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' PETITION FOR PANEL REHEARING AND REHEARING EN BANC

Peter K. Stris
Rachana A. Pathak
Dana Berkowitz
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]

Colleen R. Smith
STRIS & MAHER LLP
1717 K Street NW, Ste. 900
Washington, D.C. 20006
(213) 995-6800

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

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

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

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

INTRODUCTION AND RULE 35(b) STATEMENT

Few cases could present a more urgent need for en banc review than this one. The panel decision created three—yes, three—different circuit splits, contravened longstanding Circuit precedent, and disregarded the considered views of the U.S. government. And it did so to overturn a district court decision hailed as the "*Brown v. Board of Education* for the mental health movement" and "one of the most important and most thorough rulings ever issued against an insurance company."[1] The case has drawn *amici* that include (supporting Plaintiffs) the U.S. government, multiple states, the American Medical Association, and the American Psychiatric Association. All have told (and will tell) this Court that the panel got it disastrously wrong, with disastrous consequences not just for millions of mental health and addiction patients, but for all ERISA cases in this Circuit. In short, this is one of the most important ERISA cases—perhaps *the* most important ERISA case—of the 21st century. If any case warrants the en banc Court's attention, it is this one.

For background: Defendant United Behavioral Health ("UBH") administers ERISA plans for millions of Americans. Every one of those plans covers mental health and addiction treatment, unless the treatment is not medically necessary. (The plans have other exclusions as well, but this case concerns only denials based on the

[1] Wayne Drash, *In scathing ruling, judge rips insurer for putting 'bottom line' over patients' health*, CNN (Mar. 6, 2019) (https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html).

medical necessity exclusion.) In evaluating medical necessity, every plan likewise requires UBH to use the medical community's "generally accepted standards of care." But UBH instead evaluated medical necessity using its own internal Guidelines—which were developed to protect UBH's bottom line and are far more restrictive than the medical community's standards. That means UBH denied tens of thousands of claims as medically unnecessary when the medical community itself—whose standards the plans impose—would have said otherwise.

Plaintiffs alleged that UBH violated their right to have the medical necessity of their treatment decided under the medical community's standards, not standards controlled by UBH's finance department. Plaintiffs also alleged that by adopting Guidelines based on its own self-interest rather than participants', UBH violated its duty of loyalty under ERISA. Plaintiffs brought these claims on behalf of three certified classes: two where the plans *directly* required medical necessity to be determined by generally accepted standards (the "Guidelines Classes"), and one where *state law* governing the plans mandated the use of generally accepted standards for evaluating medical necessity (the "State Mandate Class").

Following a lengthy bench trial, the district court issued more than 100 pages of meticulous findings. It found that UBH violated its fiduciary duties, as well as participants' right under the plans to have medical necessity determined according to the medical community's standards. The court ordered UBH to apply generally accepted standards going forward, and, as required by the binding law of this Circuit,

ordered UBH to "reprocess," under those standards, the claims it had denied based on its Guidelines. *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996) ("remand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator . . . has misconstrued the Plan and applied a wrong standard to a benefits determination").

UBH appealed, and the panel initially reversed the district court's decision entirely in an unpublished memorandum disposition. After Plaintiffs sought rehearing, the panel withdrew its unpublished decision and issued a published one. The new decision affirmed crucial parts of the district court's judgment: for all three classes, the panel affirmed the district court's core fiduciary breach findings, and for the State Mandate Class, the panel affirmed that UBH violated participants' right to have medical necessity determined under state law-mandated standards.

The panel also, however, reversed crucial parts of the district court's judgment. And these aspects of the panel's decision warrant rehearing.

First, the panel held that remand for reprocessing is not a remedy authorized by ERISA. This contravenes decades of Circuit law, disregards the view of the expert agency tasked with implementing ERISA, and creates a split with every other circuit. Remand is *the central remedy* in cases where the administrator applied the wrong standard in denying benefits. Holding otherwise disregards the statutory text and converts district judges into plan administrators—requiring them to sift through

complicated plan documents and medical records, and wreaking havoc on their ability to manage the thousands of ERISA benefits cases filed every year.

Second, the panel held that absent class members must exhaust their ERISA benefits claims, even where the named plaintiffs have exhausted—and had their internal appeals uniformly denied. This creates a second circuit split. As Judge Posner explained for the Seventh Circuit, the question is "not difficult": only class representatives need to exhaust; absent class members do not. *In re Household International Tax Reduction Plan*, 441 F.3d 500, 501 (7th Cir. 2006). The Tenth Circuit adopted Judge Posner's reasoning. *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180, 1193 n.5 (10th Cir. 2007). And before the panel decision here, no circuit had ever held otherwise. The panel departed from this consensus *without even addressing it*. And along the way, it took the extraordinary step of eliminating the rule that exhaustion is excused where it would be futile. This creates still another split and would mark a cataclysmic change in the law governing ERISA benefits claims.

Third, the panel held that, contrary to the plans' plain terms, UBH can evaluate medical necessity using its finance department's preferred standards rather than the medical community's. This conclusion, as dozens of *amici* have told this Court, is both wrong and an incalculable setback in the nation's fight against the mental health and addiction crisis. Rehearing is needed.

GROUNDS FOR REHEARING

I. Rehearing is needed because the panel eliminated a core remedy in ERISA plan-interpretation cases, contrary to the law of every circuit.

Rehearing is necessary because the panel effectively eliminated the core remedy in cases under 29 U.S.C. § 1132(a)(1)(B) when a plan administrator applied the wrong standard in denying a claim. This not only contravenes the view of every circuit (including this one) and the U.S. government, but will also severely overburden district courts deciding these claims.

A. When someone sues under § 1132(a)(1)(B), they are entitled "to recover benefits due . . . under the terms of the plan, to enforce their rights under the terms of the plan, or to clarify their rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (cleaned up). Often, what the plaintiff challenges is the standard the plan administrator applied in deciding the claim—not unlike a litigant arguing to this Court that the district court applied an incorrect legal standard. Here, for example, the plans and state law required UBH to use generally accepted standards of care to decide medical necessity, but UBH instead used its own, more restrictive Guidelines.

When a plaintiff successfully challenges the standard the administrator applied, the court is left with an important question: what would have happened had the administrator applied the *correct* standard? Answering that question requires close parsing of the correctly-interpreted plan document, evaluating complex medical

records, applying technical medical criteria, and more. Which leads to an equally important question: *who* should evaluate these things in the first instance?

On that question, the circuits (and the federal government) unanimously agree: it should be the plan administrator, not the district court. In this Court's words: "remand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination." *Saffle*, 85 F.3d at 461. So too in other circuits.[2] And in this very case, the U.S. government told the panel the same thing. U.S. Br. 29 (ECF 55).

B. Contravening this unanimous chorus of authority, the panel held that remand (or "reprocessing") is not a remedy authorized by ERISA. Op. 25 ("The district court abused its discretion in accepting the erroneous legal view that reprocessing is itself a remedy under § 1132(a)(1)(B) independent from the express

[2] *See, e.g.*, *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 391, 398 (5th Cir. 1998) ("Because we conclude that the plan administrator failed to make the initial benefits determination as required by the plan, we . . . remand to the plan administrator to make the necessary benefits decision in the first instance."); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 31 (1st Cir. 2005); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1073-74 (2d Cir. 1995); *Miller v. Am. Airlines, Inc.*, 632 F.3d 837, 856 (3d Cir. 2011); *Gagliano v. Reliance Standard Life Ins. Co.*, 547 F.3d 230, 240 (4th Cir. 2008); *Jones v. Metro. Life Ins. Co.*, 385 F.3d 654, 665 (6th Cir. 2004); *Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1996); *King v. Hartford Life and Acc. Ins. Co.*, 414 F.3d 994, 1005 (8th Cir. 2005); *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002); *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1330 (11th Cir. 2001).

statutory remedies that Congress created[.]"). This conclusion contravenes Circuit law and creates a circuit split; it is also wrong.

1. A plaintuff suing under § 1132(a)(1)(B) may seek not only an actual award of benefits, but *also* to "enforce [his or her] rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); Appellees' Br. 45-46. Those rights include the right to have the plan administrator decide claims under the proper standard, as required by the plan. *Saffle*, 85 F.3d at 458 ("An ERISA plan administrator abuses its discretion if it construes provisions of the plan in a way that 'conflicts with the plain language of the plan.'"); *Buffonge*, 426 F.3d at 30 (ERISA requires a "*full and fair review* by the appropriate named fiduciary" under "the benefit plan itself," which "protect[s] a plan participant from arbitrary or unprincipled decision-making") (citing 29 U.S.C. §§ 1132(a)(1)(B), 1133). The statute's plain language thus forecloses the panel's conclusion that § 1132(a)(1)(B) requires plaintiffs to actually seek a monetary award as their ultimate remedy in the case. Op. 24-25. Retrospective reprocessing under the correct standard, no less than a prospective injunction to apply the correct standard going forward, is an enforcement remedy under § 1132(a)(1)(B).

For the same reason, the panel was simply incorrect to say that "Plaintiffs expressly disclaimed the actual remedy available to them." Op. 25. That conclusion mistakes the shorthand description of § 1132(a)(1)(B) as a "benefits claim" for the scope of the civil action Congress actually authorized. What Plaintiffs sought here was "'to enforce their rights under the terms of the plan,'" in light of "UBH's denial of

coverage requests based on unlawful Guidelines." Appellees' Br. 46-47 (quoting 29 U.S.C. § 1132(a)(1)(B)) (cleaned up); 2-ER-238-39 (describing claims at issue). The panel itself recognized that this was the *very injury* giving rise to Article III standing here: "the arbitrary and capricious adjudication of benefits claims that presents a material risk to [Plaintiffs'] interest in fair adjudication of their entitlement to contractual benefits." Op. 21 (cleaned up).

And to remedy that injury, Plaintiffs sought "relief requiring the administrator to eliminate the illegal . . . rationale and then decide if the claimant would be entitled to the benefits for which she applied." Appellees' Br. 50 (cleaned up). Plaintiffs had a right to such a determination under their plans, and § 1132(a)(1)(B) allows them "to enforce [that] right[]," separate and apart from seeking an award of benefits.

The panel's holding would eliminate this critical portion of the statute.

2. In fact, this Court has held that ERISA generally *requires* remand for reprocessing when the administrator applied an incorrect standard. Courts evaluating a claim under § 1132(a)(1)(B) must resolve the claim according to the "terms of the plan." 29 U.S.C. § 1132(a)(1)(B). And where, as here, the plan gives the administrator "discretion to apply a plan," the "function *ab initio* to apply the correct standard to the participant's claim . . . is reserved to the Plan administrator." *Saffle*, 85 F.3d at 461 (cleaned up). *Saffle* thus recognized that such claims "must be remanded to the Plan administrator for a re-determination." *Id.*; *see also Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1013 (9th Cir. 1997) ("we should not allow ourselves to be seduced into making

a decision which belongs to the plan administrator in the first instance"); *see also supra* n.2 (other circuits); U.S. Br. 28-30.[3]

Put differently, reprocessing is not, as the panel thought, simply a "*means to the remedy*" allowed by § 1132(a)(1)(B). Op. 25. It *is* the usual remedy where the administrator applied the wrong standard. The panel's contrary analysis defies binding Circuit precedent, disregards the view of the U.S. government, and creates a circuit split. *Buffonge*, 426 F.3d at 31 n.14 ("Numerous decisions by this court and others have ordered, or approved in theory, remand to the administrator . . . , and we have seen none holding that remand is impermissible.").

C. The panel's holding will also create nightmarish practical consequences for district courts. As this Court put it, sitting en banc in *Vizcaino*, deciding a claim under the proper standard is the administrator's "decision . . . in the first instance," and the Court "would set a poor precedent were [it] to intrude upon that exercise of discretion before [the administrator] has even considered and ruled upon the issue." 120 F.3d at 1013. Doing so "would encourage the dumping of difficult and discretionary decisions into the laps of the courts, although one of the very purposes of ERISA is to avoid that kind of complication and delay." *Id.* Yet that is the exact

[3] As the United States explained, a plaintiff seeking reprocessing certainly "must establish that the defendant used those standards in denying coverage." U.S. Br. 28 (collecting cases). Plaintiffs unquestionably did that here.

upshot of the panel's decision any time plaintiffs do not or cannot (*e.g.*, because the record is incomplete) seek an actual award of benefits.[4]

II. Rehearing is needed because the panel's incorrect exhaustion holding creates two more circuit splits and eliminates the well-established futility exception.

