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.
GARY ALEXANDER, ET AL.
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
CASE NOS. 3:14-CV-2346-JCS, 3:14-CV-5337-JCS
(THE HONORABLE JOSEPH C. SPERO)

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, CALIFORNIA MEDICAL ASSOCIATION, AND APA CALIFORNIA DISTRICT BRANCHES AS *AMICI CURIAE* IN SUPPORT OF PETITION FOR REHEARING OR REHEARING *EN BANC*

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APA, AMA, CMA, AND APA CALIFORNIA DISTRICT BRANCHES

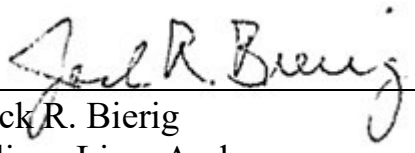
RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Amici curiae American Psychiatric Association ("APA"), American Medical Association ("AMA"), California Medical Association ("CMA"), and APA California District Branches are all not-for-profit organizations. Each certifies that it has no parent corporation and that it has issued no stock.

Dated: May 16, 2022

Respectfully submitted,

ARENTFOX SCHIFF LLP

By: 

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INTEREST OF THE *AMICI CURIAE*[1]

Amici curiae are associations of psychiatrists and other physicians who believe that the panel decision, if allowed to stand, threatens to have a devastating impact on the availability and quality of care for persons with mental health and substance use disorders ("MH/SUDs") in this country. These associations are filing this amicus brief because, as a result of its deviation from binding precedent, the panel decision will interfere with the ability of those who treat individuals with MH/SUDs to provide care in a medically appropriate manner, ultimately causing medical care for persons with these disorders to be far less available and less effective than care for persons with physical ailments. For these reasons, amici respectfully submit that review of the panel decision is a matter of great public importance.

Amicus American Psychiatric Association ("APA"), with more than 37,400 members, is the nation's leading organization of physicians specializing in psychiatry. *Amici* Southern California Psychiatric Society, Northern California Psychiatric Society, Orange County Psychiatric Society, Central California

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* state that no party's counsel authored this brief in whole or in part, and that no party, party's counsel, or other person, other than *amici,* their members, or their counsel, contributed money that was intended for preparing or submitting this brief.

Psychiatric Society, and San Diego Psychiatric Society ("APA California District Branches"), are nonprofit organizations that are district branches of APA that represent approximately 3,000 psychiatric physicians who work in every county in California. APA and its district branches' members engage in research into and education about diagnosis and treatment of MH/SUDs. For decades, APA and its district branches and their members have developed evidence-based recommendations and standards for assessment and treatment of psychiatric disorders and used such standards in treatment of their patients. As front-line physicians treating patients with MH/SUDs, these members have a strong interest in ensuring their patients can access quality, evidence-based treatment consistent with generally accepted standards of care.

Amicus American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy-making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every specialty, including psychiatry, and in every state.

Amicus California Medical Association ("CMA") is a nonprofit incorporated professional association of more than 44,000 physicians practicing in California in all specialties. CMA's membership includes most of the physicians who are engaged in the private practice of medicine in California.

The AMA and CMA each join in this brief on their own behalf and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, and the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

All *amici* are concerned about the negative impact the panel decision will have on treatment of patients with MH/SUDs if it is allowed to stand.

INTRODUCTION

The panel decision allows United Behavioral Health ("UBH"), an insurer *and* plan administrator, to determine whether services under health benefit plans are "medically necessary" – and thus covered and paid for – using an internally "created set of clinical policies and guidelines," including "Level of Care Guidelines" and "Coverage Determination Guidelines," that do not meet generally accepted standards of care.[2] These guidelines "are supposed to reflect generally

[2] 2-ER-246-51.

accepted standards of care,"[3] but they fall far short of these standards. Indeed, UBH's own expert witness admitted that UBH's guidelines are much more restrictive than generally accepted standards. That witness, Thomas Simpatico, M.D., testified that no physicians "worth their salt" would use UBH's guidelines to "make clinical judgments" due to irreconcilable "discrepanc[ies]" between the guidelines and the generally accepted standards of care required under plan terms.[4]

