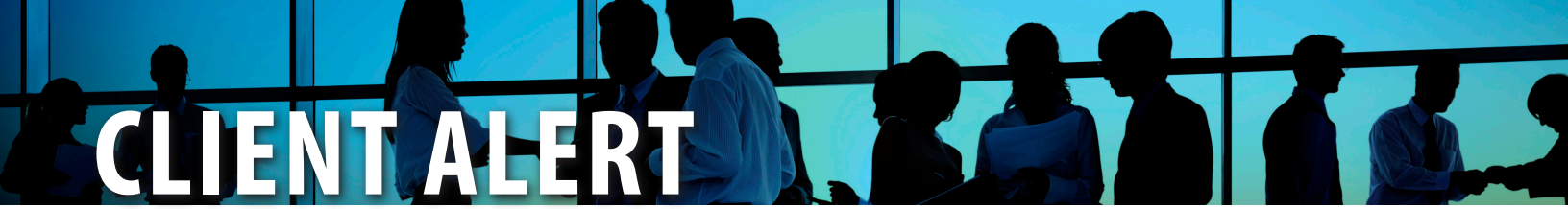

UPDATES TO WIT V. UNITED BEHAVIORAL HEALTH

by Erica A. Erman, Gregory W. Moore, Christopher J. Ryan, and Emma Trivax

The United States Court of Appeals for the Ninth Circuit recently released an unpublished memorandum decision in the landmark mental parity case of *Wit v. United Behavioral Health*. In this decision, the Ninth Circuit reversed the district court's order requiring UBH to reprocess more than 60,000 claims that had initially been denied for not meeting UBH's medical necessity guidelines. The memorandum decision was surprisingly short – and that has both positive and negative implications for mental health parity litigation.

What the *Wit* Plaintiffs did well (according to the Ninth Circuit):

The Ninth Circuit agreed that the *Wit* plaintiffs did have the standing to bring their action under Article III[1]. Plaintiffs alleged a concrete injury that was sufficiently particularized, and they showed that UBH's actions resulted in uncertainty concerning the scope of their benefits and the material risk of harm to their contractual rights. The Ninth Circuit further explained, "[d]espite 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."

The eight generally accepted standards of care (GASC) in behavioral health that the district court identified in its March 5, 2019 findings of fact remain generally accepted standards of care. *For more information about the underlying findings of fact from the district court, see our articles:* Highlights from Wit v. United Behavioural Health and Court Rules UBH Coverage Guidelines a Monumental Fixer-Upper

Where did the error occur (according to the Ninth Circuit):

In the view of the Ninth Circuit, the District Court applied the correct standard when reviewing the actions of a Plan Administrator, but in doing so, the District Court misapplied the standard of review. The UBH Plans conferred upon UBH discretionary authority to interpret the terms of the Plan. Thus, the proper standard to be applied by the District Court was to "review the plan administrator's decisions for an abuse of discretion." The Ninth Circuit held that the district court misapplied this standard "by substituting its interpretation of the Plans for UBH's." The Ninth Circuit's memorandum opinion was totally devoid of any explanation of how the standard was misapplied. In addition, and even though the Plaintiffs argued quite extensively in their briefing that the abuse of discretion standard should be given a decreased level of deference in light of a clear conflict of interest, the Ninth Circuit was of the opinion that the outcome of the matter would not have changed.

Namely, the decision abruptly ends with the following:

> 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.