A. The panel held that unnamed class members must exhaust their administrative remedies. But the rule established by the Supreme Court and this Court is that unnamed class members need not exhaust.[5] Whether that rule applies in ERISA cases is an issue of first impression for this Court, though not for the Seventh or Tenth Circuits. Unlike the panel, both hold that only named plaintiffs must exhaust.

For the Seventh Circuit, the issue was "a novel though not difficult one." *In re Household International Tax Reduction Plan*, 441 F.3d 500, 501 (7th Cir. 2006). Writing for the court, Judge Posner explained that the reasons courts usually enforce plan exhaustion requirements are to avert frivolous lawsuits, minimize costs, expedite

[4] Because the reprocessing question ticks all the boxes for en banc review (as does the exhaustion question discussed next), Plaintiffs expect UBH to contend that rehearing is unwarranted because Plaintiffs lost on the merits of the plan-interpretation question. This is wrong twice over. These questions, at minimum, affect the State Mandate Class, whose plan-interpretation claim the panel affirmed on the merits. And in any event, as to the Guidelines Classes, the plan-interpretation question is independently en-banc worthy. *See infra* Part III.

[5] *Albermarle Paper Co. v. Moody*, 422 U.S. 405, 414 n.8 (1975) (allowing class claim under Title VII "without exhaustion of administrative procedures by the unnamed class members"); *Arizona ex rel. Horne v. Geo Grp., Inc.*, 816 F.3d 1189, 1202 (9th Cir. 2016) ("[U]nnamed class members in a private class action need not exhaust administrative remedies."); 2 Newberg on Class Actions § 5:15, p. 438 (4th ed. 2002).

resolution, and develop the factual record. *Id.* But when the named plaintiff's own exhaustion satisfies those purposes, "requiring exhaustion by the individual class members would merely produce an avalanche of duplicative proceedings and accidental forfeitures, and so is not required." *Id.* at 502. For absent class members, the rationale for enforcing exhaustion requirements vanishes.[6]

The Tenth Circuit agrees. *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180, 1193 n.5 (10th Cir. 2007) ("only the class representatives must exhaust their administrative claims"). So do dozens of district courts in this Circuit and elsewhere.[7] Until the panel's decision, no circuit court and only three district courts had *ever* held otherwise (and one of those was reversed).[8]

The overwhelming weight of authority is right. Requiring unnamed class members to exhaust where the named plaintiff has already done so serves none of the

---

[6] Judge Posner noted the possibility of a different outcome if the plan expressly required absent class members to exhaust. *See id.* But that was not the case there, and it is not the case here.

[7] *E.g.*, *Des Roches v. Cal. Physicians' Svc.*, 320 F.R.D. 486, 500 (N.D. Cal. 2017) (Koh, J.) ("in an ERISA class action the exhaustion requirement is met 'so long as the named plaintiff' has exhausted administrative remedies"); *Leon v. Standard Ins. Co.*, No. 2:15-cv-07419-ODW(JC), 2016 WL 768908, at *4 (C.D. Cal. Jan. 28, 2016); *Adams v. Anheuser-Buch Cos., Inc.*, No. 2:10-cv-826, 2012 WL 1058961, at *5-6 (S.D. Ohio Mar. 28, 2012).

[8] *Stephens v. U.S. Airways Grp., Inc.*, No. 07-cv-1264, 2012 WL 13054263, at *3 (D.D.C. July 18, 2012), *rev'd*, 755 F.3d 959, 966 (D.C. Cir. 2014) (holding that exhaustion was not required because claims were statutory); *Coffin v. Bowater Inc.*, 228 F.R.D. 397, 403 (D. Me. 2005); *Gosselink v. American Telephone & Telegraph, Inc.*, No. H-97-3854, 1999 WL 33737340, at *8 (S.D. Tex. Aug. 9, 1999).

purposes of exhaustion. The panel's decision thus creates a circuit split—and leaves this Court on the wrong side of it.

B. The panel also drastically changed how exhaustion works in this Circuit. Before this case, this Court and eleven sister circuits unanimously recognized a futility exception (among others) to exhaustion in ERISA cases. *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980).[9] The panel thought this case was different because it involved "contractual," rather than "prudential," exhaustion. Op. 30-31. And it held that because the plan "explicitly mandates exhaustion," futility and other exceptions cannot apply. *Id.* at 31.

This Court and the other circuits, however, require exhaustion *only* where the plan "explicitly mandates" it. All ERISA exhaustion is in this sense "contractual." So in holding that futility does not apply to contractual exhausation, the panel effectively held that there is no futility exception at all. In so doing, the panel contravened this Circuit's law, split from the other circuits, and eliminated essential protections built

[9] *E.g.*, *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 826 (1st Cir. 1988); *Halo v. Yale Health Plan*, 546 F. App'x 2, at *5 (2d Cir. 2013); *Stampone v. Walker*, 722 F. App'x 246, 249 (3d Cir. 2018); *DuPerry v. Life Ins. Co. of North America*, 632 F.3d 860, 876 (4th Cir. 2011); *Moss v. Unum Group*, 638 F. App'x 347, 349 n.3 (5th Cir. 2016); *Barber v. Lincoln National Life Ins. Co.*, 722 F. App'x 470, 474 (6th Cir. 2018); *Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 404 (7th Cir. 1996); *Midgett v. Washington Grp. Int'l Long Term Disability Plan*, 561 F.3d 887, 898 (8th Cir. 2009); *McGraw v. Prudential Ins. Co. of America*, 137 F.3d 1253, 1264 (10th Cir. 1998); *Florida Health Sciences Ctr., Inc. v. Total Plastics, Inc.*, 496 F. App'x 6, at *10 (11th Cir. 2012); *Commc'ns Workers of Am. v. AT&T*, 40 F.3d 426, 432-33 (D.C. Cir. 1994).

into ERISA's remedial regime. This change in the law would be incredibly radical and incredibly damaging.

1. ERISA itself does not contain an exhaustion requirement. Nor have courts implied any freestanding "prudential" exhaustion requirement. When cases discuss "prudential" exhaustion, they mean that despite the absence of a statutory requirement, if plans contain express "exhaustion requirement[s]," courts "have the authority to enforce" them, and "as a matter of sound policy they should usually do so." *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008).[10]

It is likewise settled in this Circuit that "a claimant need not exhaust when the plan does not require it." *Spinedex*, 770 F.3d at 1299 (also noting that "optional" exhaustion procedures need not be followed); *see also Nelson v. EG&G Energy Measurements Grp., Inc.*, 37 F.3d 1384, 1388 (9th Cir. 1994) (rejecting attempt to impose exhaustion requirement that did not appear in the plan). That is also the rule in other circuits. *Spinedex*, 770 F.3d at 1299 (citing cases); *see also Conley v. Pitney Bowes*, 34 F.3d 714, 716 (8th Cir. 1994); *Watts v. BellSouth Telecomms., Inc.*, 316 F.3d 1203, 1209 (11th Cir. 2003); *Kirkendall v. Halliburton, Inc.*, 707 F.3d 173, 181 (2d Cir. 2013). As the Eighth Circuit put it, courts "have required exhaustion in ERISA cases only when it

[10] Unlike benefits claims, fiduciary breach claims do not require exhaustion. *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1294 (9th Cir. 2014).

was required by the particular plan involved. . . . We have declined to apply a broader, judicially-crafted exhaustion requirement in ERISA actions." *Conley*, 34 F.3d at 716.

"Prudential exhaustion," then, is just another term for "enforcing contractual exhaustion requirements." Nonetheless, this Court and other circuits have recognized that exhaustion—despite being plan-mandated—is not required when it would be futile (among other exceptions). *E.g.*, *Amato*, 618 F.2d at 568; *Fallick v. Nationwide Mut. Ins. Co.*, 162 F. 3d 410, 420 (6th Cir. 1998); *supra* n.9.

2. The panel's ruling cannot be reconciled with this precedent. The single case it cited for the rule that "exhaustion exceptions" cannot apply where a plan "explicitly mandates exhaustion" wasn't even an exhaustion case. Op. 31 (citing *Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992)). The panel contravened settled Circuit law and placed this Court badly out of step with the other circuits.

More alarming still, if futility and other exceptions (such as the failure to give proper notice of appeal rights) cannot excuse plan-mandated exhaustion, then *these exceptions no longer exist* in ERISA benefits cases. That would mark a sea-change in the law. Requiring futile exhaustion is by definition a useless act, multiplying expense and burden while causing needless forfeitures. *Supra* 10-11. But under the panel's decision, the Ninth Circuit would become *the only court anywhere* that refuses to recognize such exceptions. Rehearing is needed to prevent this catastrophic result.[11]

[11] The panel also held that the futility exception would not apply here because "some beneficiaries successfully appealed the denial of their benefit claims." Op. 31. That

III. Rehearing is needed because the panel's plan-interpretation holding is wrong and will have dire nationwide consequences.

The panel held that UBH could use its Guidelines because the plans do "not compel UBH to cover *all* treatment that is consistent with [generally accepted standards of care]." Op. 29. But Plaintiffs never argued this, and the district court never held it. As Plaintiffs' original rehearing petition explained, this case is *only* about claims that UBH denied based on the medical necessity exclusion. Appendix C at 8.[12] And the point is that in evaluating *that exclusion*, the plans indisputably mandate the use of "generally accepted standards of care." *Id.* Because UBH's Guidelines are far more restrictive than generally accepted standards, the plans forbid their use in evaluating medical necessity. *Id.* at 9.

By holding otherwise, the panel put medical necessity in the hands of UBH's finance department rather than the medical community. And that holding will have

---

statement disregards the district court's factual findings on futility and conflicts with the Supreme Court's holding that "a systemwide" illegal policy makes exhaustion futile even if "some [class members] might have received benefits despite the illegal policy." *Bowen v. City of New York*, 476 U.S. 467, 485 (1986). This rule applies equally in ERISA cases like this one, where the wrong at issue is UBH's "systemwide" use of its Guidelines to evaluate medical necessity. *Fallick*, 162 F.3d at 419 (applying *Bowen* to "methodology" in ERISA context). The success of some participants in establishing, on appeal, that they *satisfied* UBH's restrictive Guidelines does not demonstrate that any class member could have successfully challenged the UBH Guidelines themselves through an administrative appeal.

[12] The panel appears to have overlooked this, and to have disregarded (without overruling as clearly erroneous) the district court's factual findings that (1) UBH denied each class member's claim based on the medical necessity plan term, and (2) before it ever evaluated medical necessity, UBH first determined that no other plan exclusions barred coverage. 2-ER-251-53.

incredibly dangerous nationwide consequences. Appendix C at 11-13. Virtually every health plan in America works like the plans here. *See id.* And virtually every insurer in America uses commercial guidelines in its medical-necessity reviews. *See id.* As dozens of *amici* have told this Court, allowing insurers to use these guidelines to deviate from the medical community's standards will have an enormous and devastating impact.

CONCLUSION

Rehearing should be granted.

Dated: March 10, 2023

Respectfully submitted,

s/ Peter K. Stris

Peter K. Stris
Rachana A. Pathak
Dana Berkowitz
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
jstokes@stris.com

Colleen R. Smith
STRIS & MAHER LLP
1717 K Street NW, Ste. 900
Washington, D.C. 20006
(213) 995-6800
csmith@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

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 11. Certificate of Compliance for Petitions for Rehearing/Responses

Instructions for this form: http://www.ca9.uscourts.gov/forms/form11instructions.pdf

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

I am the attorney or self-represented party.

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)*:

[x] Prepared in a format, typeface, and type style that complies with Fed. R. App. P. 32(a)(4)-(6) and **contains the following number of words:** 4,168**.**
(Petitions and responses must not exceed 4,200 words)

OR

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

Signature *s/ Peter K. Stris* **Date** March 10, 2023
*(use "*s/[typed name]*" to sign electronically-filed documents)*

APPENDIX A
(New Panel Decision)

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID WIT; NATASHA WIT; BRIAN MUIR; BRANDT PFEIFER, on behalf of the Estate of his deceased wife, Lauralee Pfeifer; LORI FLANZRAICH, on behalf of her daughter Casey Flanzraich; CECILIA HOLDNAK, on behalf of herself, her daughter Emily Holdnak; GARY ALEXANDER, on his own behalf and on behalf of his beneficiary son, Jordan Alexander; CORINNA KLEIN; DAVID HAFFNER, on behalf of themselves and all others similarly situated,

Plaintiffs-Appellees,

LINDA TILLITT; MARY JONES,

Intervenor-Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

Nos. 20-17363
21-15193

D.C. No. 3:14-cv-02346-JCS

OPINION

GARY ALEXANDER, on his own behalf and on behalf of his beneficiary son, Jordan Alexander; CORINNA KLEIN; DAVID HAFFNER, on behalf of themselves and all others similarly situated,

Plaintiffs-Appellees,

MICHAEL DRISCOLL,

Intervenor-Plaintiff-Appellee,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

Nos. 20-17364
21-15194

D.C. No. 3:14-cv-05337-JCS

Appeal from the United States District Court
for the Northern District of California
Joseph C. Spero, Magistrate Judge, Presiding

Argued and Submitted August 11, 2021
San Francisco, California

Filed January 26, 2023

Before: Morgan Christen and Danielle J. Forrest, Circuit Judges, and Michael M. Anello,* District Judge.