Rehearing or rehearing *en banc* is required because the panel decision threatens to have a devastating impact on the quality and availability of mental health care, not only for patients covered by UBH, but for patients with MH/SUDs throughout this country. While paying lip service to compliance with generally accepted standards of care, UBH and other insurers across America have adopted policies that mischaracterize as "medically *un*necessary" numerous services covered under the plans even though such covered services are fully consistent with generally accepted standards of MH/SUD care. These insurers can be expected to rely on the panel decision to reduce the availability of psychiatric care and to adopt policies that impede the ability of mental health professionals to provide medically necessary care for their patients.

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[3] 2-ER-250.
[4] 8-ER-1696:15-1698:1. See also 2-ER-242.

Amici curiae urge this Court to grant Plaintiffs' petition for rehearing or rehearing *en banc* because this case involves a question of exceptional national importance regarding the quality and availability of effective care for people with MH/SUDs. These issues have real and significant impacts on millions of people.[5] If not reheard, this case will set back the significant progress that has been made in the last two decades toward improving care for people with MH/SUDs and providing non-discriminatory access to that care when compared with access to care for physical diseases.

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[5] Substance Abuse & Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, p. 7 (2021), ("SAMHSA Report"), https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf. citing Hasin, D. S., & Grant, B. F., The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: Review and summary of findings, *Social Psychiatry and Psychiatric Epidemiology*, 50, 1609-1640 (2015), https://doi.org/10.1007/s00127-015-1088-0, World Health Organization, *Mental health action plan 2013 – 2020* (2013), https://www.who.int/mental_health/publications/action_plan/en/, Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., McKnight-Eily, L. R., Harrison, L., D'Angelo, D. V., Williams, L., Morrow, B., Gould, D., & Safran, M. A., Mental illness surveillance among adults in the United States. *Morbidity and Mortality Weekly Report CDC Surveillance Summaries*, 60 (Suppl. 3), 1-29 (2011), https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm, Murray, C. J. L., & Lopez, A. D., Measuring the global burden of disease, *New England Journal of Medicine*, 369, 448-457 (2013), https://doi.org/10.1056/nejmra1201534.

ARGUMENT

I. The Panel Decision Presents an Issue of Exceptional Importance Because It Threatens to Lead to Increasingly Inadequate Care For Persons with MH/SUDs Nationwide and Risks Interfering with the Provision of Proper Medical Care to Those Persons.

The panel decision threatens to detrimentally impact the ability of psychiatrists and other mental health providers to provide necessary treatment for their patients. While purporting to reflect generally accepted standards of care, the "Level of Care Guidelines" and "Coverage Determination Guidelines" (collectively, "medical necessity guidelines") issued by UBH for *covered* outpatient, intensive outpatient, and residential treatment for MH/SUD benefits,[6] fall woefully short of generally accepted standards – as the district court found and UBH's own expert acknowledged. Thus, they leave psychiatrists who participate in UBH plans facing an impossible choice: either (i) do not provide services that are generally recognized in the medical community as required for adequate treatment or (ii) inform patients, often with very limited means, that to receive the care they need, which is actually covered by their health plans and which UBH

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[6] National Association of Insurance Commissioners, *Understanding Health Care Bills What Is Medical Necessity?,* https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf ("Generally, health plans pay a portion of the bill for covered services that fit the definition of medical necessity.").

said it would evaluate based on generally accepted standards of care, they need to pay out of pocket.

Unless patients pay out of pocket, psychiatrists who treat them will not be able to provide treatment that is covered by the plans and recognized by the medical community as consistent with generally accepted standards of care, because UBH, in its own financial interest, has characterized it as not medically necessary. This situation puts psychiatrists, and other medical practitioners, who owe a fiduciary duty to patients, in an unacceptable position.

We detail below three types of situations (all supported by the district court's factual findings) in which insurers'/managed care organizations' ("MCOs'") standards conflict with generally accepted standards of care and accordingly undermine patient treatment.

