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

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID WIT, et al.,

Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

GARY ALEXANDER, et al.,

Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH,

Defendant-Appellant.

On Appeal from the United States District Court
for the Northern District of California
Nos. 3:14-cv-2346, 3:14-cv-5337 | Hon. Joseph C. Spero

DEFENDANT-APPELLANT'S REPLY BRIEF

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INTRODUCTION

Several paths exist for plan participants to challenge disputed coverage denials under ERISA, but Plaintiffs' novel approach is not one of them. Plaintiffs concede they took multiple shortcuts to make class certification possible, and the district court accepted these shortcuts for what it believed (and Plaintiffs and *amici* argue) was a laudable goal—providing coverage to individuals with behavioral health conditions. But the resulting class-wide judgment is irreconcilable with controlling legal requirements, pyrrhic for most class members, and improperly punitive to UBH.

Plaintiffs never have shown that the district court's class-wide remand-and-reprocessing judgment and ten-year injunction will result in additional benefits to *any* class member. Nor have Plaintiffs ever disputed UBH's showing that large swaths of class members will gain nothing from these so-called remedies, because their coverage denials (1) rested on separate guidelines or independent grounds that Plaintiffs did not challenge at trial or (2) concerned treatment never obtained and no longer sought, so reprocessing could not result in additional coverage.

Although the Department of Labor ("DOL") filed an *amicus* brief ostensibly supporting Plaintiffs, the many caveats on the penultimate page reveal that DOL does *not* support Plaintiffs on the critical points. DOL acknowledges that remand is inappropriate if denials were supported by "truly independent" reasons, and declines to support remand for individuals who "accepted coverage" for "a lower level of

treatment." DOL Br. 26 & n.5. Neither DOL nor Plaintiffs justifies including these individuals in the class being remanded to UBH, much less explains how the reprocessing will provide these members meaningful relief.

The class-wide remand-and-reprocess remedy flowed from the district court's decision to excuse Plaintiffs from proving that the guidelines' alleged flaws caused coverage denials. Plaintiffs now suggest (at 17) that causation was established by limiting the class to denials "based in whole or in part on" UBH's guidelines. But determining class membership and establishing causation are entirely different exercises: To be in the class, someone's denial letter merely needed to "cite" one of over 200 guideline documents as one item considered in making the determination. At all points, Plaintiffs ignored—and assured the district court it need not consider—all other evidence concerning whether the guidelines and their alleged flaws actually impacted coverage. The court accepted Plaintiffs' argument—contrary to Article III standing, ERISA, Rule 23, and the Rules Enabling Act—that no rigorous inquiry into causation was required.

Plaintiffs offer no persuasive defense of the main theory of standing on which the district court relied: that application of challenged guidelines is a cognizable procedural injury even if it did not affect benefits. Neither Article III nor ERISA recognizes such intangible and inconsequential "injury"—a point driven home by *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020), which the district court ignored. DOL

eschews this "bare procedural violation" theory of standing and instead relies (at 11, 18) on precisely the same "'causal connection'" between the guidelines and the denials that the district court expressly disclaimed. DOL's theory is at odds with its concession that ERISA provides no remedy for claims denied on independent, unchallenged grounds.

Plaintiffs also rely on the district court's statements that UBH's guidelines were "pervasive[ly]" flawed, 2-ER-270, and any denial having any connection to any guideline was "wrongful," 1-ER-222. But UBH's appeal is not about whether an individual coverage denial under UBH's old guidelines (which UBH modified voluntarily before the trial ruling, 1-ER-155) *could*, in the right case, be overturned under ERISA. It is about whether the district court's findings concerning certain of those guidelines justified jettisoning foundational principles of Article III, ERISA, and the Rules Enabling Act. Indeed, many of UBH's guidelines contained none of the alleged flaws, yet they were swept into the class because they included a fleeting cross-reference to the guidelines challenged at trial.

Moreover, all of the supposed flaws the district court found rested on its "mistaken impression of applicable legal principles," so this Court "is not bound by the clearly erroneous standard." *Inwood Labs., Inc. v. Ives Labs., Inc.*, 456 U.S. 844, 855 n.15 (1982). For example, Plaintiffs and their *amici* take as given (as did the district court) that all ERISA plans require coverage of treatment conforming to

"generally accepted standards of care," and that UBH's guidelines thus were required to track those standards. But under ERISA, coverage is a matter of contract between plan sponsor and beneficiary, and the plans here do *not* cover all "generally accepted" treatment. While behavioral health services undoubtedly are important, neither UBH nor the courts can override lawful plan terms simply because *some* States, medical professionals, and patients would prefer broader and more costly coverage. *See* California Br. 6; APA Br. 6; NHLP Br. 6-8.

Plaintiffs likewise cite no support for the court's divergence from ERISA's deferential abuse-of-discretion standard. The court instead made its own findings about generally accepted standards and wrongly held UBH to the court's preferred standards.