Opinion by Judge Anello

SUMMARY**

Employee Retirement Income Security Act

The panel affirmed in part and reversed in part the district court's judgment finding United Behavioral Health ("UBH") liable, and awarding declaratory and injunctive relief, to classes of plaintiffs who were beneficiaries of ERISA-governed health benefit plans for which UBH was the claims administrator.

Plaintiffs submitted health plan coverage requests, which UBH denied. Plaintiffs brought claims under ERISA for breach of fiduciary duty and improper denial of benefits, based on a theory that UBH improperly developed and relied on internal guidelines that were inconsistent with the terms of the class members' plans and with state-mandated criteria. The parties stipulated to a sample class, from which they submitted a sample of health insurance plans. Plaintiffs alleged that the plans provided coverage for treatment consistent with generally accepted standards of case

* The Honorable Michael M. Anello, United States District Judge for the Southern District of California, sitting by designation.

** This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

("GASC") or were governed by state laws specifying certain criteria for making coverage or medical necessity determinations. Plaintiffs alleged that UBH's Level of Care Guidelines and Coverage Determination Guidelines for making these determinations were more restrictive than GASC and were also more restrictive than state-mandated criteria.

The district court certified three classes, conducted a bench trial, and entered judgment in plaintiffs' favor, concluding that UBH breached its fiduciary duties and wrongfully denied benefits because UBH's Guidelines impermissibly deviated from GASC and state-mandated criteria. The district court issued declaratory and injunctive relief, directed the implementation of court-determined claims processing guidelines, ordered "reprocessing" of all class members' claims in accordance with the new guidelines, and appointed a special master to oversee compliance for ten years.

The panel held that plaintiffs had Article III standing to bring their claims. The panel held that plaintiffs sufficiently alleged a concrete injury as to their fiduciary duty claim because UBH's alleged fiduciary violation presented a material risk of harm to plaintiffs' interest in their contractual benefits. Plaintiffs also alleged a concrete injury as to the denied of benefits claim because they alleged a harm—the arbitrary and capricious adjudication of benefits claims—that presented a material risk to their interest in fair adjudication of their entitlement to their contractual benefits. Further, plaintiffs alleged a particularized injury as to both claims because the Guidelines materially affected each plaintiff. Finally, plaintiffs' alleged injuries were "fairly traceable" to UBH's conduct.

The panel reversed the part of the district court's class certification order certifying plaintiffs' denial of benefits claims as class actions. The panel held that plaintiffs' "reprocessing" theory, seeking reprocessing of their benefits claims under proper guidelines, was a use of the class action procedure to expand or modify substantive rights provided by ERISA, in violation of Fed. R. Civ. P. 23 and the Rules Enabling Act, 28 U.S.C. § 2072(b).

UBH did not appeal the portion of the district court's judgment finding that the UBH Guidelines were impermissibly inconsistent with state-mandated criteria, and that portion of the district court's decision therefore remained intact.

UBH did argue on appeal that the district court erred in concluding that the Guidelines improperly deviated from GASC and that the district court did not apply an appropriate level of deference to UBH's interpretation of the ERISA plans. The panel concluded that the district court did not clearly err in finding that UBH had a structural conflict of interest in serving a dual role as plan administrator and insurer, and that UBH also had a financial conflict because it was incentivized to keep benefit expenses down. The panel held, however, that these findings did not excuse the district court from reviewing UBH's interpretation of the plans for an abuse of discretion. The panel held that, even assuming the conflicts of interest found by the district court warranted heavy skepticism against UBH's interpretation, UBH's interpretation did not conflict with the plain language of the plans. Accordingly, the district court erred by substituting its interpretation of the plans for UBH's interpretation. The panel reversed the district court's judgment that UBH wrongfully denied benefits to the named plaintiffs based upon the court's finding that the Guidelines

impermissibly deviated from GASC. The panel held that the district court also erred in its judgment on plaintiffs' breach of duty claim, which also relied heavily on the district court's conclusion that the Guidelines impermissibly deviated from GASC.

Finally, the panel held that the district court erred when it excused unnamed class members from demonstrating compliance with the plans' administrative exhaustion requirement. The panel held that when an ERISA plan does not merely provide for administrative review but, as here, explicitly mandates exhaustion of such procedures before bringing suit in federal court and, importantly, provides no exceptions, application of judicially created exhaustion exceptions would conflict with the written terms of the plan. Accordingly, to the extent that any absent class members' plans required exhaustion, the district court erred in excusing the failure to satisfy such a contractual requirement.

In sum, the panel held that plaintiffs had Article III standing to bring their breach of fiduciary duty and improper denial of benefits claims pursuant to 29 U.S.C. §§ 112(a)(1)(B) and (a)(3). And the district court did not err in certifying three classes to pursue the fiduciary duty claim. However, because plaintiffs expressly declined to make any showing, or seek a determination of, their entitlement to benefits, permitting plaintiffs to proceed with their denial of benefits claim under the guise of a "reprocessing" remedy on a class-wide basis violated the Rules Enabling Act. Accordingly, the panel affirmed in part and reversed in part the district court's class certification order. On the merits, the panel held that the district court erred in excusing absent class members' failure to exhaust administrative remedies as required under the plans. The

district court also erred in determining that the Guidelines improperly deviated from GASC based on its interpretation that the plans mandated coverage that was coextensive with GASC. Therefore, the panel reversed the judgment on plaintiffs' denial of benefits claim. To the extent the judgment on plaintiffs' breach of fiduciary duty claim was based on the district court's erroneous interpretation of the plans, it was also reversed. The panel affirmed in part, reversed in part, and remanded for further proceedings.

COUNSEL

Miguel A. Estrada (argued), Geoffrey M. Sigler, Lucas C. Townsend, and Matthew S. Rozen, Gibson Dunn & Crutcher LLP, Washington, D.C.; April N. Ross, Cromwell & Morning LLP, Washington, D.C.; Jennifer S. Romano and Andrew Holmer, Cromwell & Moring LLP, Los Angeles, California; Nathaniel P. Bualat and Thomas F. Koegel, Crowell & Moring LLP, San Francisco, California; for Defendant-Appellant

Caroline E. Reynolds (argued), David A. Reiser, and Andrew N. Goldfarb, Zuckerman Spaeder LLP, Washington, D.C.; D. Brian Hufford, Jason S. Cowart, Zuckerman Spaeder LLP, New York, New York; Adam Abelson, Zuckerman Spaeder LLP, Baltimore, Maryland; Peter K. Stris, Stris & Maher LLP, Los Angeles, California; Meiram Bendat, Meiram Bendat, Santa Barbara, California; for Plaintiffs-Appellees.

Michael B. Kimberly and Sara P. Hogarth, McDermott Will & Emery LLP, Washington, D.C.; Joshua B. Simon, Warren Haskel, and Richard Diggs; McDermott Will & Emery LLP,

New York, New York; for Amicus Curiae America's Health Insurance Plans Inc.

Andrew J. Pincus, Archis A. Parasharami, and Daniel E. Jones, Mayer Brown LLP, Washington, D.C.; Avi M. Kupfer, Mayer Brown LLP, Chicago, Illinois; Daryl Joseffer and Jennifer B. Dickey, United States Chamber Litigation Center Inc, Washington, D.C.; for Amicus Curiae the Chamber of Commerce of the United States of America.

Joana S. McCallum, Manatt Phelps & Phillips LLP, Los Angeles, California; Joseph E. Laska, and Nathaniel A. Cohen, San Francisco, California; for Amicus Curiae Association for Behavioral Health and Wellness.

Aaron M. Panner and Eric J. Maier, Kellogg Hansen Todd Figel & Frederick PLLC, Washington, D.C.; Alison L. Andersen, ArentFox Schiff LLP, Washington, D.C.; Jack R. Bierig and Neil Lloyd, ArentFox Schiff LLP, Chicago, Illinois; Wendy Qiu, Holland & Knight LLP, Los Angeles, California; for Amici Curiae American Psychiatric Association, American Medical Association, California Medical Association, Southern California Psychiatric Society, Northern California Psychiatric Society, Orange County Psychiatric Society, Central California Psychiatric Society and San Diego Psychiatric Society.

Melissa Moore and Stephen Silverman, Senior Attorneys; Jeffrey Hahn, Counsel for Litigation; G. William Scott, Associate Solicitor for Plan Benefit Security; Elena Goldstein, Acting Solicitor of Labor; United States Department of Labor, Office of the Solicitor, Plan Benefits Security Division, Washington, D.C.; for Amicus Curiae Secretary of Labor.

Ari Dybnis and Martine N. D'Agostino, Deputy Attorney Generals; Karli Eisenberg, Supervising Deputy Attorney General; Renu R. George, Senior Assistant Attorney General; Rob Bonta, Attorney General of California, Office of the Attorney General, Oakland, California; for Amicus Curiae State of California.

Kevin Costello, Center for Health Law & Policy Innovation, Harvard Law School, Cambridge, Massachusetts; Abigail K. Coursolle and Elizabeth Edwards, National Health Law Program, Los Angeles, California; for Amici Curiae National Health Law Program, et al.

Sarah W. Rice, Deputy, Public Protection Bureau; Maria R. Lenz, Assistant Attorney General; Peter F. Neronha, Attorney General; Rhode Island Office of the Attorney General, Providence, Rhode Island; Thomas Ryan, Assistant Attorney General; Clare Kindall, Solicitor General; William Tong, Attorney General of Connecticut, Office of the Attorney General, Hartford, Connecticut; Sarah A. Hunger, Deputy Solicitor General; Kwame Raoul, Attorney General of Illinois, Office of the Illinois Attorney General, Chicago, Illinois; for Amici Curiae states of Rhode Island, Connecticut, and Illinois.

OPINION

ANELLO, District Judge:

United Behavioral Health ("UBH") appeals from the district court's judgment finding it liable to classes of Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA") plaintiffs under 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3), as well as several pre- and post-trial orders, including class certification, summary judgment, and a remedies order. UBH contends on appeal that Plaintiffs lack Article III standing, and that the district court erred at class certification and trial in several respects. We have jurisdiction pursuant to 28 U.S.C. § 1291, and we reverse in part.

I

UBH is one of the nation's largest managed healthcare organizations. It administers insurance benefits for mental health conditions and substance use disorders for various commercial health benefit plans. In this role, UBH processes coverage requests made by plan members to determine whether the treatment sought is covered under the respective plans. UBH retains discretion to make these coverage determinations "for specific treatment for specific members based on the coverage terms of the member's plan."

Individually named plaintiffs David and Natasha Wit, Brian Muir, Brandt Pfeifer, Lori Flanzraich, Cecilia Holdnak, Gary Alexander, Corinna Klein, David Haffner, Linda Tillitt, and Michael Driscoll (collectively, "Plaintiffs") are all beneficiaries of ERISA-governed health benefit plans for which UBH was the claims administrator.

Plaintiffs all submitted coverage requests, which UBH denied.

Plaintiffs initiated this action on behalf of three putative classes, asserting, at issue here, two claims against UBH. The first is for breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(1)(B) and "to the extent the injunctive relief Plaintiffs seek is unavailable under that section, they assert the claim under 29 U.S.C. § 1132(a)(3)(A)." Second, Plaintiffs brought an improper denial of benefits claim under 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3)(B). Both of Plaintiffs' claims hinge on a theory that UBH improperly developed and relied on internal guidelines that were inconsistent with the terms of the class members' plans and with state-mandated criteria.[1]

Among the individually named Plaintiffs, there are ten different ERISA plans. Among the class members, there may be as many as 3,000 different plans. The Parties stipulated to a sample class of 106 members, from which they submitted a sample of health insurance plans (the "Plans"). Plaintiffs alleged that the Plans provided coverage for treatment consistent with generally accepted standards of care ("GASC") or were governed by state laws specifying certain criteria for making coverage or medical necessity determinations. Some of the plans administered by UBH were fully insured plans where UBH served a dual role as a plan administrator and insurer, both authorized to determine the benefits owed and responsible for paying such benefits.

