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

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

DAVID AND NATASHA 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. 14-cv-2346-JCS, 14-cv-5337-JCS | Hon. Joseph C. Spero

**PLAINTIFFS-APPELLEES' MOTION FOR
LEAVE TO FILE REPLY BRIEF IN SUPPORT OF PETITION FOR
PANEL REHEARING AND REHEARING EN BANC**

Peter K. Stris
Rachana A. Pathak
Dana Berkowitz
Colleen R. Smith
John Stokes
STRIS & MAHER LLP
777 S. Figueroa Street, Suite 3850
Los Angeles, CA 90017
(213) 995-6800

D. Brian Hufford
Jason S. Cowart
ZUCKERMAN SPAEDER LLP
485 Madison Avenue
10th Floor
New York, NY 10022
(212) 704-9600

Attorneys for Plaintiffs-Appellees

Caroline E. Reynolds
David A. Reiser
ZUCKERMAN SPAEDER LLP
1800 M Street, N.W.
Suite 1000
Washington, DC 20036
(202) 778-1800

Adam Abelson
ZUCKERMAN SPAEDER LLP
100 East Pratt Street
Suite 2440
Baltimore, MD 21202
(410) 332-0444

Meiram Bendat
PSYCH-APPEAL, INC.
7 West Figueroa Street
Suite 300
PMB #300059
Santa Barbara, CA 93101
(310) 598-3690, x.101

Attorneys for Plaintiffs-Appellees

Under Federal Rule of Appellate Procedure 27 and Circuit Rule 27-1, Appellees respectfully request leave to file a nine-page reply brief (containing 2,361 words) in support of their petition for rehearing or rehearing en banc. Appellees have concurrently lodged the proposed reply for the Court's review.

Although this Court's rules do not expressly permit or prohibit the filing of a reply brief in support of a petition for rehearing, the Court has granted leave to do so in other cases. *See, e.g.*, *Brice v. Haynes Investments, LLC*, No. 19-15707, ECF No. 88 (9th Cir. Jan. 5, 2022); *Young v. Hawaii*, No. 12-17808, ECF No. 194 (9th Cir. Nov. 21, 2018); *Joffe v. Google, Inc.*, 746 F.3d 920, 922 (9th Cir. 2013); *Skokomish Indian Tribe v. United States*, 410 F.3d 506, 509 (9th Cir. 2005).

The Court should grant leave here as well. The proposed reply would assist the Court's review by pointing out Appellant's failure to dispute that the panel's holding should not apply to one of the certified classes in this case, by explaining why the new arguments raised by Appellant present no impediment to rehearing, and by correcting misstatements of law and fact contained in Appellant's response.

Counsel for Appellant opposes this motion.

Dated: June 23, 2022

Respectfully submitted,

s/ Peter K. Stris
Peter K. Stris
Rachana A. Pathak
Dana Berkowitz
Colleen R. Smith
John Stokes
STRIS & MAHER LLP

777 S. Figueroa Street, Suite 3850
Los Angeles, CA 90017
Telephone: (213) 995-6800
pstris@stris.com
rpathak@stris.com
dberkowitz@stris.com
csmith@stris.com
jstokes@stris.com

D. Brian Hufford
Jason S. Cowart
ZUCKERMAN SPAEDER LLP
485 Madison Avenue, 10th Floor
New York, NY 10022
Telephone: (212) 704-9600
Facsimile: (212) 704-4256
dbhufford@zuckerman.com
jcowart@zuckerman.com

Caroline E. Reynolds
David A. Reiser
ZUCKERMAN SPAEDER LLP
1800 M Street, N.W., Suite 1000
Washington, DC 20036
Telephone: (202) 778-1800
Facsimile: (202) 822-8106
creynolds@zuckerman.com
dreiser@zuckerman.com

Adam Abelson
ZUCKERMAN SPAEDER LLP
100 East Pratt Street, Suite 2440
Baltimore, MD 21202
Telephone: (410) 332-0444
Facsimile: (410) 659-0436
aabelson@zuckerman.com

Meiram Bendat
PSYCH-APPEAL, INC.
7 West Figueroa Street
Suite 300

PMB #300059
Santa Barbara, CA 93101
Telephone: (310) 598-3690, x.101
Facsimile: (888) 975-1957
mbendat@psych-appeal.com

CERTIFICATE OF COMPLIANCE

This request complies with Rule 27 because it contains 205 words excluding the parts exempted by Rule 32(f). The request complies with the typeface requirements of Rule 32(a)(5) and the type-style requirements of Rule 32(a)(6) because it has been prepared in proportionally spaced typeface using Microsoft Word in 14-point Garamond font.

