Nos. 20-17363, 20-17364, 21-15193, 21-15194

In The United States Court of Appeals For The Ninth Circuit

DAVID WIT, *et al.*,
Plaintiffs-Appellees
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant

Appeal from the United States District Court
For the Northern District of California
Case Nos. 3:14-cv-2346, 3:14-cv-5337
The Honorable Joseph C. Spero, Chief Magistrate Judge Presiding

BRIEF OF AMICI CURIAE NATIONAL ASSOCIATION FOR BEHAVIORAL HEALTHCARE, AMERICAN HOSPITAL ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE, CALIFORNIA HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS, NATIONAL COUNCIL FOR MENTAL WELLBEING, and REDC CONSORTIUM IN SUPPORT OF REHEARING EN BANC

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CORPORATE DISCLOSURE STATEMENT

Appellate Court No.: Nos. 20-17363, 20-17364, 21-15192, 21-15194

Short Caption: *Wit v. United Behavioral Health*

The undersigned counsel of record for Amici, National Association for Behavioral Healthcare ("NABH"), American Hospital Association ("AHA"), American Psychological Association ("APA"), American Association for the Treatment of Opioid Dependence ("AATOD"), California Hospital Association ("CHA"), Federation of American Hospitals ("FAH"), National Association of Addiction Treatment Providers ("NAATP"), National Council for Mental Wellbeing ("NCMW"), and REDC Consortium certifies that AHA, APA, CHA, FAH, NAATP, NABH, NCMW, and the REDC Consortium are not subsidiaries of any other corporation and no publicly held corporation owns 10% or more of any *amicus curiae* organization's stock.

/s/ Mark D. DeBofsky
Mark D. DeBofsky

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INTEREST OF AMICI CURIAE

The National Association for Behavioral Healthcare ("NABH") is an organization that represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in all 49 states and the District of Columbia. The association was founded in 1933.

NABH represents behavioral health provider systems committed to delivering responsive, accountable, and clinically effective prevention and treatment for children, adolescents, adults, and older adults with mental and substance use disorders.

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to and affordable for all Americans. In particular, hospitals and health

systems provide essential behavioral health care services to millions of Americans every day. The AHA has a long-standing commitment to support member efforts to deliver high-quality, accessible behavioral health services.

The American Psychological Association (APA) is a scientific and educational organization dedicated to increasing and disseminating psychological knowledge. A non-profit scientific and professional organization, it has approximately 135,000 members and affiliates. The APA's major purposes include promoting the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives.

The American Association for Treatment of Opioid Dependence ("AATOD") was founded in 1984 to enhance the quality of patient care in treatment programs by promoting the growth and development of comprehensive opioid treatment services throughout the United States.

The California Hospital Association (CHA) is a nonprofit membership corporation representing the interests of more than 400 hospital and health system members in California, including psychiatric hospitals. CHA's members furnish vital health care services,

including behavioral health care services, to millions of our state's citizens. CHA provides its members with state and federal representation in the legislative, judicial, and regulatory arenas, in an effort to: support and assist California hospitals in meeting their legal and fiduciary responsibilities; improve health care quality, access, and coverage; promote health care reform and integration of services; achieve adequate health care funding; improve and update laws and regulations; and maintain the public trust in healthcare. CHA's efforts regularly include participating as *amicus curiae* in cases of importance to hospitals and other health care providers, such as this one.

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. Its members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services. These tax-paying hospitals account for nearly 20 percent of U.S. hospitals and serve their communities proudly while providing high-quality, affordable health care to their patients. Dedicated to a

market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The mission of the National Association of Addiction Treatment Providers ("NAATP") is to provide leadership, advocacy, training, and member support services to ensure the availability and highest quality of comprehensive research-driven evidence-based addiction treatment and care that addresses the medical, bio-psycho-social, and spiritual needs of individuals and families impacted by the disease of addiction.

The National Council for Mental Wellbeing ("NCMW") is a membership organization that drives policy and social change on behalf of nearly 3,200 mental health and substance use treatment organizations and the more than 10 million children, adults, and families they serve. NCMW advocates for policies to ensure equitable access to high-quality services, build the capacity of mental health and substance use treatment organizations and promote a greater understanding of mental wellbeing as a core component of comprehensive health and health care.

The REDC Consortium is the national consortium representing eating disorders care focused on standards, policy, research, and best practices. The REDC, which was founded in 2011 as the Residential Eating Disorders Consortium, was expanded in 2020 to encompass higher levels of care for treating of eating disorders. The mission of REDC is to collaboratively address issues impacting access to and quality of eating disorder treatment programs across the US for individuals and their families. REDC works to continually refine and improve standards of care, partner in collaborative research, and actively support policy that ensures quality, accessible care for people with eating disorders.

Amici all have an interest in this matter because of their commitment to safe, effective, and comprehensive treatment for behavioral health conditions, including substance use and eating disorders.