The Plans provide that a precondition for coverage is that treatment be consistent with GASC. The Plans contain

[1] Plaintiffs also alleged that UBH developed the Guidelines to benefit its self-serving financial interests in breach of its fiduciary duties.

additional conditions and exclusions, and Plaintiffs did "not dispute that a service that is consistent with [GASC] may, nonetheless, be excluded from coverage under a particular class member's plan." For example, some plans may exclude "[s]ervices that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments, or crisis intervention to be effective." Some plans also may require that the service be the "least costly alternative." The Plans grant UBH discretion to interpret these various terms and determine whether a requested service is covered. To assist with the process of making these determinations, UBH developed internal guidelines used by UBH's clinicians in making coverage determinations. These guidelines include the challenged Level of Care Guidelines and Coverage Determination Guidelines ("Guidelines"). The Level of Care Guidelines are used for plans that limit coverage to medically necessary services. The Coverage Determination Guidelines are used for plans not containing a medical necessity requirement.

Plaintiffs alleged that these Guidelines were more restrictive than GASC and were also more restrictive than state-mandated criteria for making medical-necessity or coverage determinations. Plaintiffs further alleged that UBH breached its fiduciary duties to act solely in the interests of the participants and beneficiaries to develop coverage criteria consistent with GASC. UBH also allegedly breached its fiduciary duties by developing guidelines inconsistent with criteria explicitly mandated by state laws. Plaintiffs also contended UBH breached its duties by promulgating self-serving, cost-cutting guidelines that are more restrictive than the Plans. As to their denial of benefits claim, Plaintiffs argued that UBH violated ERISA by improperly denying Plaintiffs benefits based on its

Guidelines, which are more restrictive than the Plans or criteria mandated by state laws.

Plaintiffs sought certification of three proposed classes as to both claims: (1) the *Wit* Guideline Class; (2) the *Wit* State Mandate Class; and (3) the *Alexander* Guideline Class. The *Wit* Guideline Class was defined as:

> Any member of a health benefit plan governed by ERISA whose request for coverage of residential treatment services for a mental illness or substance use disorder was denied by UBH, in whole or in part, on or after May 22, 2011, based upon UBH's Level of Care Guidelines or UBH's Coverage Determination Guidelines.
>
> The *Wit* Guideline Class excludes members of the *Wit* State Mandate Class, as defined below.

The *Wit* State Mandate Class was defined as:

> Any member of a fully-insured health benefit plan governed by both ERISA and the state law of Connecticut, Illinois, Rhode Island or Texas, whose request for coverage of residential treatment services for a substance use disorder was denied by UBH, in whole or in part, [within the Class period], based upon UBH's Level of Care Guidelines or UBH's Coverage Determination Guidelines and not upon the level-of-care criteria mandated by the applicable state law. . . .

The *Alexander* Guideline Class was defined as:

> Any member of a health benefit plan governed by ERISA whose request for coverage of outpatient or intensive outpatient services for a mental illness or substance use disorder was denied by UBH, in whole or in part, on or after May 22, 2011, based upon UBH's Level of Care Guidelines or UBH's Coverage Determination Guidelines.
>
> The *Alexander* Guideline Class excludes any member of a fully insured plan governed by both ERISA and the state law of Connecticut, Illinois, Rhode Island or Texas, whose request for coverage of intensive outpatient treatment or outpatient treatment related to a substance use disorder.

The classes differ in that the *Wit* State Mandate Class includes members whose denial of benefits was based on UBH's Guidelines and not on state-mandated level-of-care criteria. The Guideline classes include members whose denials were based on the Guidelines and not on the terms of the Plans. The *Wit* Guideline Class included members who requested coverage of residential treatment services, whereas the *Alexander* Guideline Class included members who requested coverage of outpatient or intensive outpatient services.

For their breach of fiduciary duties claim, Plaintiffs sought injunctive and declaratory relief. As to their denial

of benefits claim, Plaintiffs sought reprocessing of their claims[2] and argued:

> Individual circumstances are . . . irrelevant to [this claim]. Plaintiffs are ***not*** asking this Court to determine whether Class members were owed benefits or whether UBH should be ordered to cause its plans to pay such benefits. Rather, Plaintiffs seek a reprocessing remedy, which stems directly from their allegation that UBH used an arbitrary process, premised on fatally flawed Guidelines, to deny their requests for coverage. For that reason, Plaintiffs need not prove at trial that UBH reached the wrong outcome in every single one of its coverage determinations.

Plaintiffs also asserted at the class certification hearing that their denial of benefits claim was "a process claim." Plaintiffs stipulated that "if the case is certified as a class case" then "additional theories" requiring "individualized inquiries as to why UBH's denials of the named Plaintiffs' claims for benefits were wrongful" would "not be part of this case."

[2] Plaintiffs relatedly sought a declaration that UBH's denial of benefits was improper and an order for UBH to apply the new guidelines in processing future claims.

On September 19, 2016, the district court granted Plaintiffs' motion to certify these classes.[3] In its order, the district court stated:

> Of particular significance is the fact that Plaintiffs do not ask the Court to make determinations as to whether class members were *actually* entitled to benefits (which would require the Court to consider a multitude of individualized circumstances relating to the medical necessity for coverage and the specific terms of the member's plan).

Beginning October 16, 2017, the district court held a ten-day bench trial. The district court, in its post-trial findings of fact and conclusions of law, relied upon Plaintiffs' representations that their denial of benefits claim was a "process claim" only, stating "Plaintiffs stipulated at the class certification stage of the case that they do not ask the Court to make determinations as to whether individual class members were actually entitled to benefits . . . . Rather, they assert only facial challenges to the Guidelines."

The district court entered judgment in Plaintiffs' favor, concluding that UBH breached its fiduciary duties and wrongfully denied benefits because the Guidelines impermissibly deviated from GASC and state-mandated criteria. The district court also found that financial

[3] The district court later issued an order partially decertifying the class to exclude class members who successfully appealed their coverage denials, members who were initially improperly included because of a "flaw in the method used to identify class members," and to modify the Illinois State Mandate Class period.

incentives infected UBH's Guideline development process, particularly where the Guidelines "were riddled with requirements that provided for narrower coverage than is consistent with" GASC. Based on these findings, the district court concluded that UBH breached its fiduciary duty to comply with Plan terms and breached its duties of loyalty and care "by adopting Guidelines that are unreasonable and do not reflect" GASC. It also held that UBH improperly denied Plaintiffs benefits by relying on its restrictive Guidelines that were inconsistent with the Plan terms and state law.

The parties had stipulated, and the district court found, that the Plans gave UBH discretionary authority to create tools, such as the Guidelines, to facilitate interpretation and administration of the Plans. But the district court viewed UBH's interpretation with "significant skepticism" because it found that UBH had a financial conflict of interest and a structural conflict of interest as a dual administrator and insurer for some plans. Ultimately, the district court held that UBH's interpretation embodied in the Guidelines was unreasonable and an abuse of discretion.

In its extensive Findings of Fact and Conclusions of Law, the district court excused any unnamed class members for failing to exhaust their administrative remedies under the Plans despite acknowledging evidence that "some class members who did not exhaust available administrative remedies were required under their Plans to exhaust those remedies before they could bring a legal action against UBH." The district court cited to one of the sample plans, which states: "You cannot bring any legal action against us to recover reimbursement until you have completed all the steps [described in the plan]." The district court further found that exhaustion would have been futile.

The district court issued declaratory and injunctive relief, directed the implementation of court-determined claims processing guidelines, ordered "reprocessing" of all class members' claims in accordance with the new guidelines, and appointed a special master to oversee compliance for ten years.

II

ERISA is a federal statute designed to regulate "employee benefit plan[s]." 29 U.S.C. § 1003(a). Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983), "by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts,'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (alteration in original) (quoting 29 U.S.C. § 1001(b)). "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Id.*

ERISA does not "require[] employers to establish employee benefits plans." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). "Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Id.* (first citing *Shaw*, 463 U.S. at 91; and then citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)). Rather, ERISA "ensure[s] that employees will not be left empty-handed once employers have guaranteed them certain benefits." *Id.* The Supreme Court has "recognized that ERISA represents a 'careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.'" *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (quoting *Aetna Health*,

542 U.S. at 215). "Congress sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Id.* (alterations in original) (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Id.* (alteration in original) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002), *overruled in part on other grounds by Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003)).

Accordingly, 29 U.S.C. § 1132(a) "set[s] forth a comprehensive civil enforcement scheme." *Aetna Health*, 542 U.S. at 208 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), *overruled in part on other grounds by Miller*, 538 U.S. 329).

III

UBH argues that Plaintiffs lacked Article III standing to bring their claims because: (1) Plaintiffs did not suffer concrete injuries; and (2) Plaintiffs did not show proof of benefits denied, and so they cannot show any damages traceable to UBH's Guidelines. We disagree. We review de novo the district court's determination that Plaintiffs have Article III standing. *See Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1288 (9th Cir. 2014).

To establish standing under Article III, "a plaintiff must show (i) that he suffered an injury in fact that is concrete, particularized, and actual or imminent; (ii) that the injury was likely caused by the defendant; and (iii) that the injury

would likely be redressed by judicial relief." *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2203 (2021) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992)). "If 'the plaintiff does not claim to have suffered an injury that the defendant caused and the court can remedy, there is no case or controversy for the federal court to resolve.'" *Id.* (quoting *Casillas v. Madison Ave. Assocs., Inc.*, 926 F.3d 329, 333 (7th Cir. 2019)).

To determine whether a statutory violation caused a concrete injury, we ask: "(1) whether the statutory provisions at issue were established to protect [the plaintiff's] concrete interests (as opposed to purely procedural rights), and if so, (2) whether the specific procedural violations alleged in this case actually harm, or present a material risk of harm to, such interests." *Patel v. Facebook, Inc.*, 932 F.3d 1264, 1270–71 (9th Cir. 2019) (alteration in original) (quoting *Robins v. Spokeo, Inc.*, 867 F.3d 1108, 1113 (9th Cir. 2017)).

A

We find Plaintiffs sufficiently alleged a concrete injury as to their fiduciary duty claim. ERISA's core function is to "protect contractually defined benefits," *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013) (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)), and UBH's alleged fiduciary violation presents a material risk of harm to Plaintiffs' interest in their contractual benefits, *see Ziegler v. Conn. Gen. Life Ins. Co.*, 916 F.2d 548, 551 (9th Cir. 1990) ("Congress intended to make fiduciaries culpable for certain ERISA violations even in the absence of actual injury to a plan or participant."). Under the fiduciary duties section of ERISA, a fiduciary has a duty to administer plans "solely in the interest of the participants and beneficiaries . .

. with . . . care, skill, prudence, and diligence," and "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a). Plaintiffs alleged that UBH administered their Plans in UBH's financial self-interest and in conflict with Plan terms. This presents a material risk of harm to Plaintiffs' ERISA-defined right to have their contractual benefits interpreted and administered in their best interest and in accordance with their Plan terms. Their alleged harm further includes the risk that their claims will be administered under a set of Guidelines that impermissibly narrows the scope of their benefits and also includes the present harm of not knowing the scope of the coverage their Plans provide. The latter implicates Plaintiffs' ability to make informed decisions about the need to purchase alternative coverage and the ability to know whether they are paying for unnecessary coverage.

We also find Plaintiffs alleged a concrete injury as to the denial of benefits claim. As explained, ERISA protects contractually defined benefits, *see McCutchen*, 569 U.S. at 100. Plaintiffs alleged a harm—the arbitrary and capricious adjudication of benefits claims—that presents a material risk to their interest in fair adjudication of their entitlement to their contractual benefits. Plaintiffs need not have demonstrated that they were, or will be, entitled to benefits to allege a concrete injury. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 424–25 (2011); *cf. Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656, 666 (1993) ("When the government erects a barrier that makes it more difficult for" someone "to obtain a benefit" a plaintiff challenging "the barrier need not allege that he would have obtained the benefit but for the barrier in order to establish standing").

