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
Nos. 3:14-cv-2346, 3:14-cv-5337 | Hon. Joseph C. Spero

DEFENDANT-APPELLANT'S RESPONSE TO PLAINTIFFS-APPELLEES' PETITION FOR PANEL REHEARING AND REHEARING EN BANC

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INTRODUCTION

United Behavioral Health ("UBH") administers health benefits for the treatment of mental health conditions and substance use disorders, on behalf of benefit plans governed by the Employee Retirement Income Security Act ("ERISA"). The plans delegate discretion to UBH to interpret plan terms in determining whether requested services are covered. 2-ER-253. UBH used lengthy, publicly available guidelines to facilitate those coverage determinations.

Plaintiffs are plan members whose coverage requests UBH denied. Plaintiffs allege that UBH violated plan terms by applying guidelines that were more restrictive than generally accepted standards of medical care. A smaller "state-mandate" class also claims those guidelines were inconsistent with four states' laws. The district court accepted Plaintiffs' allegations and certified classes comprising some 67,000 coverage denials. The court ordered UBH to "reprocess" these 67,000 denials under Plaintiffs' preferred guidelines and entered declaratory and prospective injunctive relief. The court did all this despite never finding that the challenged guidelines caused *any* class member's denial of benefits, much less that reprocessing would benefit any class member.

The panel reversed, holding that the plans did not "mandate coverage for all treatment that is consistent with" generally accepted standards of care, or otherwise "require consistency" with those standards, Mem. 7, so any alleged inconsistency

would not violate the plans. It also rejected Plaintiffs' argument that UBH suffered from a conflict of interest, holding that any such conflict "would not change th[is] outcome on these facts." *Id.*

Given these holdings, the panel declined to decide "whether the district court's 'reprocessing' remedy overextended Rule 23" and whether Plaintiffs' failure to meet their plans' administrative exhaustion requirement precluded their claims. Mem. 6-7. Judge Forrest, concurring, would have reached the reprocessing issue and held that granting that remedy on a classwide basis was error. Forrest Op. 1-3.

The panel's fact-bound, unpublished decision fails the ordinary requirements for rehearing, and nowhere approaches the type of earth-shattering ruling Plaintiffs portray it as. The district court committed fundamental errors at the outset—indeed, the most fundamental error, disregarding plain plan language. And Plaintiffs' supposedly "landmark" victory, Pet. 3, was built on that error, and not salvageable without it. The panel's interpretation of what the plans say about generally accepted standards is correct and of little import beyond this case. Plaintiffs offer no support for their hyperbolic claim that the panel's ruling will directly impact the interpretation of nearly all health plans in the United States. And the panel's conflict-of-interest holding is likewise correct and fact-bound. Plaintiffs' rehearing request on that issue mainly challenges a stray quotation in a parenthetical to the source cited for that one-sentence holding. That unusual request just further proves Plaintiffs

have no real case for rehearing.

Unable to mount a serious case for rehearing on the panel's main holdings, Plaintiffs instead lead with the state-mandate class, an issue that affects less than 1.5% of the 67,000 coverage denials Plaintiffs want reprocessed. Plaintiffs claim the arguments on which UBH prevailed are not relevant to the state-mandate class. But Plaintiffs failed to make that argument to the panel at the merits stage, even in response to the panel's questions at oral argument. And rehearing on that insignificant issue is also unwarranted because Plaintiffs have not established their right to any relief even as to that narrow class.

The petition should be denied.

ARGUMENT

I. Rehearing Is Not Warranted As To The State-Mandate Class

The state-mandate class encompasses claims for substance use treatment made under "fully-insured" plans "governed by" the laws of four states—Rhode Island, Connecticut, Illinois, and Texas. 1-ER-214. Plaintiffs claim these states required UBH to apply specific state-mandated guidelines, but UBH applied its own guidelines instead. Pet. 5. The district court certified a small class comprising "hundreds" of individuals, 2-ER-353—a tiny fraction of the 67,000 coverage determinations Plaintiffs challenged—and ordered UBH to reprocess each denial, 1-ER-181. Plaintiffs claim the panel erred in reversing that judgment because its

merits holding—that UBH's guidelines need not exclusively track generally accepted standards of care—does not apply to this narrow class. Pet. 6.