This brief is being submitted in accordance with Fed. R. App. P. 29(b) without opposition by any of the parties. 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.

Amici submit this brief to provide the Court with additional information and to reinforce the exceptional importance of the issues presented in this case with respect to access to care and treatment of behavioral health and substance use disorders consistent with each patient's individualized needs and medically necessary requirements.

INTRODUCTION

This case presents an issue of exceptional importance to the health of the American public. The district court's two 100-page opinions, issued after the conclusion of a 10-day bench trial, were landmark rulings that produced an immediate and profound nationwide impact on coverage for treatment of behavioral health and substance use disorders. Most significantly, the district court found the country's largest managed healthcare and health insurance company for behavioral health services, United Behavioral Health (UBH), routinely denied patients access to covered outpatient, intensive outpatient, and residential mental health and substance use disorder treatment based on the application of guidelines that were inconsistent with generally accepted standards of care ("GASC").

The lower court's decisions should have been affirmed in view of the court's well-grounded evidentiary findings and legal analysis. Instead, the panel's brief Memorandum ruling disregarded the district court's findings of fact concerning UBH's conduct and deviated from established standards of appellate review and ERISA principles. Most important from the perspective of *amici*, though, is that the panel

ruling slammed shut the door to patient access to safe and effective, and treatment for behavioral health and substance use disorders and sets a dangerous precedent for healthcare throughout this Circuit and the country.

The importance of such public health issues, especially as more and more Americans struggle with mental illness, is reason alone to grant *en banc* review.

ARGUMENT

THE PANEL'S DECISION WILL RESTRICT PATIENT ACCESS TO APPROPRIATE CARE FOR BEHAVIORAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

According to the National Institute of Mental Health, nearly one in five American adults lives with a mental illness.[1] The data are scarcely better for America's children: one in six Americans between the ages of 6 and 17 experiences mental illness each year, which recently led the American Academy of Pediatrics to issue a "Declaration of National Emergency in Child and Adolescent Mental Health."[2]

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[1] "Mental Illness" at https://www.nimh.nih.gov/health/statistics/mental-illness

[2] "Mental Health By the Numbers," (National Alliance on Mental Illness); available at https://www.nami.org/mhstats; AAP-AACAP-CHA Declaration of National Emergency in Child and Adolescent Mental Health, available at https://www.aap.org/en/advocacy/child-and-

Adolescent suicides are also at crisis levels.[3] And this problem is only getting worse. The demand for mental health treatment for both adults and children has been growing, and the Covid-19 pandemic has significantly increased that demand,[4] including the need for substance use disorder treatment.[5]

For the overwhelming majority of Americans, effective treatment requires health insurance, though. Advocating for more widely

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adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

[3] "Hundreds of Suicidal Teens Sleep in Emergency Rooms. Every Night," *New York Times* May 8, 2022.

[4] See, e.g., American Psychological Association, "Demand for mental health treatment continues to increase, say psychologists," at https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand#:~:text=The%20number%20of%20psychologists%20who,the%20start%20of%20the%20pandemic.; "'Nobody Has Openings'" Mental Health Providers Struggle to meet Demand, *New York Times* February 17, 2021; updated September 14, 2021.

[5] Even before the pandemic increased the demand for those services, a 2019 Milliman Research Report found continuing problems with patient access to care despite the parity law, e.g., consumers were almost 5.5 times as likely to go out-of-network for mental health services/substance use as for medical/surgical primary care. "Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbusement," available at https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

available health insurance to pay the burgeoning cost of needed healthcare, the National Academy of Sciences Institute of Medicine published a white paper in 2001 entitled "Coverage Matters: Insurance and Health Care."[6] The article explained the benefits of health insurance, which "pools the risks and resources of a large group of people so that each is protected from financially disruptive expenses resulting from an illness, accident or disability."

Even when a patient has insurance, the availability of coverage is only meaningful if it allows the patient to receive appropriate and necessary care. According to a finding made by the district court based on expert witness trial testimony, "[r]esearch has demonstrated that patients with mental health and substance use disorders who receive treatment at a lower level of care than is clinically appropriate face worse outcomes than those who are treated at the appropriate level of care." 2-ER-265-66. Inadequate mental health treatment also places patients at greater risk of unemployment, homelessness, substance use, suicide, and incarceration, all of which impose "financial and social

[6] "Coverage Matters: Insurance and Health Care," Executive Summary available at https://www.ncbi.nlm.nih.gov/books/NBK223643/

costs borne by [States] and [their] residents."[7] And emergency mental health treatment that only addresses crisis management is plainly insufficient, since expert trial testimony quoted by the district court explained that such care results in "people going in and out of hospital, rotating back and forth between trying to make outpatient treatment work, failing in it, having chronic ongoing crises that need to be managed, winding up in an inpatient unit." 2-ER-262.