B

We also find that Plaintiffs alleged a particularized injury as to both claims. "For an injury to be 'particularized,' it 'must affect the plaintiff in a personal and individual way.'" *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016) (citation omitted), *as revised* (May 24, 2016). Plaintiffs' alleged injuries are particularized because the Guidelines are applied to the contractual benefits afforded to each individual class member. The fact that Plaintiffs did not ask the court to determine whether they were individually entitled to benefits does not change the fact that the Guidelines materially affected each Plaintiff. *Cf. Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020) (holding no injury where alleged ERISA violations had no effect on plaintiffs' *defined benefit plan*).

Finally, Plaintiffs' alleged injuries are "fairly traceable" to UBH's conduct. An injury is "fairly traceable" where there is a causal connection between the injury and the defendant's challenged conduct. *Lujan*, 504 U.S. at 560. Plaintiffs' alleged injuries are fairly traceable to UBH's conduct because their interest in the proper interpretation of their contractual benefits, inability to know the scope of coverage under their Plans, and denial of coverage requests, are all connected to UBH's alleged conduct of improperly developing Guidelines in its own self-interest and using those improper Guidelines in denying Plaintiffs' coverage requests.

IV

UBH also appeals from the district court's class certification order. The district court's class certification decision is reviewed for an abuse of discretion. *Pulaski & Middleman, LLC v. Google, Inc.*, 802 F.3d 979, 984 (9th Cir. 2015). A district court abuses its discretion when its ruling

is based "on an erroneous view of the law." *Id.* (citation omitted). We review de novo the district court's interpretation of ERISA. *See Shaver v. Operating Eng'rs Loc. 428 Pension Tr. Fund*, 332 F.3d 1198, 1201 (9th Cir. 2003). UBH argues that the district court erred in certifying the three classes based on Plaintiffs' "novel reprocessing theory" because Rule 23 of the Rules of Civil Procedure and the Rules Enabling Act, 28 U.S.C. § 2072(b), forbid using the class action procedure to expand or modify substantive rights. As to Plaintiffs' denial of benefits claim, we agree.[4]

"[T]he Rules Enabling Act forbids interpreting Rule 23 to 'abridge, enlarge or modify any substantive right.'" *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 367 (2011) (quoting 28 U.S.C. § 2072(b)). We must therefore begin with the ERISA statute to determine Plaintiffs' substantive rights.

As discussed above, the purpose of ERISA is to "provide a uniform regulatory regime over employee benefit plans." *Aetna Health*, 542 U.S. at 208. Accordingly, 29 U.S.C. § 1132(a) "set[s] forth a comprehensive civil enforcement scheme" for accomplishing the overall purposes of ERISA. *Id.* (quoting *Dedeaux*, 481 U.S. at 54). Two provisions are particularly relevant: § 1132(a)(1)(B) and § 1132(a)(3). Under § 1132(a)(1)(B), "[i]f a participant or beneficiary

[4] UBH's Rule 23 argument in its Opening Brief disputed class certification only on the grounds that Plaintiffs facially challenged the Guidelines and have asserted a "novel reprocessing theory" to advance their denial of benefits claim on a class-wide basis. This argument does not implicate a Rules Enabling Act issue as to the fiduciary duty claim. Thus, we deem any challenge to certification of the breach of fiduciary duty claim forfeited, and our analysis leaves class certification as to that claim intact.

believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to 'enforce his rights' under the plan, or to clarify any of his rights to future benefits." *Id.* at 210 (quoting 29 U.S.C. § 1132(a)(1)(B)). Because the remedy provided under § 1132(a)(1)(B) is to recover benefits or to enforce or clarify rights under the plan, a remand to the administrator for reevaluation is a *means* to the ultimate remedy. *See Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1008, 1013–15 (9th Cir. 1997) (remanding for reevaluation of plaintiffs' rights under plan pursuant to § 1132(a)(1)(B)'s right to enforce the plan terms, where plaintiffs "sought a determination that they were entitled to participate in the plan benefits"); *see also Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 458, 460–61 (9th Cir. 1996) (remanding for reevaluation to determine whether plaintiff was entitled to benefits under § 1132(a)(1)(B) where plaintiff filed suit for benefits due); *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 949–51 (9th Cir. 1993) (similar). A plaintiff asserting a claim for denial of benefits must therefore show that she may be entitled to a positive benefits determination if outstanding factual determinations were resolved in her favor. *See, e.g.*, *Saffle*, 85 F.3d at 460–61; *Patterson*, 11 F.3d at 951. Here, there are numerous individualized questions involved in determining Plaintiffs' entitlement to benefits given the varying Guidelines that apply to their claims and their individual medical circumstances. To avoid the individualized inquiry involved in assessing whether Plaintiffs may be entitled to benefits under the Plan terms, Plaintiffs framed their denial-of-benefits claims as seeking a procedural remedy only.

Simply put, reprocessing is not truly the *remedy* that Plaintiffs seek, it is the *means to the remedy* that they seek. But Plaintiffs expressly disclaimed the actual remedy available to them and narrowed their theory of liability under § 1132(a)(1)(B) in an attempt to satisfy Rule 23's commonality requirement.

Yet here, the district court found that "reprocessing" *itself* was an appropriate class-wide remedy for Plaintiffs' denial of benefits claim under § 1132(a)(1)(B). The district court abused its discretion in accepting the erroneous legal view that reprocessing is itself a remedy under § 1132(a)(1)(B) independent from the express statutory remedies that Congress created, justifying class treatment. *See Russell*, 473 U.S. at 146 ("The . . . carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."). Doing so improperly allowed Plaintiffs to use Rule 23 as a vehicle for enlarging or modifying their substantive rights where ERISA does not provide reprocessing as a standalone remedy. *See Dukes*, 564 U.S. at 367.

The district court found that the reprocessing remedy could alternatively fall under § 1132(a)(3). This also was an abuse of discretion. Section 1132(a)(3) is a "catchall" provision to offer appropriate equitable relief for injuries that § 1132 does not otherwise remedy. *Varity*, 516 U.S. at 511–12, 515; *see also Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 959 (9th Cir. 2016), *as amended on denial of reh'g and reh'g en banc* (Aug. 18, 2016). Where the alleged injury is improper denial of benefits, "a claimant may not bring a claim for denial of benefits under § 1132(a)(3) when a claim under § 1132(a)(1)(B) will afford adequate relief."

Castillo v. Metro. Life Ins. Co., 970 F.3d 1224, 1229 (9th Cir. 2020). The issue here is that Plaintiffs have expressly disclaimed a remedy under § 1132(a)(1)(B) by declining to show that reprocessing might allow any plaintiff or class member to recover benefits. But as discussed above, Plaintiffs cannot modify their ERISA rights to obtain the benefits of proceeding as a class action under Rule 23. *See Dukes*, 564 U.S. at 367.

Further, "[a]n individual bringing a claim under § 1132(a)(3) may seek 'appropriate equitable relief,' which refers to 'those categories of relief that, traditionally speaking (*i.e.*, prior to the merger of law and equity) were *typically* available in equity.'" *Castillo*, 970 F.3d at 1229 (quoting *CIGNA Corp. v. Amara*, 563 U.S. 421, 439 (2011)). Plaintiffs and the district court did not explain or refer to precedent showing how a "reprocessing" remedy constitutes relief that was typically available in equity. Consequently, the district court erred in concluding that "reprocessing" was an available remedy under 29 U.S.C. § 1132(a)(3).

The district court abused its discretion in certifying Plaintiffs' denial of benefits claims as class actions. Therefore, we reverse this part of the district court's class certification order.

V

Turning to the merits of Plaintiffs' claims, UBH challenges the district court's final judgment, arguing that the district court erred in concluding that the UBH Guidelines improperly deviated from GASC, and the district court did not apply an appropriate level of deference to UBH's interpretation of the Plans. As an initial matter, UBH did not appeal the portions of the district court's judgment finding the Guidelines were impermissibly inconsistent with

state-mandated criteria. This portion of the district court's decision therefore remains intact.

As discussed above, ERISA does not "mandate what kind of benefits employers must provide." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) (quoting *Lockheed*, 517 U.S. at 887). ERISA "focus[es] on the written terms of the plan" which "in short, [are] at the center of ERISA." *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013). The question then is not whether ERISA mandates consistency with GASC—it does not—but whether UBH properly administered the Plans pursuant to the Plan terms. *See id.*

"Where the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, we ordinarily review the plan administrator's decisions for an abuse of discretion." *Schikore v. BankAmerica Suppl. Ret. Plan*, 269 F.3d 956, 960 (9th Cir. 2001); *see also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The administrator's interpretation is an abuse of discretion if the interpretation is unreasonable. *Moyle*, 823 F.3d at 958. Where the administrator or fiduciary has a conflict of interest, review of its interpretation will be "informed by the nature, extent, and effect on the decision-making process" of such conflict. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006). "We review de novo a district court's choice and application of the standard of review to decisions by fiduciaries in ERISA cases." *Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129, 1133 (9th Cir. 2017) (quoting *Estate of Barton v. ADT Sec. Servs. Pension Plan*, 820 F.3d 1060, 1065 (9th Cir. 2016)). We review findings of fact for clear error. *Abatie*, 458 F.3d at 962.

It is undisputed that the Plans in this case confer UBH with discretionary authority to interpret the Plan terms. The parties stipulated, and the district court found as a matter of fact, that this includes the discretion to create interpretive tools, such as the Guidelines. This finding was not clearly erroneous. Accordingly, UBH's interpretation of the Plans via its Guidelines is reviewed for an abuse of discretion. *Schikore*, 269 F.3d at 960. And the district court correctly identified this standard of review.

But the district court also found that UBH had a significant conflict of interest and therefore gave little weight to UBH's interpretation of the Plans. Where an administrator has a dual role as plan administrator and plan insurer, there is a structural conflict of interest. *See Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 929 (9th Cir. 2012). UBH served such a dual role as Plan administrator and insurer (authorized to determine the benefits owed and responsible for paying such benefits) for at least some of the Plans. The district court found, in addition to this structural conflict of interest, that UBH also had a financial conflict because it was incentivized to keep benefit expenses down. Again, the district court's factual findings are not clearly erroneous.

However, the district court's findings did not excuse it from applying the abuse of discretion standard. "Abuse of discretion review applies to a discretion-granting plan *even if* the administrator has a conflict of interest." *Abatie.*, 458 F.3d at 965 (emphasis added). The conflict is weighed as a factor in determining whether the administrator abused its discretion. *Stephan*, 697 F.3d at 929; *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115–17 (2008). The district court purported to apply an abuse of discretion standard tempered by high skepticism of UBH's interpretation given

UBH's conflict of interest. But even with such a tempered abuse of discretion standard, we cannot agree that UBH abused its discretion on the facts of this case.

Even assuming the conflicts of interest found by the district court warrant heavy skepticism against UBH's interpretation, UBH's interpretation does not conflict with the plain language of the Plans. To the contrary, it gives effect to all the Plan provisions. The Plans exclude coverage for treatment *inconsistent* with GASC or otherwise condition treatment on consistency with GASC. While the GASC precondition mandates that a treatment be consistent with GASC as a starting point, it does not compel UBH to cover *all* treatment that is consistent with GASC. Nor does the exclusion—or any other provision in the Plans—require UBH to develop Guidelines that mirror GASC. And while treatment consistent with GASC is a precondition to coverage, there are other Plan provisions that still exclude certain treatments even if they are consistent with GASC. Thus, if UBH had interpreted the GASC exclusion to mandate coverage for and consistency with GASC, these other exclusions would be rendered nugatory.

The district court disagreed. Although it acknowledged some treatment consistent with GASC may be excluded under the Plans, it ultimately ruled that UBH abused its discretion because the Guidelines did not require coverage for all care consistent with GASC. The district court's substitution of its interpretation of the Plans for UBH's interpretation that is consistent with the language of the Plans was erroneous.

We reverse the district court's judgment that UBH wrongfully denied benefits to the named Plaintiffs based upon the court's finding that the Guidelines impermissibly

deviate from GASC. The district court's judgment on Plaintiffs' breach of fiduciary duty claim also relied heavily on its conclusion that the Guidelines impermissibly deviated from GASC.[5] This also was error.

VI

Finally, UBH contends that the district court erred when it excused unnamed class members from demonstrating compliance with the Plans' administrative exhaustion requirement. We agree.