First, with respect to the covered services at issue in this case - namely outpatient, intensive outpatient, and residential MH/SUD treatment - UBH and other MCOs continue to focus on "crisis stabilization" and symptom suppression, rather than treating patients' underlying conditions.[7] The district court detailed several practices that revealed this acute-focused perspective, including a

[7] Eric M. Plakun, *Clinical and Insurance Perspectives on Intermediate Levels of Care in Psychiatry*, 24 J. Psychiatric Prac. 111, 114-15 (2018).

requirement that treatment will improve a patient's "presenting problem," the use of so-called "why now" factors, and the cessation of coverage once acute systems have been managed.[8] These and similar practices employed by MCOs make it difficult, if not impossible, for physicians to effectively guide their patients through the continuum of care. Clinicians understand that gradual movement through the continuum is necessary to preserve gains made in more intensive levels of care.[9]

As the district court described, a patient's acute symptoms may justify a relatively intensive level of care. Once those acute symptoms are controlled, however, payors such as UBH may decline to approve coverage for a course of treatment that gradually transitions the patient through increasingly less intensive levels of care. Instead, because each level of care decision is made with a primary focus on acute symptoms, in the absence of such symptoms, a payor may next approve only *minimal* care.[10] As a result, the course of treatment will fail to achieve the gradual transition envisioned by generally accepted standards of care.[11]

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[8] 2-ER-270-82.

[9] Plakun, *supra* note 7, at 112 (explaining that intermediate levels of care "help patients achieve enough masters of . . . underlying issues to return to outpatient treatment better able to use it and better able to function between sessions").

[10] 2-ER-278; Plakun, *supra* note 7, at 114.

[11] The panel's decision allows UBH to make substandard treatment decisions and to deny coverage for treatment that allows patients to progress through various levels of care. The focus of the UBH medical necessity guidelines on crisis stabilization puts these patients at serious risk. For example, individuals discharged from inpatient psychiatric care are 100 times more likely to die by

Second, MCOs such as UBH fail to provide for continuing care, even though this continuing care is entirely consistent with generally accepted standards of care.[12] As is true of UBH's guidelines, MCOs often demand that treatment be associated with tangible "improvement" in a patient's condition.[13] Supports for *maintenance* of patient progress, however, are vital in treating MH/SUDs.[14]

Third, the medical necessity guidelines of UBH and other payors fail to pay for *coordinated* care of *co-occurring* conditions. Coverage decisions that do not properly account for co-occurring conditions hamper the accurate multidimensional assessments that form the basis of any level of care decision. By focusing on a patient's "current condition,"[15] payors like UBH risk denying patients more effective integrated care for all co-occurring conditions.[16] Similarly,

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suicide than the general population. Nat'l Action All. for Suicide Prevention, *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* (2019), https://bit.ly/3yjx6Ab; Daniel Thomas Chung et al., *Suicide Rates After Discharge from Psychiatric Facilities*, 74 JAMA Psychiatry 694 (2017) ("The immediate post-discharge period is a time of marked risk.").

[12] 2-ER-289 (district court finding that UBH Level of Care Guidelines fail to provide "treatment to maintain level of function").

[13] 2-ER-289-90.

[14] Plakun, supra note 7, at 112-13 (explaining that treatment addressing more than intermittent acute crises "may be the best hope for interrupting cycles of recurrent crisis admissions to inpatient units").

[15] 12-ER-2504.

[16] Michael Dennis & Christy K. Scott, *Managing Addiction as a Chronic Condition*, 4 Addiction Sci. & Clinical Prac. 45, 48 (2007) ("Clinical trials have demonstrated that when patients have an SUD combined with one or more non-

medical necessity guidelines that purport to be consistent with generally accepted professional standards but that "push patients to lower levels of care"[17] risk ultimately requiring more care for a particular patient than if the patient received the appropriate level of care (again, care keyed to generally accepted standards of care) from the start.[18]

UBH offered testimony before the district court to support its contention that, to the extent there was a mismatch between generally accepted standards of care and UBH's guidelines, the generally accepted standards of care guided benefit decisions.[19] The district court considered this testimony and found it *not* credible.[20]

Amici's experience and the academic literature suggest that MCOs' internally developed medical necessity guidelines have a significant adverse

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substance-related disorders, it can be more effective—in terms of both clinical outcome and cost—to provide integrated care.").