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Dana Berkowitz
Rachana A. Pathak
Colleen R. Smith
John Stokes
STRIS & MAHER LLP
777 S. Figueroa Street, Suite 3850
Los Angeles, CA 90017
(213) 995-6800

D. Brian Hufford
Jason S. Cowart
ZUCKERMAN SPAEDER LLP
485 Madison Avenue
10th Floor
New York, NY 10022
(212) 704-9600

Attorneys for Plaintiffs-Appellees
[Additional Counsel on Following Page]

Caroline E. Reynolds
David A. Reiser
ZUCKERMAN SPAEDER LLP
1800 M Street, N.W.
Suite 1000
Washington, DC 20036
(202) 778-1800

Adam Abelson
ZUCKERMAN SPAEDER LLP
100 East Pratt Street
Suite 2440
Baltimore, MD 21202
(410) 332-0444

Meiram Bendat
PSYCH-APPEAL, INC.
7 West Figueroa Street
Suite 300
PMB #300059
Santa Barbara, CA 93101
(310) 598-3690, x.101

Attorneys for Plaintiffs-Appellees

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INTRODUCTION

If anything, UBH's response *confirms* the need for further review. UBH does not dispute that the panel's plan-interpretation holding is inapplicable to the State Mandate Class. And its other arguments do not apply to Plaintiffs' claims on behalf of that class. There is thus an undeniable error in the decision—one that, as the affected states told this Court, "run[s] roughshod over Amici States' laws" and deeply offends principles of federalism. Br. of Illinois, Connecticut, & Rhode Island 5. Rehearing is patently warranted as to the State Mandate Class.

As to the other two classes, UBH's arguments are also unavailing. In disputing the stakes here, UBH ignores not only the dozens of amici who have explained the implications of the panel's decision, but even its *own* plea about the enormous consequences flowing from this case. Opening Br. 4. And on the merits, UBH largely refuses to engage with Plaintiffs' points, instead attacking a strawman of its own creation and otherwise repeating the incorrect arguments from its briefs. Not one of these arguments, however, presents any impediment to rehearing.

The issue in this case is exceptionally important: Should medical necessity be determined by an insurance company's finance department or (as the ERISA plans here and across the country require) under the medical community's generally accepted standards of care? The panel answered this question incorrectly, undermining mental health and addiction treatment nationwide and contravening Circuit and Supreme Court precedent. Rehearing is urgently needed.

ARGUMENT

I. Rehearing is manifestly necessary as to the State Mandate Class.

The most notable aspect of UBH's response is that *it does not dispute* that the panel's plan-interpretation holding is inapplicable to the State Mandate Class. Pause here. It is now undisputed that the panel's only basis for reversal does not apply to one of the certified classes. That is a paradigmatic circumstance warranting rehearing.

Rather than contest the issue, UBH argues that despite the panel's oversight, rehearing just isn't worth the trouble. But each of UBH's arguments is some combination of wrong, already rejected, and never before raised.

A. Mainly, UBH argues that Plaintiffs "never previously raised this issue with the panel." Resp. 4. But that is factually wrong and legally irrelevant. Plaintiffs' brief noted that UBH's failure to raise any claim of error specific to the State Mandate Class was a concession that "its guidelines did not comport with the state law requirements." Answering Br. 5 n.1. Plaintiffs thus specifically alerted the panel that UBH's plan-interpretation arguments did not apply to the State Mandate Class. UBH did not deny the concession in its reply. There was no reason for Plaintiffs to devote time at argument to issues UBH did not raise, and which *UBH*, not Plaintiffs, had the obligation to identify if it sought reversal of the State Mandate Class judgment.