We review the applicability of exhaustion principles de novo. *See Barboza v. Cal. Ass'n of Pro. Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011). "ERISA itself does not require a participant or beneficiary to exhaust administrative remedies in order to bring an action under § 502 of ERISA, 29 U.S.C. § 1132." *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1088 (9th Cir. 2012) (quoting *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008)). Instead, ERISA mandates an opportunity for administrative review, *see* 29 U.S.C. § 1133(2), and we have treated completion of this administrative review as a prudential exhaustion requirement. *Castillo*, 970 F.3d at 1228. We have also consistently recognized three exceptions to the prudential exhaustion requirement: futility, inadequate remedy, and unreasonable claims procedures. *See Vaught*, 546 F.3d at

[5] This was not the only finding relevant to the district court's judgment on the breach of fiduciary duties claim. The district court also found, among other things, that financial incentives infected UBH's Guideline development process and that UBH developed the Guidelines with a view toward its own interests. Our decision does not disturb these findings to the extent they were not intertwined with an incorrect interpretation of the Guidelines as inconsistent with the Plan terms.

626–27. Plaintiffs have not shown that we have extended these exceptions to a contractual exhaustion requirement, and even if we were inclined to do so, here it is uncontested that some beneficiaries successfully appealed the denial of their benefit claims, so these exceptions are not satisfied.

The Supreme Court has explained that "[t]he plan, in short, is at the center of ERISA," and accordingly, "[t]his focus on the written terms of the plan is the linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Heimeshoff*, 571 U.S. at 108 (third and fourth alterations in original) (first quoting *McCutchen*, 569 U.S. at 101; and then quoting *Varity*, 516 U.S. at 497). While Congress, in enacting ERISA, "empowered the courts to develop, in . . . light of reason and experience, a body of federal common law governing employee benefit plans," *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984), federal common law doctrines cannot alter or override clear and unambiguous plan terms, *see Cinelli v. Security Pacific Corp.*, 61 F.3d 1437, 1444 (9th Cir. 1995).

When an ERISA plan does not merely provide for administrative review but, as here, explicitly mandates exhaustion of such procedures before bringing suit in federal court and, importantly, provides no exceptions, application of judicially created exhaustion exceptions would conflict with the written terms of the plan. *Cf. Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992) ("Because the plan was unambiguous, the Greanys cannot avail themselves of the federal common law claim of equitable estoppel.").

This outcome is consistent with the Rules Enabling Act. Exhaustion is a contractual limitation that impacts the availability of remedies. In this case, by excusing all absent class members' failure to exhaust, the district court abridged UBH's affirmative defense of failure to exhaust and expanded many absent class members' right to seek judicial remedies under Rule 23(b)(3). *Cf. Dukes*, 564 U.S. at 367 ("[A] class cannot be certified on the premise that [the defendant] will not be entitled to litigate its statutory defenses to individual claims."). Accordingly, to the extent any absent class members' plans required exhaustion, the district court erred in excusing the failure to satisfy such a contractual requirement. On this basis, we reverse.

VII

In sum, Plaintiffs have Article III standing to bring their breach of fiduciary duty and improper denial of benefits claims pursuant to 29 U.S.C. §§ 112(a)(1)(B) and (a)(3). And the district court did not err in certifying three classes to pursue the fiduciary duty claim. However, because Plaintiffs expressly declined to make any showing, or seek a determination of, their entitlement to benefits, permitting Plaintiffs to proceed with their denial of benefits claim under the guise of a "reprocessing" remedy on a class-wide basis violated the Rules Enabling Act. Accordingly, we affirm in part and reverse in part the district court's class certification order.

On the merits, the district court erred in excusing absent class members' failure to exhaust administrative remedies as required under the Plans. The district court also erred in determining that the Guidelines improperly deviate from GASC based on its interpretation that the Plans mandate coverage that is coextensive with GASC. Therefore, the

judgment on Plaintiffs' denial of benefits claim is reversed, and to the extent the judgment on Plaintiffs' breach of fiduciary duty claim is based on the district court's erroneous interpretation of the Plans, it is also reversed.

AFFIRMED in part, REVERSED in part, and REMANDED FOR FURTHER PROCEEDINGS. Each party to bear its own costs.

APPENDIX B
(Original Panel Decision)

NOT FOR PUBLICATION

FILED

MAR 22 2022

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID WIT; et al.,

Plaintiffs-Appellees,

LINDA TILLITT; MARY JONES,

Intervenor-Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

Nos. 20-17363
21-15193

D.C. No. 3:14-cv-02346-JCS

MEMORANDUM*

GARY ALEXANDER, on his own behalf and on behalf of his beneficiary son, Jordan Alexander; et al.,

Plaintiffs-Appellees,

MICHAEL DRISCOLL,

Intervenor-Plaintiff-Appellee,

v.

Nos. 20-17364
21-15194

D.C. No. 3:14-cv-05337-JCS

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

Appeal from the United States District Court
for the Northern District of California
Joseph C. Spero, Magistrate Judge, Presiding

Argued and Submitted August 11, 2021
San Francisco, California

Before: CHRISTEN and FORREST, Circuit Judges, and ANELLO,[**] District Judge. Partial Concurrence by Judge FORREST.

Defendants appeal the district court's judgment in an ERISA class action against United Behavioral Health (UBH) for breach of fiduciary duties and wrongful denial of benefits pursuant to 29 U.S.C. § 1132(a)(1)(B) and (a)(3)(A). "We review the district court's conclusions of law de novo and its findings of fact for clear error." *Democratic Nat'l Comm. v. Hobbs*, 948 F.3d 989, 998 (9th Cir. 2020) (en banc). We have jurisdiction pursuant to 28 U.S.C. § 1291, and we reverse. Because the parties are familiar with the facts, we do not recite them here.

1. UBH argues that plaintiffs lacked Article III standing to bring their claims because: (1) plaintiffs did not suffer concrete injuries; and (2) plaintiffs did

[**] The Honorable Michael M. Anello, United States District Judge for the Southern District of California, sitting by designation.

not show proof of benefits denied, they cannot show any damages traceable to UBH's Guidelines. We disagree.

To determine whether a statutory violation caused a concrete injury, we ask: "(1) whether the statutory provisions at issue were established to protect [the plaintiff's] concrete interests (as opposed to purely procedural rights), and if so, (2) whether the specific procedural violations alleged in this case actually harm, or present a material risk of harm to, such interests." *Patel v. Facebook, Inc.*, 932 F.3d 1264, 1270–71 (9th Cir. 2019) (quoting *Robins v. Spokeo, Inc.*, 867 F.3d 1108, 1113 (9th Cir. 2017)).

Plaintiffs alleged that UBH developed Guidelines for use in administering claims, and that the Guidelines were not coextensive with the benefits afforded to them by the terms of their respective Plans. Plaintiffs argue they have standing to bring their claims because they were denied their rights to Guidelines that were developed for their benefit and to a fair adjudication of their claims. As to plaintiffs' fiduciary duty claim, plaintiffs alleged that they suffered injury because UBH failed to develop Guidelines that were consistent with generally accepted standards of care (GASC) in violation of its duty to administer the class members' health benefit plans "solely in the interest of the participants and beneficiaries," 29 U.S.C. § 1104(a)(l), "with . . . care, skill, prudence, and diligence," 29 U.S.C. § 1104(a)(l)(B), and "in accordance with the documents and instruments governing

the plan," 29 U.S.C. § 1104(a)(l)(D). Plaintiffs further argue that ERISA allows members to clarify their rights to future benefits under their Plans' terms allowing beneficiaries to enforce their rights.

ERISA's core function is to "protect contractually defined benefits," *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013) (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)), and UBH's alleged fiduciary violation presents a material risk of harm to plaintiffs' interest in the interpretation of those contractual benefits, *see Ziegler v. Connecticut Gen. Life Ins. Co*., 916 F.2d 548, 551 (9th Cir. 1990) ("Congress intended to make fiduciaries culpable for certain ERISA violations even in the absence of actual injury to a plan or participant."). Plaintiffs' alleged harm includes the risk that their claims will be administered under a set of Guidelines that narrows the scope of their benefits, and also includes the present harm of not knowing the scope of the coverage their Plans provide. The latter implicates plaintiffs' ability to make informed decisions about the need to purchase alternative coverage and the ability to know whether they are paying for unnecessary coverage. Plaintiffs sufficiently alleged a concrete injury.

The alleged injury is also sufficiently particularized because the Guidelines are applied to the contractual benefits afforded to each class member. *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016) ("For an injury to be 'particularized,' it 'must affect the plaintiff in a personal and individual way.'" (citation omitted)).

The fact that plaintiffs did not ask the court to determine whether they were individually entitled to benefits does not change the fact that the Guidelines materially affected each plaintiff. *Cf. Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615, 1616 (2020) (holding no injury where alleged ERISA violations had no effect on plaintiffs' *defined benefit plan*). 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.

As to plaintiffs' denial of benefits claim, plaintiffs alleged that UBH adjudicated and denied their requests for coverage based on criteria that were inconsistent with the terms of member plans in an arbitrary and capricious manner. We conclude this claim also satisfies the concrete and particularized injury requirement. ERISA protects contractually defined benefits, *McCutchen*, 569 U.S. at 88, 100, and plaintiffs alleged a harm—the arbitrary and capricious adjudication of benefits claims—that presents a material risk to their interest in a fair adjudication of their entitlement to benefits. Despite UBH's argument to the contrary, plaintiffs need not have demonstrated that they were, or will be, actually denied benefits to allege a concrete injury. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 424-25 (2011); *Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656 (1993). Finally, the alleged injury is "fairly

traceable" to UBH's conduct. *See Spokeo*, 578 U.S. at 338. Thus, plaintiffs have established Article III standing to assert their claims.

2. UBH argues the district court erred by certifying a class that required individualized determinations. But plaintiffs' fiduciary duty claim, alleging that UBH applied overly restrictive Guidelines and thereby compromised their contractual rights under their Plans, is capable of being resolved on a class-wide basis. The district court did not abuse its discretion by concluding the claim was within Rule 23's ambit. As to certification of the denial of benefits claim, plaintiffs avoided the individualized nature of the benefits remedy available under § 1132(a)(1)(B) by seeking "reprocessing." We need not reach whether the district court's "reprocessing" remedy overextended Rule 23 in violation of the Rules Enabling Act because this claim fails on its merits.

3. UBH further argues the district court did not afford it the proper level of deference. "We review de novo a district court's choice and application of the standard of review to decisions by fiduciaries in ERISA cases." *Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129, 1133 (9th Cir. 2017) (quoting *Estate of Barton v. ADT Sec. Servs. Pension Plan*, 820 F.3d 1060, 1065 (9th Cir. 2016)). Because the Plans in this case confer UBH with discretionary authority to interpret the terms of the Plans, we "review the plan administrator's decisions for an abuse of discretion." *Schikore v. BankAmerica Supplemental Ret. Plan*, 269 F.3d 956, 960–

61 (9th Cir. 2001). While the district court noted the correct standard of review, the district court misapplied this standard by substituting its interpretation of the Plans for UBH's.

UBH's interpretation—that the Plans do not require consistency with the GASC—was not unreasonable. *See Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 957–58 (9th Cir. 2016) (quoting *Canseco v. Constr. Laborers Pension Tr. for S. California*, 93 F.3d 600, 606 (9th Cir. 1996)). The Plans exclude coverage for treatment *inconsistent* with the GASC; Plaintiffs did not show that the Plans mandate coverage for all treatment that is consistent with the GASC. Plaintiffs argue UBH had a conflict of interest, which would decrease the level of deference to be afforded in applying an abuse of discretion standard. *See Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 929 (9th Cir. 2012). But even if UBH has a conflict of interest because it serves as plan administrator and insurer for fully insured plans that are the main source of its revenue, this would not change the outcome on these facts. *See Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008) ("We view[] 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." (internal quotations omitted)). We therefore reverse. We need not reach UBH's argument that unnamed plaintiffs failed to comply with the Plans' administrative exhaustion requirement.

REVERSED

FILED

MAR 22 2022

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

Wit v. United Behavioral Health, No. 20-17363
FORREST, J., concurring in part and in the judgment:

I agree that plaintiffs have standing and that the district court erred in rejecting UBH's interpretation of the Plan and granting judgment in favor of plaintiffs. I write separately because I disagree that plaintiffs "avoided" the individualized questions presented in their denial-of-benefits claims by seeking reprocessing of their claims as their remedy. We should have reached the merits of this issue and held that the district court erred in certifying plaintiffs' denial-of-benefits claims for class treatment.