Rehearing is not warranted because Plaintiffs never previously raised this issue with the panel. Given the class's small size, Plaintiffs mentioned the class just three times in passing in their merits brief (at 5-6, 34), and *not once* at oral argument. Plaintiffs' brief stated in a footnote (at 5 n.1) that UBH raised no issue "specific to the State Mandate Class," but never explained which of UBH's arguments applied to that class. And at oral argument, Plaintiffs' counsel fielded multiple questions regarding the plans' "generally accepted standards" provisions without ever once suggesting this issue did not impact the state-mandate class. *See* Oral Arg. 22:15-27:00, 28:27-30:50, 37:22-40:25, 41:40-42:32. Plaintiffs did not mention that class even in response to Judge Forrest's description of the generally accepted standards issue as the "fundamental premise of this litigation" and the "premise" on which "*everything* else … in this case is based." *Id.* at 22:03-24:12 (emphasis added). Having kept these issues from the panel, Plaintiffs cannot blindside the panel by leveraging them now to reopen this case.

Nor would rehearing serve any purpose. Plaintiffs mainly seek an order requiring UBH to "reprocess" any affected denials using state-mandated guidelines. 1-ER-181. But as UBH argued in its merits briefs, that remedy is unavailable even as to the state-mandate class.

First, as Judge Forrest recognized, Plaintiffs' right to reprocessing turns on "numerous individualized questions" that cannot be, and were not, addressed through classwide proof. Forrest Op. 2. Plaintiffs made only a facial attack on UBH's guidelines, without showing that the guidelines (let alone the specific aspects Plaintiffs challenged) caused the wrongful denial of benefits or resulted in concrete, particularized harm to anyone. UBH Br. 24. The district court acknowledged that "Plaintiffs' claims would fail for lack of causation" if they needed to show a causal link to denial of benefits, and Plaintiffs "stipulated that they d[id] not seek" to make that showing. 1-ER-77.

Many denials were independently supported by grounds other than the challenged guidelines. UBH Br. 29-30. That is especially true as to the state-mandate class because in many cases UBH applied "both" guidelines in denying coverage and thus the denial was supported by the guidelines Plaintiffs claim should have been used. 1-ER-207. And even where UBH did not apply those guidelines, many class members "likely would not benefit from reprocessing," Forrest Op. 2, either because their requests would have been denied anyway under other guidelines, or because UBH approved coverage for alternative treatment, and they chose to pursue that option instead of the treatment for which coverage was denied. UBH Br. 30-31. Especially given the small size of the class, there is no evidence reprocessing would result in meaningful relief for *any* state-mandate class member. Certifying

Plaintiffs' reprocessing claims for class treatment and awarding classwide relief was thus contrary to Rule 23 and the Rules Enabling Act. Forrest Op. 3; UBH Br. 31-43.

Second, many class members failed to exhaust their administrative remedies. UBH Br. 59-60. The district court "excused" absent class members from exhaustion because: (1) each "named Plaintif[f] has exhausted administrative remedies"; and (2) exhaustion "would be futile." 2-ER-325. But neither is a ground for excusing exhaustion, and Plaintiffs have not proven futility. UBH Br. 60-63. Further, there was no named Plaintiff for Connecticut, Rhode Island, or Texas, 2-ER-231, -347, so there was no proof that any class member satisfied exhaustion in those states, nor any futility finding specific to the state-mandate class. 2-ER-325-26. It is pure speculation how UBH would have responded had members cited state-mandate laws in administrative appeals, instead of seeking to reopen their denied claims years after the fact.

The panel majority did not reach these issues because it ruled for UBH on other grounds, Mem. 6-7—though Judge Forrest, concurring, would have decertified the reprocessing claims, Forrest Op. 3. Rehearing the state-mandate class, however, would require the panel to decide these issues, which ultimately preclude reprocessing.