[17] 2-ER-286-87.

[18] David Mee-Lee & David R. Gastfriend, *Patient Placement Criteria, in The American Psychiatric Publishing Textbook of Substance Abuse Treatment*, Ch. 6, at 9 (2008) (describing study showing that accurate use of the ASAM "was associated with reductions in subsequent hospital utilization").

[19] For example, UBH's sole retained expert explained that "[a]ny practitioner worth their salt" would not rely on level of care guidelines or similar documents "to conduct the art of the practice of medicine" and that he would not follow the level of care guidelines' more specific commands, but would instead "adhere to generally accepted standards of care." 8-ER-1696-97.

[20] 2-ER-242.

impact on access to care.[21] For example, as noted above, medical necessity guidelines that primarily address acute symptoms and that push patients to lower levels of care "represent a short sighted clinical focus intended to reduce costs."[22] Payors such as UBH have a financial incentive to enforce those medical necessity guidelines as written, notwithstanding that generally accepted standards of care require less intensive levels of care to be comparably safe and effective before they are recommended.

Millions of individuals remain untreated because they simply cannot afford needed care. Of the 7.7 million adults[23] with a mental illness who went without needed mental health services in 2020, 44.9% blamed the cost.[24] This is even higher among those with severe mental illness – 49.5% – and inability to afford the cost of care was again cited as the most common reason for not receiving mental health services.[25]

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[21] Plakun, supra note 7, at 114 ("Clinicians who interface with utilization managers have the experience from frequent denials of care that a different perspective is being used by insurance or managed care entities.")
[22] *Id*. at 115.
[23] SAMHSA Report at 50.
[24] *Id.* at 51.
[25] *Id.*

The medical necessity guidelines thus have a real effect on coverage determinations, and concomitantly, on the treatment patients can afford and ultimately receive.[26]

II. The Panel Decision Risks Substantially Reducing the Availability and Effectiveness of Care for Patients with MH/SUDs.

There has long been a medical undertreatment crisis for patients with mental illness. And despite the district court's landmark ruling in 2019, the situation is only worsening. The following chart illustrates this development.

	2019[27]	**2020**[28]
Number of adults with either mental illness or a substance use disorder	61.2 million	73.8 million
Number of adults with both mental illness and a substance use disorder	9.5 million	17 million

[26] Indeed, despite the managed care industry's call to "control[] costs" and to "prevent[] unnecessary utilization of healthcare services," ABHW Br. at 21, spending on behavioral health care pales in comparison to spending on physical health, *see generally*, Stoddard Davenport et al., *How Do Individuals with Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?* (2020).

[27] Substance Abuse & Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health,* pp. 46, 59, 63 (2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf.

[28] SAMHSA Report at pp. 3, 5, 9, 42.

Percentage of adults with mental illness that received mental health service	44.8%	46.2%
Percentage of adults with substance use disorder that received treatment	10.3%	6.5%
Percentage of adults with mental illness and substance use disorder that received treatment	7.8%	5.7%

The COVID-19 pandemic exacerbated these conditions, creating an unprecedented mental health crisis across the country. According to the World Health Organization, global prevalence of anxiety and depression increased by 25% during the pandemic.[29] COVID-19 infections likely have contributed to more than 14.8 million new cases of mental health disorders worldwide and 2.8 million in the United States.[30] One study found that the share of adults reporting symptoms of anxiety or depressive disorder in January 2021 increased nearly 400% from a similar period in 2019.[31] And in the first two weeks of March 2022,