B. The remainder of UBH's response either rehashes meritless arguments from the briefs (many of which the panel already rejected) or raises new arguments that are forfeited. Resp. 5-8. None presents an impediment to rehearing.

1. UBH argues that an unresolved question of "'whether the district court's "reprocessing" remedy overextended Rule 23'" is an obstacle to rehearing as to the State Mandate Class, because not all class members may receive monetary relief on reprocessing. Resp. 2, 5 (quoting Mem. 6). But Plaintiffs asserted two distinct claims—one for denial of benefits under the Plans' terms and one for breach of the fiduciary duties imposed by ERISA. *See* Mem. 3, 6. The unresolved reprocessing question is relevant only "[a]s to certification of the denial of benefits claim." Mem. 6; *accord* Forrest, J. Op. 1. On the fiduciary breach claim, by contrast, the panel unanimously agreed that certification was appropriate, that Plaintiffs had adequately established Article III injury, and that this injury was redressable under ERISA's remedial scheme. Mem. 3-6. There can thus be no dispute that, at minimum, rehearing is necessary for the State Mandate Class as to the fiduciary breach claim.[1]

Moreover, as Plaintiffs explained in their answering brief (at 47-50), remand for reprocessing is standard operating procedure where the administrator "misconstrued the [plan] and applied an incorrect standard" in denying benefits. *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 456 (9th Cir.

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[1] Even if reprocessing were both relevant to the panel's decision on the fiduciary breach claim and unavailable as a remedy under ERISA (neither is true), declaratory and injunctive relief would undeniably be available on the fiduciary breach claim. *See* 29 U.S.C. § 1132(a)(3) (authorizing suits to "enjoin" practices that violate ERISA); Mem. 5 (holding as to fiduciary breach claim that "Plaintiffs have shown that UBH's actions resulted in uncertainty concerning the scope of their benefits and the material risk of harm to their contractual rights"). These remedies independently support affirmance of the district court's judgment as to the State Mandate Class.

1996). Whether the incorrect standard was applied to one plan member or thousands, "[i]t should be up to the administrator . . . in the first instance" to apply the "properly construed" standard. *Id.* at 460. That is just what the district court ordered here.

Nor does the possibility that some class members will be denied benefits after UBH's reprocessing stand in the way of class certification, as the en banc Court recently clarified. *Olean Wholesale Grocery Coop., Inc. v. Bumble Bee Foods LLC*, 31 F.4th 651, 669 (9th Cir. 2022) (en banc). A common, illegal policy (the Guidelines) is implicated in the denial of every class member's request for coverage. In certifying the classes under Rule 23(b)(3), the district court correctly "determine[d] after rigorous analysis [that this] common question predominates over any individual questions, including individualized questions about injury or entitlement to damages." *Id.*

Moreover, the Supreme Court's decision in *TransUnion* disposes of any concern that class members who do not ultimately receive money did not suffer injury; the denial of contractual benefits under an improper standard is enough. *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2204-08 (2021); *see also Springer v. Cleveland Clinic Emp. Health Plan Total Care*, 900 F.3d 284, 287 (6th Cir. 2018) ("Every circuit court to consider this issue agrees" that "the denial of plan benefits is a concrete injury for Article III standing" and thus a plaintiff "does not need to suffer financial loss.") (citing, inter alia, *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1289-91 (9th Cir. 2014)).

2. UBH also argues that it was not enough for the class representatives to exhaust remedies under the Plans. Resp. 6. Again, this argument does not apply to Plaintiffs' fiduciary breach claim. *Spinedex*, 770 F.3d at 1294. On the denial of benefits claim, the district court found as fact that exhaustion would have been futile (2-ER-325 (FFCL)), and UBH did not challenge that finding as clearly erroneous. As Plaintiffs explained at length in their answering brief, futility excuses contractual exhaustion requirements. *E.g.*, *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980) (excusing exhaustion for futility where it was contractually required by plan); Answering Br. 61-66. Exhaustion thus presents no obstacle to rehearing.