Nor have state-mandate class members established a right to other relief. The

panel's ruling undercut the district court's sprawling, ten-year prospective injunction—requiring UBH to apply criteria "consistent with generally accepted standards of care" to future coverage determinations, 1-ER-13—and the state-mandate class provides no basis to reinstate it. The injunction was based mainly on the finding that the panel overruled: that UBH's guidelines must track such standards exclusively. 1-ER-12. The district court never found that injunctive relief could be justified based on the diminutive state-mandate class alone. Indeed, it cannot be, because it is undisputed that UBH already voluntarily adopted the ASAM Criteria required in Illinois in 2016 and in Rhode Island and Connecticut in 2019, applied the Texas-mandated criteria since even before the class period, and ceased using the challenged substance use disorder guidelines *anywhere* in 2019. 2-ER-313-15; ECF No. 451, at 14-16. Nor could the court simply enjoin UBH to obey "any applicable state law," 1-ER-13, without violating Federal Rule of Civil Procedure 65(d)(1)(C)'s requirement that the "acts restrained" be described "in reasonable detail" in the injunction itself, "not by referring to" some "other document." At a minimum, the injunction is clearly broader than the state-mandate class because it encompasses all states, all plan types (fully-insured or self-funded), and mental health services, not just substance use treatment. 1-ER-12-15.

Further, with no valid reprocessing remedy or prospective injunctive relief, the district court's limited declaratory relief for the state-mandate class serves no

purpose and therefore must be reversed. Acknowledging the mandates and finding that UBH violated them years ago, 1-ER-5-7, does not protect class members from any "imminent threat," and any controversy lacks "'sufficient immediacy and reality to warrant the issuance of a declaratory judgment,'" as required for Article III standing. *MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 127 (2007).

Granting rehearing as to the state-mandate class thus would provide no basis to affirm any part of the district court's judgment, leaving the panel's judgment intact. Nor is rehearing necessary to protect "states' interests in regulating insurance," Pet. 2, since nothing in the panel's ruling on a *private* class action prevents *states* from enforcing their regulations. Rehearing would merely burden the panel with deciding additional issues it declined to reach, all for a class so small that Plaintiffs barely mentioned it during merits briefing and never mentioned it during oral argument. Rather than incur that burden, the Court should deny rehearing.

II. Rehearing Is Not Warranted On The Panel's Merits Holdings

Plaintiffs' remaining rehearing grounds seek to revive their principal theory that UBH violated plan terms because its guidelines were "more restrictive" than "generally accepted standards of care." Pls' Br. 38. But the panel unanimously rejected that theory, holding that "the Plans do not require consistency" with such standards. Mem. 7. Plaintiffs challenge that interpretation, and further argue that

the panel failed to account for UBH's purported conflict of interest. Pet. 7-17. But neither of these case-specific, record-dependent holdings meets the criteria for rehearing—and both holdings were correct.

A. The Panel's Fact-Bound, Unpublished Review Of UBH's Plan Interpretation Is Not "Exceptionally Important" Or Otherwise Worthy Of Rehearing

Plaintiffs cast this case as an "inflection point" for national mental health and addiction policy. Pet. 1. But the principal issue they present for rehearing is not about public policy, but interpreting plan documents: Do UBH's plans permit it to "use guidelines inconsistent with … the medical community's generally accepted standards of care?" *Id.* This Court ordinarily does not grant rehearing to rehash failed arguments about the interpretation of particular ERISA plans, and there is nothing exceptional about the question here.

1. Plaintiffs do not even mention, let alone attempt to satisfy, the requirements for rehearing. They do not contend that the panel's interpretation "conflicts with" a decision of the "Supreme Court," this Court, or any "other … Cour[t] of Appeals." Fed. R. App. P. 35(b)(1)(A)-(B). Indeed, they do not even *cite* any case on this issue except for the bland proposition that UBH must follow plan terms—a rule the panel plainly understood and followed. Pet. 10. Rather than identifying legal authority that the panel misapplied, Plaintiffs seek rehearing by relitigating

their positions on the district court's findings and excerpts of UBH's plans. *Id.* at 8-9.

Plaintiffs claim these fact-bound issues are "far-reaching" because the plans at issue cover "millions," and "[v]irtually every ERISA plan in the country" has similar terms. Pet. 2-3 (emphasis omitted). Neither argument warrants rehearing.