Despite the critical need for meaningful behavioral health coverage, access to adequate benefits remains problematic for many insured Americans. For example, a survey conducted by the National Alliance on Mental Illness (NAMI) found that patients seeking mental health care were *twice as likely* to be denied care based on "medical necessity."[8] Such barriers to care result in gaps in the continuum of care patients receive and thus exacerbate America's behavioral health crisis.

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[7] Brief of the State of California as Amicus Curiae in Support of Plaintiffs-Appellees (Dkt Entry 56) at 16

[8] National Alliance on Mental Illness (NAMI). (2015). A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care. https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf

The panel's decision makes a problematic situation even worse. In literally a single paragraph lacking any analysis of the detailed trial record or the comprehensive findings made by the district court, the panel granted UBH, along with other health insurers, broad authority to deny covered outpatient, intensive outpatient, and residential treatment. The panel also countenanced the use of financially infected self-serving medical necessity guidelines that are overly restrictive and inconsistent with GASC despite the fact that many of the plans covering the class members and multiple states' laws mandate that treatment standards consistent with GASC must be used in making coverage determinations.

The GASC standards cited and discussed at length in the district court's decision were established (and are regularly updated) by well-respected, reputable professional associations of clinical experts in the fields of mental health and addiction treatment, such as the American Society of Addiction Medicine (ASAM), the American Academy of Child and Adolescent Psychiatry, and the American Association of Community Psychiatrists. Yet by siding with financially conflicted insurers over the clinical experts, the panel's opinion will result in

patients being denied medically necessary treatment that offers them the best long-term outcome.

Patients will suffer as a result. When insurers are given the authority to ignore expert consensus treatment guidelines and deny authorization for covered medically necessary treatment based on financially influenced internally developed guidelines, patients are forced to forego medically necessary care. This is especially problematic in a world where so many people with behavioral illnesses *already* do not receive the care they need. Statistics from 2016, the most recent year available, show that only 43 percent of the 44.7 million adults with any mental health disorder received treatment, and less than 11 percent of adults with a substance use disorder received treatment.[9] And if only some care is covered, logic suggests that the panel's decision may force some providers to provide only minimal treatment instead of more comprehensive care geared toward sustained improvement in the

[9] Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

patient's health. Put simply, if insurers are permitted to deny treatment based on their own clinical standards rather than GASC, even fewer patients will be treated properly, and the mental health crisis will further worsen.

As plaintiffs and other *amici* have explained, the law does not countenance this result. ERISA cannot be read to strip plan participants and their beneficiaries of the protection that a health benefit plan subject to ERISA is obligated to provide. Among other things, UBH's use of its treatment guidelines in place of GASC is fundamentally inconsistent with the Supreme Court's directive in *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105, 115 (2008) which pronounced: "ERISA imposes higher-than-marketplace quality standards on insurers." UBH's use of internally developed guidelines in place of guidelines developed by authoritative expert medical experts cannot be squared with a requirement to apply "higher-than-marketplace quality standards." Nor would such conduct comport with *Glenn's* reminder that a plan administrator must "discharge [its] duties in respect to discretionary claims processing solely in the interests of the participants and beneficiaries of the plan," [29 U.S.C.] § 1104(a)(1).

Id. (internal quotations omitted). In the circumstances at issue here, there can be no more heightened obligation to act "solely in the interest of the participants and beneficiaries" than when the health and well-being of the plans' participants and their beneficiaries is at stake.

At bottom, this Court must recognize that this is no ordinary case. The district court's decisions had a transformative impact on how behavioral health care is administered in ERISA-governed plans that cover the majority of Americans.[10] Unfortunately, the likely consequence of the panel decision is that the gains achieved as a result of the district court's rulings will be wiped out as even further restrictions are placed on the care patients receive for treatment of mental illness. Instead of medical necessity determinations based on GASC developed by non-profit expert bodies, the decision-making power will be left to the discretion of for-profit insurers such as UBH. *Amici* are steadfastly opposed to a regime that permits such disregard of

[10] United States Census Bureau, "Health Insurance Coverage in the United States: 2020 (September 14, 2021); available at https://www.census.gov/library/publications/2021/demo/p60-274.html#:~:text=Highlights%201%20In%202020%2C%208.6%20percent%20of%20people%2C,and%2034.8%20percent%2C%20respectively.%20...%20More%20items...%20

GASC. Consequently, rehearing *en banc* should be granted, and the panel decision should be vacated.

CONCLUSION

For the reasons presented above, *amici curiae*, respectfully request that rehearing *en banc* is granted and the district court decisions are affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE FOR BRIEFS

Nos. 20-17363, 20-17364, 21-15193, 21-15194

I am the attorney or self-represented party.

This brief contains 2,621 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

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Signature /s/ Mark D. DeBofsky **Date** May 13, 2022

CERTIFICATE OF SERICE

Mark D. DeBofsky certifies that on May 13, 2022, I electronically filed the foregoing brief with the Clerk of the Court by using the CM/ECF system and that all counsel of record have been served electronically by CM/ECF delivery thereof.

Dated: May 13, 2022

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