The district court's class certification decision is reviewed for an abuse of discretion. *Pulaski & Middleman, LLC v. Google, Inc.*, 802 F.3d 979, 984 (9th Cir. 2015). To avoid the inherent individualized issues involved in assessing whether plaintiffs are entitled to benefits under the Plan terms, plaintiffs framed their denial-of-benefits claims as seeking a procedural remedy—reprocessing of their claims based on the interpretation of the Plan that they advance. The district court abused its discretion in accepting that reprocessing *is itself* a remedy that justifies class treatment under 29 U.S.C. § 1132(a)(1)(B) independent from the express statutory remedies that Congress created. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) ("The . . . carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to

incorporate expressly."); *see also Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1013 (9th Cir. 1997) (remanding for reevaluation of plaintiff's rights under Plan under § 1132(a)(1)(B)'s right to enforce the Plan terms); *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996) (remanding for reevaluation to determine whether plaintiff was entitled to benefits under § 1132(a)(1)(B)); *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 951 (9th Cir. 1993) (same).

Plaintiffs sought reprocessing so that UBH would re-look at their claims applying the interpretation of the Plan that they advance and award them benefits. But there are numerous individualized questions involved in determining plaintiffs' entitlement to benefits given the varying Guidelines that apply to their claims and their individual medical circumstances, and many class members have proceeded with alternative treatment and, therefore, likely would not benefit from reprocessing. Simply put, reprocessing is not the *remedy* that plaintiffs seek, it is the *means to the remedy* that they seek. And styling their sought-after relief as procedural for class-certification purposes does not resolve the individualized questions necessarily involved in deciding their claims. Moreover, plaintiffs are not entitled to seek reprocessing as an equitable remedy under § 1132(a)(3) because payment of benefits is an available remedy under § 1132(a)(1)(B). *See Castillo v. Metro. Life Ins. Co.*, 970 F.3d 1224, 1229 (9th Cir. 2020).

For these reasons, I would hold that the district court abused its discretion in certifying plaintiffs' denial-of-benefits claims for class treatment.

APPENDIX C
(Original Petition for Rehearing)

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' 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
[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

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

INTRODUCTION AND RULE 35(b) STATEMENT

In the battle against the nation's mental health and addiction crises, this case is an inflection point and a bellwether. Former Congressman Patrick J. Kennedy, sponsor of the federal mental health parity act, hailed it as the "*Brown v. Board of Education* for the mental health movement," while a major news outlet dubbed it "one of the most important and most thorough rulings ever issued against an insurance company."[1] As reflected in the response of industry watchers—and the amicus briefs that have been (and will be) filed by the U.S. government, multiple states, the American Psychiatric Association, American Medical Association, and others—it is no exaggeration to call this one of the most significant ERISA cases of the 21st century.

The issue is simple: when an insurer denies coverage as not "medically necessary," may it use guidelines inconsistent with the plan's requirement to use the medical community's generally accepted standards of care? Here, the panel said "yes," even though Defendant United Behavioral Health's ("UBH") Guidelines were not plan terms, were infected by an egregious conflict of interest, and were shown, in unchallenged factual findings, to be far stricter than the medical community's standards.

---

[1] Wayne Drash, *In scathing ruling, judge rips insurer for putting 'bottom line' over patients' health*, CNN (Mar. 6, 2019) https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html.

Indeed, for one certified class (the "State Mandate Class"), state law expressly requires insurers to determine medical necessity under criteria promulgated by the medical community, and expressly forbids insurers from using any other criteria. The panel's decision literally does not mention the State Mandate Class. Yet, by reversing the judgment as to that class, it effectively nullifies these important state laws and, as several of these states will tell this Court as amici on rehearing, seriously affronts the states' interests in regulating insurance to protect their citizens.

The panel also gutted the well-established conflict of interest doctrine that is vital to protecting ERISA plan participants. Despite Supreme Court and Circuit precedent dictating otherwise, the panel disregarded the district court's factual findings that UBH's conflict of interest actually infected its Guidelines—which, the district court found, were shaped by UBH's finance department and designed to save itself money, not serve plan members. *E.g.*, 2-ER-331–32 (Findings of Fact and Conclusions of Law ("FFCL") ¶ 202) (unchallenged finding that finance department had "veto power" over Guidelines "and used it to prohibit even a change in the Guidelines that all of [UBH's] clinicians had recommended"). By refusing to strip UBH of deference under these circumstances, the panel gave insurers a roadmap for insulating from scrutiny decisions tainted by even egregious conflicts of interest.

The implications of the panel's decision are far-reaching. For one thing, the panel invalidated injunctive relief that protected the mental health and addiction coverage of *everyone* insured by UBH—millions of Americans across the country. And

the impact doesn't stop there. *Virtually every ERISA plan in the country*, often as a condition of state law, requires medical necessity decisions to follow the medical community's generally accepted standards of care. And *virtually every insurer* relies on guidelines separate from the plans to evaluate that question. *See* Assoc. for Behavioral Health and Wellness ("ABHW") Br. 1–2 (ECF No. 41) (amicus supporting *UBH* explaining that "guidelines are essential tools" for its member insurers, who collectively "provide coverage to over 200 million people"). By allowing the mental health subsidiary of the nation's largest insurer to use guidelines that are much stricter than the medical community's views, the panel's resolution of this test case will affect the coverage of mental health and addiction patients nationwide.

This case has garnered attention throughout the industry ever since the district court's landmark post-trial ruling in 2019. Its reversal—on grounds that effectively nullify state laws, ignore the district court's factual findings, and contravene Circuit and Supreme Court precedent—is a devastating setback in the fight against the nation's mental health and addiction crises that will only serve to embolden other insurers to follow UBH's lead. Rehearing is urgently needed.

GROUNDS FOR PANEL REHEARING AND REHEARING EN BANC

I. Rehearing is required because the panel's reason for upholding UBH's Guidelines has no application to one of the three certified classes

Rehearing is required to correct the panel's grievous error in omitting from its decision, and seemingly failing to consider at all, the "State Mandate Class" certified

by the district court. The ERISA plans of these class members are subject to state laws that require addiction treatment coverage decisions to be made using specified criteria promulgated by the medical community, and forbid the use of any other criteria (like UBH's Guidelines). The panel's opinion does not mention this class. Yet its rationale for reversing—that UBH had discretion *under the plans* to adopt and use its Guidelines—does not apply at all to the State Mandate Class. Rehearing is necessary to avoid nullifying these state laws and offending bedrock principles of federalism.

The district court certified three classes in this case: (1) the *Wit Guideline Class*, consisting of all members of ERISA health benefit plans whose requests for coverage of residential treatment services UBH denied based upon UBH's Guidelines; (2) the *Alexander Guideline Class*, consisting of members whose requests for coverage of outpatient or intensive outpatient services UBH denied based upon UBH's Guidelines; and (3) the *State Mandate Class*, consisting of all members of fully-insured ERISA health benefit plans governed by the state law of Connecticut, Illinois, Rhode Island, or Texas, whose requests for coverage of residential treatment services for a substance use disorder UBH denied based upon UBH's Guidelines, and not upon the state-mandated criteria. 2-ER-236–37 (FFCL ¶ 13) & 1-ER-214–15 (defining classes).

There are four states' laws implicated in the State Mandate Class: Connecticut, Illinois, Rhode Island, and Texas. The district court meticulously reviewed each state's law and concluded that they all required UBH to use specifically-prescribed criteria to determine the medical necessity of residential treatment for substance use disorders.

Connecticut, Illinois, and Rhode Island required UBH to use the American Society of Addiction Medicine ("ASAM") Criteria, or something equivalent. 2-ER-313–14 (FFCL ¶ 162) (Connecticut law "required insurers to use the ASAM Criteria, or a set of criteria that UBH 'demonstrates to the Insurance Department is consistent with' the ASAM Criteria"); 2-ER-310–13 (FFCL ¶¶ 157–61) (Illinois law "required that UBH use the ASAM Criteria rather than its own Guidelines"); 2-ER-314–15 (FFCL ¶¶ 163–64) (Rhode Island law required "guidelines [used] to make coverage determinations" to be "consistent with ASAM Criteria"). For Texas, UBH was required to apply criteria issued by the Texas Department of Insurance; Texas law did not allow for the use of different criteria, even if equivalent. 2-ER-315–16 (FFCL ¶¶ 165–67). UBH did not appeal the district court's legal determinations regarding the requirements of these states' laws.

The district court then made detailed factual findings, based partly on UBH's own admissions, that in denying the claims of each State Mandate Class member, (1) UBH applied its own Guidelines rather than the state-mandated criteria, and (2) UBH's Guidelines were not consistent with the ASAM Criteria. 2-ER-306–16 (FFCL ¶¶ 150–67). The court further found, as fact, that "UBH lied to state regulators" "[t]o conceal its misconduct." 1-ER-92 (Remedies Order at 1) (summarizing findings); 2-ER-308–09, -313–14 (FFCL ¶¶ 152–53, 162). UBH did not appeal any of these findings.

Finally, the district court concluded that UBH knowingly violated state law by applying its own Guidelines instead of the state-mandated criteria in evaluating medical necessity and that the State Mandate Class was entitled to relief. 2-ER-334 (FFCL ¶ 213); 1-ER-92, -179–80 (Remedies Order). UBH also did not appeal these conclusions.

Although UBH's challenges to Article III standing and class certification applied to all three Classes, UBH raised no challenge to the district court's ruling that UBH could not substitute its Guidelines for state-specified criteria. Nor did the panel identify any basis for reversing the district court's judgment as to the State Mandate Class. But the panel also did not exclude the State Mandate Class from its ruling.

The panel appears to have overlooked this class altogether. And the effect of this oversight is to allow UBH to use its restrictive Guidelines to deny coverage *even when state law mandates otherwise*. The panel's decision renders these state laws a dead letter and denies states the authority to decide for themselves how to protect their citizens by regulating insurance—a role ERISA expressly preserved for the states. 29 U.S.C. § 1144(b)(2)(A). Because the panel seemingly overlooked the State Mandate Class—effectively nullifying state laws and seriously offending principles of federalism—rehearing is needed.

II. Rehearing is required because the panel's decision undermines ERISA in ways that will have undeniable nationwide consequences

As to the other two classes, the panel held that the plans could reasonably be interpreted as allowing UBH to apply its Guidelines over the medical community's standards. But the Guidelines are not terms of any plan in the class; the plans, rather, require medical necessity to be determined under "generally accepted standards of care," 2-ER-253–55 (FFCL ¶¶ 53-56), and the unchallenged factual findings showed that the Guidelines were inconsistent with those standards. Rehearing is necessary because the panel's resolution of this exceptionally important question will resonate nationwide, severely undermining access to mental health and addiction treatment across the country.

A. The panel's decision allows UBH to substitute the judgment of its finance department for that of the medical community, despite clear plan language to the contrary

The panel's core error stems from UBH's fundamentally misleading argument about how health insurance plans work. UBH appears to have convinced the panel that, in finding UBH's Guidelines to be an unreasonable interpretation of generally accepted standards of care, the district court converted an *exclusion* for treatment *inconsistent* with generally accepted standards into an *affirmative mandate* for coverage of all services *consistent* with those standards. But that was not the basis for the district court's decision, and nobody thinks that is how the plans work. UBH's argument obfuscates what the Plaintiffs challenged and the district court found. *E.g.*, 2-ER-253

(FFCL ¶ 53). The result was a decision that allows UBH to ignore plan terms entirely when it makes coverage decisions using its own Guidelines.

1. It was undisputed below that each plan in the class includes mental health and addiction treatment as "covered" services. *E.g.*, 12-ER-2624 ("Covered Services" include treatment for "Mental Illness [and] substance use disorders"); 2-ER-230 (FFCL ¶ 1). Those plan provisions mandate coverage for the listed services unless they are excluded or limited by another plan term. In one way or another, each plan *excludes* coverage for treatment that is inconsistent with the medical community's generally accepted standards of care. 2-ER-253 (FFCL ¶ 53) (unchallenged factual findings that every plan in the case includes a "requirement that the requested treatment must be consistent with generally accepted standards of care"); 12-ER-2624 (treatment must be "[c]onsistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines"); *see also* 2-SER-380–98 (chart excerpting relevant plan language). As a shorthand, UBH describes its application of this exclusion as a "medical necessity determination." Opening Br. 10 (ECF No. 25).[2]

Contrary to UBH's suggestions, this case is *entirely* about UBH's interpretation of that "medical necessity" exclusion, which is in every UBH-administered plan. 2-

[2] Some plans use "clinical appropriateness" or similar language rather than "medical necessity." *E.g.*, 12-ER-2634; *see* 2-SER-380–98 (plan language chart). For simplicity's sake, we use UBH's shorthand.