To start, there is nothing at stake for other UBH plan members who fall outside the class. Plaintiffs tout the prospective injunction requiring UBH to apply their preferred guidelines to future claims. Pet. 2. But they fail to mention that UBH *already* voluntarily adopted those guidelines to replace the challenged guidelines *before* the district court ordered UBH to do so. ECF No. 451, at 14-16. UBH has no plans to restore the challenged guidelines, so the injunction is not needed to expand mental health coverage in America, as Plaintiffs and *amici* suggest.

Nor does the "reprocessing" awarded justify rehearing. As explained *supra* at 5-6, given their failures to prove causation and exhaust their administrative remedies, Plaintiffs have not established a right to reprocessing, much less shown that reprocessing would benefit any class members.

Meanwhile, Plaintiffs' assertion that "there is almost complete uniformity across all health plans in the United States in tying medical necessity determinations to generally accepted standards of care," Pet. 11, is unsupported and irrelevant. Plaintiffs fail to cite a single plan outside the class with similar terms. And even if

other plans, like UBH's, *referenced* "generally accepted standards of care," the import of that language would have to be determined based on specific plan language and in the context of other plan provisions. Plaintiffs cite no case—in the nearly *six* years since the district court held that UBH's plans "require coverage consistent with generally accepted standards of care," 2-ER-368—that has relied on that holding to interpret a non-UBH plan. Nor do Plaintiffs claim any overarching *legal* requirement—apart from specific plan terms—mandates compliance with generally accepted standards. With or without rehearing, therefore, this Court's unpublished and non-precedential interpretation of *UBH*'s plans would not control the interpretation of other plans. 9th Cir. R. 36-3(a).

Plaintiffs' *amici*—many of them provider organizations with a direct financial stake in coverage determinations—are thus mistaken in viewing this case as a vehicle to expand access to mental health and substance use treatment. Tellingly, the Department of Labor—which participated as an *amicus* on other issues before the panel—has not called for rehearing (or even addressed plan interpretation). Only four states have supported Plaintiffs' petition, and only one (California) focused on plan interpretation. There is thus no reason to believe reversing the panel's unpublished decision on guidelines UBH no longer uses will materially impact "the

nation's mental health and addiction crises." Pet. 3.[1]

2. In any event, the panel was correct: The plans "do not require consistency with" generally accepted standards. Mem. 7. The reason is simple: The plans "*exclude* coverage for treatment inconsistent with" those standards, but do not "*mandate* coverage for all treatment that is consistent with" those standards. *Id.* (emphasis altered). The panel was right to reject Plaintiffs' attempts to transform a coverage exclusion into an affirmative basis for coverage. UBH Br. 46.

Plaintiffs counter by shifting their focus from *coverage* to "medical necessity." Pet. 7-9. But the district court focused on *coverage*, holding that each plan "require[d] coverage consistent with generally accepted standards of care." 2-ER-368. Plaintiffs never suggested otherwise in the barely more than a page they devoted to plan interpretation in their merits brief. Pls.' Br. 22, 55. By correctly attributing that express holding to the district court, UBH did not "mislea[d]" the panel. Pet. 7.

Plaintiffs' "medical necessity" arguments fare no better than the district court's rulings about "coverage." Indeed, one set of guidelines Plaintiffs chal-

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[1] Contrary to Plaintiffs' contention (at 12), none of UBH's *amici* suggested that the specific terms of UBH's plans have importance beyond this case. Two of the *amici* quoted were addressing the trial court's rulings on *reprocessing*, Dkt. 30, at 4; Dkt. 40, at 4-9—which the panel majority did not reach—not any plan interpretation issue. The third merely warned against the dangers of overriding the deference due to plan administrators. Dkt. 41, at 4.

lenged—the "Coverage Determination Guidelines"—had nothing to do with medical necessity. They were applied to plans that lacked a medical necessity requirement, 2-ER-247, and were expressly designed to "'assis[t] in interpreting'" UBH's plans as a whole—not just generally accepted standards. UBH Br. 48.