[29] World Health Organization, *Covid-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide* (2022), https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide.
[30] Yan Xie, et al., *Risks of mental health outcomes in people with covid-19: cohort study* (2022), https://www.bmj.com/content/376/bmj-2021-068993.
[31] Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KFF (2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

over a quarter of adults experiencing symptoms of anxiety or depressive disorder said their treatment needs went unmet.[32]

There is a significant shortage of mental health professionals in general, which is exacerbated in the aftermath of COVID-19.[33] More specifically, there is currently a 6.4% shortage of psychiatrists in the workforce, which is expected to increase to 12% in 2025.[34]

The panel decision promises to make these problems worse. It will encourage UBH and other payors to deny covered services because under their own, financially driven guidelines (which admittedly fall below the accepted

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[32] *Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic*, KFF, https://www.kff.org/other/state-indicator/unmet-need-for-counseling-or-therapy-among-adults-reporting-symptoms-of-anxiety-and-or-depressive-disorder-during-the-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 12, 2022).

[33] *See* Michael Dill, *We already needed more doctors. Then COVID-19 hit*, AAMC (2021), https://www.aamc.org/news-insights/we-already-needed-more-doctors-then-covid-19-hit; *see also* Andis Robeznieks, *How an aging nation, COVID-19 stretch the doctor workforce thin, AMA* (2022), https://www.ama-assn.org/practice-management/sustainability/how-aging-nation-covid-19-stretch-doctor-workforce-thin#:~:text=The%20nation%20faces%20a%20projected,American%20Medical%20Colleges%20(AAMC).

[34] *Healthcare Cost and Utilization Project*, Agency for Healthcare Research and Quality (2018, February), https://www.ahrq.gov/research/data/hcup/index.html; see also *The Psychiatric Shortage Causes and Solutions*, National Council for Mental Wellbeing, p. 16 (2018), https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Revised-Final-Access-Paper.pdf ("Psychiatric Shortage")

medical standards of care), those services are supposedly not medically necessary. Conflicted insurance companies may feel emboldened to characterize covered, generally accepted psychiatric treatments as medically unnecessary, which will serve only to exacerbate the mental health crisis the country is facing. The panel decision and its impacts will further drive psychiatrists and other mental health care providers from plan networks and drastically reduce the number of patients who can be treated for MH/SUDs, while simultaneously reducing health care spend for insurers. The effects of the decision may be felt not only by patients with UBH coverage but also by MH/SUD patients nationwide - because in *amici*'s experience the practice of using guidelines to evaluate medical necessity is ubiquitous - and may set back decades of progress in MH/SUD treatment. These are issues of enormous public importance warranting review of the panel decision.[35]

CONCLUSION

Amici curiae respectfully urge this Court to grant Plaintiffs-Appellees' Petition for Rehearing or Rehearing *En Banc* and to put a stop to the pervasive problem of lack of quality, available care for patients with MH/SUDs nationwide.

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[35] In addition, the panel's decision is contrary to binding legal precedent regarding plan administrator conflicts of interest, as set forth in the petition for panel rehearing and rehearing *en banc* of the Plaintiffs-Appellees. For this reason as well, rehearing is essential.

Dated: May 16, 2022

Respectfully submitted,

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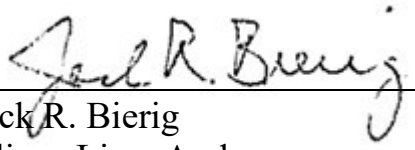
By: 

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

This brief complies with the type-volume limitation of Fed. R. App. P. 29(b)(4) and Ninth Circuit Local Rule 29-2(c)(2) because it is 15 pages and alternatively contains 3,232 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word 2007 in 14 point Times New Roman type style.

Dated: May 16, 2022

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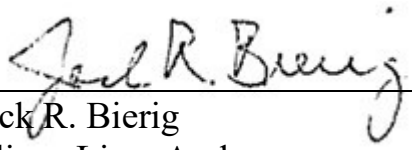
By: 

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CERTIFICATE OF SERVICE

I hereby certify that on May 16, 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

Dated: May 16, 2022

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