While the Ninth Circuit cited *Saffon*, it appears to have (wrongly) ignored the conflict of interest standard enumerated in its more recent precedent, *Harlick v. Blue Shield of California*, 696 F.3d 699 (9th Cir. 2012). In Harlick, the Ninth Circuit provided additional factors to consider in determining whether the conflict of interest that "always" exists "where the same entity makes the coverage decisions and pays for the benefits" is of greater or lesser importance: (1) whether there were circumstances that suggest a higher likelihood that the conflict affected the benefits decision[2], (2) whether the administrator took active steps to reduce potential bias and promote accuracy such as employing a neutral, independent review process, or segregating employees who make coverage decisions from those who deal with the company's finances[3], (3) whether there is a history of biased claims administration, (4) whether the administrator gave inconsistent reasons for a denial, (5) whether the administrator failed to provide full review of a claim, and (6) whether the administrator failed to follow proper procedures in denying the claim.[4]

If the Ninth Circuit had considered the conflict of interest factors outlined in *Harlick* on the *Wit* facts, the abuse of discretion standard logically should have been given a decreased level of deference, and the outcome may well have been different.

What the Ninth Circuit left unanswered:

A whole lot.

The Ninth Circuit decision in *Wit* does not appear to address the plaintiffs' discriminatory application argument at all. Further, the Ninth Circuit's memorandum decision limits its ruling to the specific facts of the *Wit* case. Interestingly enough, the Ninth Circuit declined to recite the facts in its decision, so we do not know the facts they paid particular attention to or which facts they ignored.

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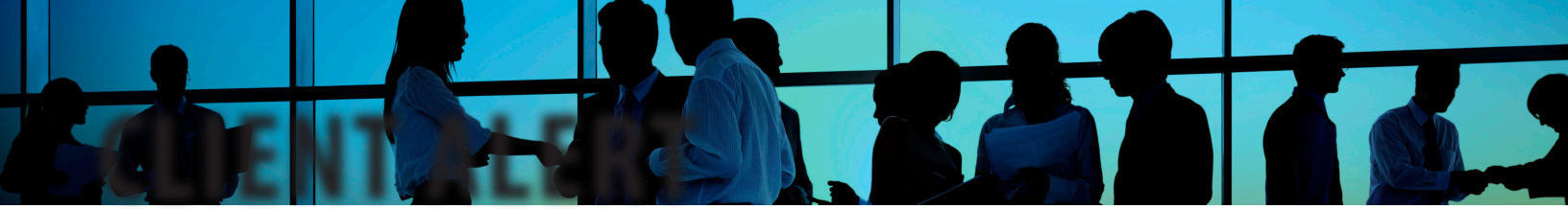
[1] Article III, Section 2, Clause 1 of the United States Constitution requires that a person must have a personal stake in the outcome of a matter asserting sufficient, redressable injury.

[2] In the March 5, 2019 Findings of Fact, the District Court specifically found that UBH's financial self-interest was a "critical consideration": UBH's Financial and Affordability Departments played "key roles in the Guideline development process." As the court stated, "The Court finds that the financial incentives discussed above have, in fact, infected the Guideline development process. In particular, instead of insulating its Guideline developers from these financial pressures, UBH has placed representatives of its Finance and Affordability Departments in key roles in the Guidelines development process throughout the class period."

[3] See fn. 2

[4] In listing these factors, *Harlick* cited *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006), *Friedrich v. Intel Corp.*, 181 F.3d 1105 (9th Cir. 1999), and *Lang v. Long–Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997).



What lessons can be learned from this memorandum decision?

Parity litigation is inherently fact-specific. Therefore, the result of one case—whatever its outcome—does not determine the course of all parity litigation.

What are some points that plaintiffs or defendants can draw as distinguishing factors from *Wit*?

- The level of the administrator or plan's conflict of interest.
- The balance (or lack thereof) between financial considerations and proper care for patients that goes into *creating* a plan's guidelines and the medical necessity decision-making process.
- The balance (or lack thereof) between financial considerations and proper care for patients that goes into *applying* a plan's guidelines and the medical necessity decision-making process.

While mental health parity litigation has thus far primarily been anchored to historical ERISA standards, there are other avenues to get to court. In the future, we may see more cases anchored to statutes and regulations regarding discrimination since parity has at its core whether there is discriminatory treatment of medical/surgical claims and behavioral health claims.

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