The other guidelines Plaintiffs challenged—the "Level of Care Guidelines"—were used for plans that require services to be "medically necessary" to be covered. 2-ER-247. But consistency with generally accepted standards is just one *component* of that medical necessity requirement. For example, many plans' definition of "medically necessary" required services to meet four separate requirements—including that the services must be "not more costly" than an equivalent "alternative." ECF No. 435-3, at 130-31. Consistency with generally accepted standards is just one of those requirements, meaning it is a necessary but not sufficient condition for medical necessity. Plaintiffs cite no plan provision to the contrary.

Plaintiffs' attempt to relabel the generally accepted standards exclusion as the "'medical necessity' exclusion," Pet. 8, is thus misleading. The plans each either treat conformity with generally accepted standards as just one requirement for medical necessity among many, or do not refer to medical necessity at all. They nowhere suggest that all treatment consistent with such standards is medically necessary. Simply put, because the generally accepted standards provision is an "exclu[sion]," not a basis for affirmatively establishing coverage *or* medical necessity, the plans

"do not require consistency with" generally accepted standards either in interpreting the plans as a whole or in determining medical necessity. Mem. 7.

Though Plaintiffs deny it, their attempt to "conver[t] [this] *exclusion* … into an *affirmative mandate* for coverage," Pet. 7, has been apparent through this case. They agreed at oral argument (at 41:28-42:32), for example, with Judge Forrest's statement that "the bad thing that happened here" was that "the guidelines are only covering a small subset of things that everyone agrees are generally accepted standards of care," even though they now apparently concede that not all of those things must be covered. Plaintiffs' *amici* likewise lament that coverage may "be denied … even when the treatments, in the view of medical professionals, are actually medically necessary." Dkt. 113, at 11. But the plans *compel* that result where other requirements for medical necessity are not satisfied, or other plan exclusions apply.

Finally, to the extent there is any ambiguity in the plans, UBH's interpretation is entitled to substantial "deference" because the plans each grant UBH "'discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *Conkright v. Frommert*, 559 U.S. 506, 512 (2010); 2-ER-253. This Court thus reviews UBH's interpretation "'for abuse of discretion.'" *Lehman v. Nelson*, 943 F.3d 891, 897 (9th Cir. 2019). "[T]he only question is whether [UBH's] interpretation … was unreasonable." *Day v. AT&T Disability Income Plan*, 698 F.3d 1091, 1098 (9th Cir. 2012). Eight years into this case, Plaintiffs still offer no basis

to find UBH's interpretation "unreasonable." Mem. 7. The panel's holding on this issue was correct and should not be revisited.

B. The Panel's One-Sentence Conflict-Of-Interest Holding Does Not Create A Conflict Of Authority

Plaintiffs also seek rehearing of the panel's holding on UBH's alleged conflict of interest. Pet. 13-17. But the entire holding spanned a single, fact-bound sentence: "[E]ven if UBH has a conflict of interest because it serves as plan administrator and insurer for fully insured plans that are the main sources of its revenue, this would not change the outcome on these facts." Mem. 7. That holding was unremarkable, eminently correct, and self-evidently not worthy of rehearing.

1. The panel's holding is case-dependent and a straightforward consequence of its plan-interpretation ruling. Because the plans' "generally accepted standards" provisions serve only to "*exclude* coverage"—not to "mandate" a finding of coverage or medical necessity—UBH's conclusion that the plans "do not require consistency with [generally accepted standards]," Mem. 7 (emphasis added), was not only reasonable but "correc[t]," *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 968 (9th Cir. 2006) (en banc). As such, it would survive even *de novo* review. *Id.*

Plaintiffs do not argue (or cite authority) that a "correct" interpretation can be an abuse of discretion. And even when a conflict of interest exists, the court must "continu[e] to apply a deferential [abuse-of-discretion] standard of review." *Metro.*

Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008). The conflict merely "act[s] as a tiebreaker when the other factors are closely balanced." *Id.* at 117.

Here, there is no tie to break, so it does not matter whether UBH had a conflict of interest. Mem. 7. There would still be nothing in the plan that requires UBH's guidelines to track generally accepted standards. A conflict of interest cannot create a plan requirement that does not exist.

2. As further support for its one-sentence holding, the panel cited *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008), quoting in a parenthetical the following: "We 'vie[w]' the conflict with a 'low' 'level of skepticism' if there's no evidence 'of malice, of self-dealing, or of a parsimonious claims-granting history.'" *Id.* While not necessary to the panel's ruling, that quotation is fitting, given the superficial nature of the alleged conflict.