The shortcuts Plaintiffs proposed to facilitate both class certification and a sprawling remand-and-reprocessing remedy were legally flawed at every turn. In accepting those shortcuts, the district court erred, and the judgment should be reversed.

ARGUMENT

I. Plaintiffs' Novel Facial Challenge To UBH's Guidelines Does Not Excuse Their Admitted Failure To Prove Causation

A. Plaintiffs' Latest Theories Of Article III Standing Lack Merit

UBH has consistently argued that the only injury relevant to Article III standing is the denial of benefits. The district court disagreed, holding that "the

relevant injury" was the allegedly "defective process" UBH applied in determining coverage, irrespective of its effect on benefits. 1-ER-79. Plaintiffs now join UBH in focusing on the "denial of coverage," Pls. Br. 27, but they failed to prove that this asserted injury is "fairly traceable" to the alleged guidelines flaws, as Article III requires, *Spokeo v. Robins*, 136 S. Ct. 1540, 1547 (2016).

1. Plaintiffs argue (at 26) that they satisfied causation and traceability by defining classes to include any denial letter "based" even "in part" on UBH's guidelines. But that criterion for membership—a denial letter referencing the guidelines as one document that was considered, 2-ER-369-370—does not prove that the guidelines (or any alleged defect in them) caused the denial. Plaintiffs litigated this case based on the "stipulat[ion] that they d[id] not seek" to establish causation, and the district court expressly found that "Plaintiffs' claims would fail for lack of causation" if it were required. 1-ER-77. As the district court recognized, a denial letter's mere reference to the guidelines does not prove that they actually caused the denial. Given the disparities within the classes, only individualized review of each class member's administrative record could meet that burden.

First, Plaintiffs do not dispute that the classes include thousands of denials that never even cited the guidelines challenged at trial (the Level of Care Guidelines ("LOCGs")). In fact, most class members' denials—51% of the parties' stipulated sample—cite only different guidelines (the Coverage Determination Guidelines

("CDGs")) that the court later found to "incorporate" the LOCGs. UBH Br. 28-29. Plaintiffs (at 41) rely entirely on this flimsy incorporation-by-reference to establish standing for these class members, but the CDGs are lengthy documents with numerous provisions never challenged below. *E.g.*, 12-ER-2399-2553. Even if briefly referencing the LOCGs sufficed to "incorporate" them in some technical sense, that would not mean—and the court did not find—that the *CDGs* were pervasively flawed or that alleged flaws in the LOCGs *caused* every denial that cited a CDG. The link between these benefits denials and the guideline challenges is "too attenuated" to satisfy Article III's "fairly traceable" requirement. *Washington Envtl. Council v. Bellon*, 732 F.3d 1131, 1141 (9th Cir. 2013).

Second, Plaintiffs acknowledge (at 42) that some denial letters cite independent grounds for denying coverage that Plaintiffs never challenged. For these denials, Plaintiffs (at 34) cite *Carney v. Adams*'s statement that parties may challenge unlawful barriers to obtaining benefits without "alleg[ing] that [they] would have obtained the benefit[s] but for the [unlawful] barrier." 141 S. Ct. 493, 503 (2020). *Carney* derived that statement from three Equal Protection cases holding that plaintiffs applying for *future* benefits need not prove that the challenged barrier deprived them of benefits in the *past*. In context, that is all the statement means. *See Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 210-12 (1995) (contractor had "standing to seek forward-looking relief" against "future"

discriminatory practices because it was "likely" to bid on affected contracts in the "near future"); *Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656, 668 (1993) (association's members "regularly bid on contracts" that challenged ordinance made unavailable); *Gratz v. Bollinger*, 539 U.S. 244, 262 (2003) (petitioner stood "'able and ready' to apply" as "transfer student" should university "cease to use race in undergraduate admissions"); *Carney*, 141 S. Ct. at 500 (plaintiff lacked standing to challenge judicial appointments criteria because he was not "'able and ready' to apply" for appointment).[1]

Here, by contrast, UBH has already made the 67,000 denials that Plaintiffs want reprocessed, and Plaintiffs identify no pending requests for future benefits that these denials may impact.[2] Plaintiffs have no interest in reprocessing coverage requests that UBH had valid, independent reasons for denying.

Plaintiffs argue (at 42) that only a "tiny fraction" of the denials rest on independent grounds, but the examples in UBH's opening brief are not exhaustive. By joint stipulation, only 96 denial letters from current class members were

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[1] Plaintiffs' other authorities likewise involved forward-looking relief. *See Trinity Lutheran Church of Columbia, Inc. v. Comer*, 137 S. Ct. 2012, 2018 (2017); *Conservation Force, Inc. v. Manning*, 301 F.3d 985, 990 & n.3 (9th Cir. 2002); *LSO, Ltd. v. Stroh*, 205 F.3d 1146, 1156 (9th Cir. 2000).