3. Everything else UBH has to say about the State Mandate Class is wrong, but more importantly, entirely new and therefore waived. *E.g.*, Resp. 6 (new argument about necessity of named Plaintiffs from certain states); *id.* at 7 (new argument about scope of injunction as to State Mandate Class). UBH raised no arguments specific to the State Mandate Class in its opening brief, reply brief, or at oral argument. It cannot do so for the first time in response to Plaintiffs' petition for rehearing.

* * *

To emphasize: it is now *undisputed* that the panel's holding on the plan-interpretation question—the panel's only basis for reversal—cannot apply to the State Mandate Class. And UBH's other arguments, even if correct (which they are not), would still require affirmance on the fiduciary breach claim. UBH may scoff at the prospect of *only a few* states' laws being effectively nullified and *only a few hundred*

individuals being wrongly denied medically necessary treatment. Resp. 2, 3, 8, 11. But as those states have told this Court, the stakes are incredibly high—respecting their sovereignty and protecting critical treatment for the 950-plus people in the class are well worth the Court's attention. Br. of Ill., Conn., & R.I. 2-3, 5, 17-18.

II. Rehearing is also necessary as to the other two classes.

As to the other two classes, UBH tries two tactics to undermine rehearing on the panel's plan-interpretation holding. Both should fail.

A. UBH first attempts to minimize the importance of the issue and the implications of the panel's decision. Plaintiffs think the importance of this case is self-evident. But at this stage, the Court need not take their word for it. Four states have told this Court as much. ECF Nos. 104, 113. Dozens of prominent patient and provider organizations have done the same. ECF Nos. 101, 105. As have the American Psychiatric Association and the American Medical Association. ECF No. 112. UBH's amici, too. *E.g.*, Assoc. for Behavioral Health & Wellness Br. 1-2 (ECF No. 41) (explaining that "guidelines are essential tools" for its member insurers, who collectively "provide coverage to over 200 million people"); Chamber of Commerce Br. 4 (ECF No. 40); Am. Health Ins. Plans Br. 4 (ECF No. 30).

But perhaps most tellingly, UBH *itself* told this Court that its decision would have far-reaching implications—promising "an avalanche of litigation seeking to substitute a judicial command-and-control model of employer healthcare" that

"threatens to overload administrators" absent reversal. Opening Br. 4. The reality is clear: this issue is critically important.

B.1. On the merits, UBH simply refuses to engage with the points in Plaintiffs' petition, opting instead to simply repeat its misstatements about how the Plans work. Tellingly, UBH still refuses to even acknowledge the Plans' actual language: "Covered Services" include treatment for "Mental Illness [and] substance use disorders." 12-ER-2624; *see* 2-ER-230 (FFCL ¶ 1). Those services, in other words, are covered *unless an exclusion applies*. And every denial at issue in this case was based on the exclusion for treatment that is inconsistent with "generally accepted standards of care"—an exclusion that *UBH* (not Plaintiffs) described as a "medical necessity" requirement. 2-ER-253 (FFCL ¶ 53) (finding every plan at issue contained this exclusion); 2-SER-380-98 (chart excerpting plan language); Opening Br. 10.[2]

UBH admitted at trial, and the district court found as fact, that UBH used its Guidelines to define what "generally accepted standards of care" means for purposes of applying *that exclusion*. 2-ER-247-48 (FFCL ¶ 39). That is why UBH never argued, at trial or on appeal, that its Guidelines could depart from generally accepted standards; instead, UBH tried (and failed) to prove that its Guidelines *were* consistent with those standards. *See*, *e.g.*, 3-ER-488, 506 (UBH's opening argument).

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[2] Plaintiffs adopted UBH's shorthand in the petition, acknowledging that different plans used different language to accomplish the same thing. Pet. 8 & n.2. UBH's attempt to fault Plaintiffs for using its own language is curious. *See* Resp. 12.

Plaintiffs challenged UBH's use of its own self-serving Guidelines to determine medical necessity because the Guidelines' criteria reflected UBH's desire to pay less, rather than the medical community's standards. This was contrary to the Plans' terms and thus illegal. *See* Pet. 10-11. Stripped of UBH's obfuscations, the case is really that simple. And so is the upshot: this Court should not leave medical necessity determinations in the hands of insurance companies' finance departments. Medical necessity must be determined, as virtually *all* ERISA plans (like the Plans here) require, by the medical community. Rehearing is necessary.