ER-253 (FFCL ¶ 53); *see also* 2-SER-380–98 (plan language chart). *That* is the plan term—the only one—that UBH was interpreting when it drafted the Guidelines, and that it was applying when it denied each class member's claim. 2-ER-247–48 (FFCL ¶ 39); 1-ER-221–22 (Further FFCL ¶ 223); 2-SER-302–03 (excerpt from UBH's description of its utilization review procedures). In other words, UBH denied every claim at issue on the ground that the services—which were covered as long as they were not subject to a plan exclusion—were excluded as not "medically necessary."

The problem, however, was that in making these medical necessity determinations, UBH substituted its own, highly-restrictive Guidelines for the standard required by the plans: generally accepted standards of care. *See* 2-ER-236–37 (FFCL ¶ 13) & 1-ER-214 (defining classes to include only denials based on the Guidelines); Opening Br. 10 (ECF No. 25) (UBH diagram showing Guidelines are used to make "medical necessity determinations"); 2-ER-230–31 (FFCL ¶ 3) (quoting representative claim denial stating "member's treatment does not meet the medical necessity criteria for residential mental health treatment per . . . Guidelines"); 2-ER-247–48 (FFCL ¶ 39) (purpose of UBH's Guidelines was "to establish criteria consistent with generally accepted standards for determining the appropriate level of care"). *That* substitution is the entirety of what the Plaintiffs challenged as to these classes. And the district court's findings, therefore, pertained to just that one plan term: the "medical necessity" exclusion.

2. If UBH had not obfuscated this key premise, the panel could never have let UBH swap its Guidelines for the medical community's standards. Mem. 7. The plans require this exclusion to be evaluated using "generally accepted standaards of care," not UBH's more-restrictive internal Guidelines. 2-ER-253. And neither *Moyle v. Liberty Mutual Retirement Benefit Plan*, 823 F.3d 948 (9th Cir. 2016), nor any other authority, permits an ERISA plan administrator to make coverage decisions inconsistent with plan terms. A grant of discretion to interpret a plan is not a delegation of authority to *amend* a plan by substituting internal guidelines that are inconsistent with the standards set forth in the plan. *See* 29 U.S.C. § 1102(b)(3); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

Here, the district court found as fact (and the panel did not disagree) that UBH's Guidelines were not terms of any plan in the class, even plans that referenced the Guidelines in some way. 2-ER-253–55 (FFCL ¶¶ 55–56). ERISA requires that benefits be determined "under the terms of [the] plan," 29 U.S.C. § 1132(a)(1)(B)—not a separate set of criteria, never approved by a plan sponsor, that the insurer can change on a whim, without following any of ERISA's strict rules for amending a plan or providing notice to participants. *E.g.*, 29 U.S.C. § 1022(a); 29 C.F.R. § 2520.104b-3; 29 C.F.R. § 2520.102-3.

Since the Guidelines were not part of the plans, and the district court found them inconsistent with plan terms, UBH could not use them to deny coverage. The

panel's decision to the contrary is not only incorrect, but deals an enormous blow to mental health and addiction coverage nationwide.

B. Absent rehearing, the panel's decision will undermine patients' access to care nationwide

The district court's decision in this case represented a nationally recognized step forward in the battle against mental illness and addiction. The panel's reversal is an equally significant step backwards. It will dramatically affect not only the millions of Americans *directly* covered by the relief the district court ordered, 1-ER-187 (barring UBH from using Guidelines across *all* ERISA-governed plans it administers), but also virtually every health plan and every insurer across the country. *E.g.*, APA and AMA Br. 6 (ECF No. 54) (explaining that insurers' reliance on guidelines that depart from generally accepted standards is "a pervasive problem affecting the quality and availability of care nationwide").

The direct impact on the millions insured by UBH, standing alone, warrants the en banc Court's attention. But this case promises enormous consequences far beyond UBH as well. One might reasonably ask why that is, given that an insurer's ability to use its own guidelines will depend on the terms of the individual plan and the state law that governs it. That fair question has a straightforward answer: there is almost complete uniformity across all health plans in the United States in tying medical necessity determinations to generally accepted standards of care.

As UBH's own amici explain, insurers almost always use standardized guidelines, which are separate from plan terms, to evaluate that key question. *See* ABHW 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"). In other words, the panel's resolution of this case bears on virtually every ERISA health plan in the United States.

That is why this case has drawn such a wide array of high-profile amici on both sides. On the payor side, multiple nationwide trade associations, alongside the Chamber of Commerce, have beseeched this Court to understand how high the stakes are. ABHW Br. 4 (ECF No. 41) (court's findings will "impact[] the entire industry, not just UBH"); Chamber of Commerce Br. 4 (ECF No. 40) (describing "significant . . . impact" of district court's decision); Am. Health Ins. Plans Br. 4 (ECF No. 30) (describing "lasting . . . impact on ERISA-covered benefits plans").

The same is true on the patient care side, as told by amici that include the federal government, several states, the American Psychiatric Association, the American Medical Association, the medical associations of numerous states and localities, and over two-dozen other prominent mental health advocacy organizations. In the words of the American Psychiatric Association and the American Medical Association:

> These [insurer] guidelines "are supposed to reflect generally accepted standards of care," but the district court found that Defendant's guidelines departed from those standards in

> significant ways. In *amici*'s experience, such departures—and the resulting obstacles to appropriate treatment—are a pervasive problem affecting the quality and availability of care nationwide.

APA and AMA Br. 5–6 (ECF No. 54).

If the district court's decision reshaped the landscape, it is a certainty that the panel's decision will have an even greater impact, and it will not be a positive one. *E.g.*, California Br. 16 (ECF No. 56) ("Reversal of the district court's remedial order will undo these benefits to California residents and to the State."). It will put medical necessity determinations squarely in the purview of insurance companies' finance departments—even when plans require those decisions to be based on the medical community's standards. This presents real and serious risks to those who rely on mental health and addiction treatment. *E.g.*, *id.* at 15 ("[W]hen health plans or administrators impose barriers to mental healthcare, like UBH did here, patients are at a greater risk of unemployment, homelessness, substance abuse use, suicide, and incarceration, imposing financial and societal costs borne by the State and its residents."). Rehearing is warranted on this exceptionally important issue.

III. Rehearing is also required because the panel's disregard for UBH's overwhelming conflict of interest contravenes established Circuit and Supreme Court precedent

Rehearing is also required because the panel disregarded Ninth Circuit and Supreme Court precedent regarding ERISA plan administrators' conflicts of interest. In assessing UBH's actions, the district court applied an abuse of discretion standard

with "significant skepticism" based on its findings that UBH had a deep conflict of interest that infected its coverage decisions by allowing money, rather than the best interests of participants, to drive the development of its Guidelines. 2-ER-331–32 (FFCL ¶ 202). The panel summarily disregarded the district court's factual findings, contravening *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105, 115 (2008), and this Court's en banc decision *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955, 965 (9th Cir. 2006). Instead, the panel suggested, relying on an incomplete quote from a different case, that there was "no evidence of malice, of self-dealing, or of a parsimonious claims-granting history" and therefore, even if it had considered UBH's conflict of interest, that conflict would not change its view. Mem. 7.

This holding improperly limits the types of conflicts that warrant stripping insurers of the deference typically afforded to their plan interpretations, and fails to give the district court's unchallenged factual findings the required weight. The resulting decision contravenes settled law and guts the conflict doctrine that is vital to fair adjudication of ERISA claims.

1. The district court, in more than ten pages of factual findings supported by abundant evidence, laid out far more than the run-of-the-mill structural conflict that underlies every health benefit determination by an insurance company. Its findings conclusively established that UBH had a deep conflict of interest that actually infected its coverage decisions because it made cost savings the central tenet of its Guidelines. 2-ER-318–25, -329–32 (FFCL ¶¶ 174–89, 200–02).

Instead of insulating the development of its Guidelines from its financial self-interest—denying more claims means more money for itself—UBH embedded that self-interest into the Guidelines, thereby biasing every coverage determination made using those Guidelines. *Id.* UBH placed administrators from its Finance and Affordability Departments in key roles on the Guidelines committees and "provided detailed relevant financial briefings to other members of those committees" "on a monthly basis" so "the committee members were intimately familiar[] with the financial implications of their decisions in creating and revising the Guidelines." 2-ER-320–21, -331–32 (FFCL ¶¶ 180–82, 202). As a result, financial incentives tainted the entire Guideline development process, and the content of the Guidelines was ultimately designed to deny more claims and save money for UBH and its clients. *Id.*

Efforts to alter the Guidelines throughout the class period were also stymied by financial considerations. The record is replete with examples of UBH refusing to bring its Guidelines into line with generally accepted standards of care—despite consensus among the medical community and UBH's own clinicians that the Guidelines should be revised—solely because of the financial implications of the proposed changes. 2-ER-322–25 (FFCL ¶¶ 185–89). In the most extreme examples, UBH's Finance Department and CEO exercised their "veto power" to block Guideline changes that would affect UBH's bottom line. 2-ER-322, -324–25, -331–32 (FFCL ¶¶ 185, 189, 202).

2. Those findings, *none* of which UBH challenged on appeal, established a conflict of interest that "affected the benefits decision," *Glenn*, 554 U.S. at 117—precisely the type of conflict that requires heightened "skepticism" of an insurer's plan interpretation. *Abatie*, 458 F.3d at 968–69. "[W]here circumstances suggest a higher likelihood that [the conflict] affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration," the conflict should be considered "more important (perhaps of great importance)." *Glenn*, 554 U.S. at 117. The district court's findings of fact established both the severity of UBH's conflict and the actual impact it had on UBH's interpretation of the plans and development of the Guidelines (and thus the benefit decisions UBH made using those Guidelines). This Court, sitting en banc, has instructed that such findings must be treated as akin to "credibility determination[s]." *Abatie*, 458 F.3d at 969.

The panel, however, summarily disregarded the district court's skepticism and its findings regarding the conflict's *actual impact*, in direct contravention of *Abatie* and *Glenn*. The panel defied precedent by failing to treat the district court's findings the same as "credibility determinations." And the panel further erred by suggesting that the illustrative list of "malice," "self-dealing," and "a parsimonious claims-granting history" in *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008), was an exhaustive list of circumstances warranting skepticism. *Abatie* and its progeny make clear there are many ways insurance administrators' bias may impact

their decision-making, and courts should not restrict their review as the panel did here. If the district court's findings here don't establish the type of severe, corrupting conflict that justifies stripping a claims administrator of deference, then no case does.[3]

The implications of the panel's decision on this issue will also resonate far beyond UBH. As amici have told and will tell the Court, the practice of adopting coverage guidelines more restrictive than plan terms is not unique to UBH and is already pervasive throughout the industry. *See* § II.B, *supra*. With the panel's decision in hand, insurance administrators will now have no fear that their coverage decisions, let alone the guidelines on which they are based, will be closely scrutinized notwithstanding the self-dealing baked into them. Rehearing en banc is required to restore the critical protections prescribed by *Abatie* and *Glenn*.

CONCLUSION

The district court's ruling was a landmark decision following nearly a decade of hard-fought litigation, and it had begun to turn the tide in the nation's fight against mental illness and addiction. If the panel's decision stands, that progress will be undone, and it is hard to imagine anyone mounting a comparable effort again.

[3] Even if the *Saffon* list were exclusive, however, the panel's memorandum would still violate *Abatie*, because the findings established that UBH's conflict did constitute "self-dealing" and resulted in a "parsimonious claims-granting history," *cf.* Mem. 7 (quoting *Saffon*). As the district court found, UBH embedded its financial self-interest into the Guidelines, *see* § III.1, *supra*, and in applying them to deny benefits, "significantly narrow[ed]" the "scope of coverage" under the class members' plans. *E.g.*, 2-ER-270 (FFCL ¶ 82).

Panel or en banc rehearing is desperately needed.

Dated: May 5, 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

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 11. Certificate of Compliance for Petitions for Rehearing/Responses

Instructions for this form: http://www.ca9.uscourts.gov/forms/form11instructions.pdf

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

I am the attorney or self-represented party.

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)*:

[x] Prepared in a format, typeface, and type style that complies with Fed. R. App. P. 32(a)(4)-(6) and **contains the following number of words:** 4,179**.**
(Petitions and responses must not exceed 4,200 words)

OR

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

Signature *s/ Peter K. Stris* **Date** May 5, 2022
*(use "*s/[typed name]*" to sign electronically-filed documents)*