The district court held that UBH had a "structural conflict of interest" because—like many insurers—some of the plans it administered were "fully insured," meaning UBH bore the cost of any approved treatment. 2-ER-331. But such "conflicts" are commonplace, and do not on their own compel the "significant skepticism" the district court applied here. *Id.* Plaintiffs do not contend otherwise.

Plaintiffs instead rely on the district court's findings that "conflict of interest … actually infected [UBH's] coverage decisions." Pet. 14. Those findings, Plaintiffs claim, compelled the panel to apply "heightened 'skepticism'" because

UBH purportedly did not "challenge [them] on appeal." *Id.* at 16. But that argument—which Plaintiffs already raised, Pls' Br. 60-61—did not persuade the panel, for good reason: UBH *did* challenge these findings, citing the lack of "evidence that UBH considered benefit expense in developing any of the guideline provisions that Plaintiffs challenged, or that such consideration would be improper." UBH Br. 57. UBH was obliged to *track* the financial consequences of its decisions as part of its fiduciary duty to "'guard the assets of the [plans] from improper claims.'" *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005); *see* UBH Br. 56; UBH Reply Br. 23. But "financial considerations were rarely discussed" at committee meetings on developing the guidelines, and the lone finance department representative on the committee "rarely attended or spoke." 2-ER-321 (citing 6-ER-1239:3-1241:9). Far from showing that UBH's finance department "'veto[ed]'" medical recommendations on financial grounds, Pet. 2, Plaintiffs presented only three instances, out of 180 meetings, in which the committee that approved the guidelines discussed benefit expense in *any* context, and none reflects any improper considerations. UBH Br. 57. "[O]n these facts," the panel could reasonably have concluded that no significant skepticism was warranted. Mem. 7.

3. Plaintiffs nonetheless attempt to manufacture a conflict of authority from the panel's accurate quotation from *Saffon* in a parenthetical. Even if that quotation could be deemed a holding, it conflicts with no decision from any court, and

would not warrant en banc rehearing.

Plaintiffs read the parenthetical as holding that only certain types of conflict of interest—"'malice,'" "'self-dealing,'" and "'parsimonious claims-granting history'"—are grounds for denying deference to plan administrators. *See* Pet. 16. They then claim this supposed holding is inconsistent with this Court's decision in *Abatie* and the Supreme Court's decision in *Glenn*. *Id*.

Plaintiffs fail to mention, however, that *Saffon* was *itself* quoting *Abatie*. 522 F.3d at 868. Unsurprisingly, then, *Saffon*'s statement is perfectly consistent with *Abatie*. *Abatie* stated that a court "may" view a conflict of interest with a "low" "level of skepticism" "if a structural conflict of interest is unaccompanied, for example, by any evidence of malice, of self-dealing, or of a parsimonious claims-granting history." 458 F.3d at 968. That is exactly what *Saffon* said, and the panel was free to do the same here. *Glenn*, meanwhile, just spelled out the flip side—that greater skepticism may be warranted in circumstances "including, but not limited to, cases where an … administrator has a history of biased claims administration." 554 U.S. at 117.

In all events, how a court views a conflict depends on "all the circumstances." *Abatie*, 458 F.3d at 968. The panel's parenthetical reproduction of *Saffon*'s statement is not a holding to the contrary. Whatever buzzwords connoting "bias" one uses, there was no bias here that would warrant heightened skepticism. And UBH's

interpretation was correct even if "strip[ped] … of deference" entirely, Pet. 16-17. *See supra*, at 12-15. This Court thus need not and should not grant rehearing to review an imagined conflict of authority with a parenthetical quotation that was unnecessary to the panel's fact-bound, unpublished holding.

CONCLUSION

Plaintiffs' petition should be denied.

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Respectfully submitted.

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

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I certify that pursuant to Circuit Rule 35-4 or 40-1, the attached petition for panel rehearing/petition for rehearing en banc/response to petition is (*select one*):

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○ In compliance with Fed. R. App. P. 32(a)(4)-(6) and does not exceed 15 pages.

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