnecessarily large medical bills and debt, which are often connected to worsening mental health, and deters them 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 mental health services, including non-acute community-based care, may not only experience a deterioration in their mental health condition, but also face physical health complications, which can exacerbate or create additional mental health symptoms, producing a dangerous cyclical relationship in which conditions worsen each other. *See, e.g.*, S. Goodell et al., *Mental Disorders and Medical Comorbidity*, The Synthesis Project 1 (Feb. 1, 2011), https://perma.cc/GFP5-6PB6; 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.

Going without needed 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 (discussing research suggesting that enforcement of mental parity laws and improved access to care may reduce suicide rates). This is not hyperbole, the record below confirms as much. *See* 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 six 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 ten weeks after UBH's denials of his claims at the age of 21).

Moreover, 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." 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; *see also* GAO-22-104597, *supra*, at 20-22 (discussing shifting children to Medicaid due to parent's employer-based coverage not providing needed behavioral health services). 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.; Medicaid also pays for a high proportion of substance use disorder services. *See* Ctrs. Medicare & Medicaid Servs., *Behavioral Health Services*, https://perma.cc/B6FS-QMBV (last visited March 16, 2023). Meanwhile, those not covered by Medicaid scramble to pay for needed care out-of-pocket, including some of the *Wit* plaintiffs (even though the treatment they needed 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 for residential treatment); *id.* at ¶ 90 (Cecilia Holdnak paid over $100,000 out-of-pocket for her daughter's treatment, including residential treatment); *id.* ¶ 130 (Lauralee Pfeifer spent about $54,000 out-of-pocket and was deterred from seeking additional residential treatment due to denials); *id.* at ¶ 180 (Lori Flanzraich paid nearly $90,000 out-of-pocket for residential treatment).

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 burdens on taxpayer-funded programs, particularly Medicaid.

C. Insurers Hide Behind Internal Guidelines When Reviewing Medical Necessity of Behavioral Health Services.

The *Wit* case is particularly important because it highlights how insurers skirt scrutiny for their improper denials of behavioral health care. Insurers inappropriately rely on internally developed clinical guidelines whose terms and criteria are purposefully opaque for insureds. The guidelines are used to restrict coverage and ration behavioral health care in ways that are inconsistent with requirements, in particular the plan terms to evaluate whether covered services are medically necessary using GASC. When insurers determine that a covered service is not necessary for an insured, where that coverage is clearly supported under GASC, is hard for insured people to understand why coverage was denied and whether the determination was wrong such that they should appeal. It is also often difficult for insured people to rebut their insurers' determination, leading many people to instead forego needed treatment. *See Sircar*, *supra*, at 3. 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 (last accessed March 15, 2023) . The existing legal scheme does not ensure that regulators scrutinize the quality and empirical underpinnings of insurers' internal guidelines for medical necessity determinations, with disastrous results. *Id.* at 28-29.

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 time-consuming and ineffective. Putting aside the fact that many people do not understand their appeal rights, filing an appeal 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 provide meaningful review of an insurer's misapplication of medical necessity. Individuals must typically prevail based on the insurer's self-selected medical necessity criteria and often cannot meaningfully challenge those criteria through an appeal, even when they are inconsistent with

GASC or otherwise flawed. *See* NAMI, *A Long Road Ahead* at 5 (explaining how insurers using their own standards makes it difficult for individuals to "assert their rights in the face of an adverse decision"). Many individuals cannot readily take on appeals involving conflicts between their provider and their insurer, as such battles require costly experts and the help of a professional advocate. The Kennedy Forum & NAMI at 49, 67; *see also* Sircar, *supra*, at 15-16. All too often, instead of fighting denials, people simply go without medically necessary behavioral health services.

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

Over the last 30 years, Congress has repeatedly recognized the critical unmet need for behavioral health services in the United States. Efforts to expand access to behavioral health coverage began decades earlier, but Congress first amended ERISA with the Mental Health Parity Act of 1996 (MHPA) to address the disparities in coverage of behavioral health benefits perpetuated by insurers.[2] 104 Pub. L. No. 204, 110 Stat. 2945 (1996). In 2000, the GAO found that, about 87 percent of insurers had adopted restrictive mental health benefit design features to offset the impact of complying with MHPA, while about 14 percent remained non-compliant. U.S. Gov't Accountability Office, GAO/HEHS-00-95, Mental Health Parity Act: Despite New

[2] *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).

Federal Standards, Mental Health Benefits Remain Limited 5 (2000), https://perma.cc/P373-59Y9. A cat-and-mouse scenario has ensued. In 2002, federal regulations were implemented to amend claims procedures in an attempt to rein in misuse of medical necessity guidelines. 29 C.F.R. § 2560.503-1. In 2008, Congress amended ERISA to explicitly address access to behavioral health services and expand parity to substance use disorder treatment. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), Pub. L. No. 110-343, Div. C, 122 Stat. 3765 (2008). In 2016, in the 21st Century Cures Act, Congress again amended ERISA in an attempt to increase transparency, especially with respect to insurers' medical necessity decision making processes. Pub. L. No. 114-255, 130 Stat. 1033 (2016). Congress also enacted parity legislation 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. No. 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). Many states have also enacted laws to address problems, including 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.

Even with these legal protections in place, 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 denial rate for mental health care is twice the denial rate for general medical care); U.S. Gov't Accountability Office, *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 Department of Labor "reviewed between April 10, 2021, and October 31, 2021, were initially insufficient regarding the[] statutory requirements"); *id.* at 8 (DOL sent 156 noncompliance letters to insurers across 86 investigations). As Congress and other regulators have scrutinized insurance coverage of behavioral health benefits more closely, insurers have responded by finding legal loopholes that obscure their actions to avoid the consequences of their improper denials.

III. En Banc Review is Warranted Because the Question of 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 ignore requirements. Without

review, the fundamental error in the Panel Opinion will license arbitrary, harmful insurer conduct going forward.[3]

First, the Opinion's cardinal conclusion is that UBH had no obligation to ensure that its guidelines are consistent with GASC. *Wit*, 58 F.4th at 1097. 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 conflates the fact that UBH may sometimes permissibly exclude care that is consistent with GASC (for example, when a particular benefit is not covered at all under the Plan contract) with its obligation to ensure that the guidelines it uses to evaluate the medical necessity of covered benefits are consistent with GASC: "While the GASC precondition mandates that a treatment be consistent with GASC as a starting point, it does not compel UBH to cover all treatment that is consistent with GASC. Nor does . . . any other provision in the Plans—require UBH to develop Guidelines that mirror GASC." *Wit*, 58 F.4th at 1097. At every opportunity, the Plaintiff-Appellees made clear that they did not claim that the plan terms mandate

[3] Putting aside the issue for GASC, plans must comply with anti-discrimination laws that may require inclusion of benefits beyond existing GASC standards.

coverage for every service within the umbrella of GASC, and the District Court did not understand them to make that argument.[4] Instead, as the record below makes 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 medical necessity of covered behavioral health services for particular individuals. *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 to determine whether covered services are medically necessary for insureds. Such a practice would be the very definition of arbitrary.[5]

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

[5] 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 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

IV. CONCLUSION

For the foregoing reasons, and those in the Appellees' brief, *amici* respectfully request that this Court accept this case for rehearing *en banc*.

Dated: March 17, 2023

Respectfully submitted,

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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.").

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** March 17, 2023

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Date: March 17, 2023

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