2. Plaintiffs submit that the Plans can only mean what the district court found them to mean. But if there is *any* ambiguity, rehearing is required because the panel disregarded Circuit and Supreme Court precedent regarding conflicts of interest. In response, UBH contends that Plaintiffs are quibbling with the precise language the panel used in setting out the well-settled legal standard in evaluating administrator conflicts. Resp. 15, 16. But UBH's attempt to downplay the matter is unavailing.

Here is the problem: the panel quoted *Saffon*'s three *examples* of administrator conflicts as if those examples were an exhaustive list. Mem. 7 (quoting *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008)). But those examples, as the Court made clear in both *Saffon* and the en banc decision in *Abatie* on which *Saffon* relied, are not exhaustive—they are examples. *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955, 965 (9th Cir. 2006). *Abatie* made clear there are many ways an administrator's bias could affect its decisionmaking. *See id.*; *see also Met. Life Ins. Co.*

v. Glenn, 554 U.S. 105, 115 (2008). And if the deep, egregious, and undisputed conflicts that the district court found here are not enough to undermine deference to the plan administrator, then it is unclear what could ever be enough.

UBH is also wrong in arguing that the panel's conflict analysis had no effect on the outcome because UBH's interpretation would withstand even de novo review. Resp. 15. The panel said the Guidelines did not need to be consistent even with plan terms *explicitly requiring* UBH to apply generally accepted standards when evaluating the medical necessity exclusion. That conclusion is the polar opposite of a ruling that the Guidelines are a plainly correct interpretation of the Plans. The panel's statement that a conflict arising from UBH's status as *both* "plan administrator *and* insurer . . . would not change the outcome on these facts" referred to the outcome *of the conflict analysis* under the unduly limited standard the panel adopted. Mem. 7 (citing *Saffon*, 522 F.3d at 868) (emphasis added). The panel did not address what the outcome would be had it applied heightened skepticism under the standard as stated in *Abatie*.

The panel's holding thus gives insurers the green light to craft guidelines for coverage determinations based on their own financial self-interest, knowing that those guidelines will never be scrutinized. That untenable situation undermines the protections prescribed by *Abatie* and *Glenn*.

CONCLUSION

Panel or en banc rehearing should be granted.

Dated: June 23, 2022

Respectfully submitted,

s/ Peter K. Stris
Peter K. Stris
Dana Berkowitz
Rachana A. Pathak
Colleen R. Smith
John Stokes
STRIS & MAHER LLP
777 S. Figueroa Street, Suite 3850
Los Angeles, CA 90017
Telephone: (213) 995-6800
pstris@stris.com
rpathak@stris.com
dberkowitz@stris.com
csmith@stris.com
jstokes@stris.com

D. Brian Hufford
Jason S. Cowart
ZUCKERMAN SPAEDER LLP
485 Madison Avenue, 10th Floor
New York, NY 10022
Telephone: (212) 704-9600
Facsimile: (212) 704-4256
dbhufford@zuckerman.com
jcowart@zuckerman.com

Caroline E. Reynolds
David A. Reiser
ZUCKERMAN SPAEDER LLP
1800 M Street, N.W., Suite 1000
Washington, DC 20036
Telephone: (202) 778-1800
Facsimile: (202) 822-8106
creynolds@zuckerman.com
dreiser@zuckerman.com

Adam Abelson
ZUCKERMAN SPAEDER LLP
100 East Pratt Street, Suite 2440

Baltimore, MD 21202
Telephone: (410) 332-0444
Facsimile: (410) 659-0436
aabelson@zuckerman.com

Meiram Bendat
PSYCH-APPEAL, INC.
7 West Figueroa Street
Suite 300
PMB #300059
Santa Barbara, CA 93101
Telephone: (310) 598-3690, x.101
Facsimile: (888) 975-1957
mbendat@psych-appeal.com

Attorneys for Plaintiffs-Appellees

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s/ Peter K. Stris
Peter K. Stris

Counsel for Plaintiffs-Appellees