[2] Plaintiffs have not even attempted to show what percentage of class members remain members of UBH-administered ERISA plans. Several named plaintiffs are not. *See* 1-FER-10 n.35, 12 n.76. Only *current* plan members may sue to clarify their future rights under the plan. 29 U.S.C. § 1132(a)(1)(B); DOL Br. 16.

introduced into the record. UBH Br. 28 n.2. UBH's opening brief cites multiple examples from this sample, *id.* at 29-30, and UBH cited others below, *e.g.*, 1-FER-15. Even "5% to 6%" of uninjured class members is sufficient to defeat class certification, and it is Plaintiffs' burden to show that enough of the class was injured. *Olean Wholesale Grocery Coop., Inc. v. Bumble Bee Foods LLC*, 993 F.3d 774, 792-93 (9th Cir. 2021). Plaintiffs never did so because they stipulated early on that they did not intend to prove causation, 1-ER-77, and the court then ruled—incorrectly—that causation was "not relevant." 1-SER-283:13-20 (noting later joint stipulation, "based on" that ruling, that neither party would cite denial letters at trial); Pls. Br. 10 n.4. Speculation about how many Plaintiffs were uninjured is not an alternative basis to affirm.

Third, Plaintiffs do not dispute that up to 65% of the class may be ineligible for benefits regardless of the outcome of reprocessing because there is no evidence they received the requested treatment after UBH denied coverage. UBH Br. 30-31. DOL pointedly takes no position on whether such class members are entitled to remand. DOL Br. 26 n.5. Plaintiffs argue (at 43-44) that reprocessing will help these class members "'obtain coverage for future treatment'" because UBH supposedly considers "'past … coverage decisions in making further coverage determinations.'" That unsupported assertion contradicts the record, which shows that UBH considers only past *treatment*—not past coverage decisions. *See* 1-FER-

6-7. None of the challenged guidelines lists past coverage determinations as a factor. *See* 12-ER-2399-2620. Nor do Plaintiffs' preferred guidelines, which UBH voluntarily adopted before the district court ruled. 1-ER-155. And two UBH witnesses have sworn that UBH's past coverage denials will not impact future coverage. 2-ER-439; Rosenzweig Decl., 9th Cir. Dkt. 16-2 ¶¶ 16-18. Reprocessing is thus pointless at best—and potentially disruptive and invasive at worst—for class members who have no possibility of obtaining coverage for any treatment they actually received.

2. As a fallback, Plaintiffs attempt to defend the district court's procedural harm theory of standing—*i.e.*, that simply using flawed guidelines harmed class members even if they had no impact on coverage. Plaintiffs never grapple with the "far-reaching and significant" consequences of their procedural-harm theory for ERISA plans, AHIP Br. 6-7, 11-16, or other statutory claims, Chamber Br. 8, 25-32.

Plaintiffs argue (at 30) that under *Spokeo*, the "merely 'procedural'" nature of an injury "has no bearing on … Article III." But the Supreme Court has "clearly and repeatedly" said the opposite, AHIP Br. 7-8, including in *Spokeo*: A "bare procedural violation, divorced from any concrete harm," cannot satisfy Article III. 136 S. Ct. at 1549.

On remand in *Robins v. Spokeo, Inc.*, this Court also noted that "Robins must allege more than a bare procedural violation." 867 F.3d 1108, 1115 (9th Cir. 2017).

Robins thus upheld standing only because the plaintiff alleged that publishing inaccurate credit reports "'actual[ly] harm[ed]'" his "'employment prospects,'" *id.* at 1117—not merely because the reports were "false," Pls. Br. 32-33. Although the Court did not require proof that "loss of a specific job opportunity" was "likely," it required at least a "material risk," 867 F.3d at 1115, 1118. Here, by contrast, there is no "risk" of future harm because the denial has "already occurred," Chamber Br. 15-16, and the administrative record reflects its causes.[3]

Were there any doubt about *Spokeo*'s application to Plaintiffs' ERISA claims, *Thole* resolved it by holding that Plaintiffs cannot establish standing just by "claim[ing] that the defendants violated ERISA's duties." 140 S. Ct. at 1618. Plaintiffs' suggestion that *Thole* does not apply where Plaintiffs' "own statutory rights [a]re violated," Pls. Br. 40, ignores *Thole*'s express holdings that Article III requires "'a concrete injury even in the context of a statutory violation,'" and "ERISA" is "no … exception." 140 S. Ct. at 1620-22. Regardless, the only "statutory rights" Plaintiffs assert are: (1) the right to "benefits due," 29 U.S.C. § 1132(a)(1)(B), which they declined to prove; and (2) fiduciary rights, which *Thole*

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[3] Plaintiffs' other post-*Spokeo* cases involved concrete harms absent here. *See Nayab v. Capital One Bank (USA), N.A.*, 942 F.3d 480, 493 (9th Cir. 2019) ("right to privacy"); *Ramirez v. TransUnion LLC*, 951 F.3d 1008, 1027 (9th Cir. 2020) (harm to "privacy and reputational interests"). Plaintiffs are incorrect (at 32) that the credit report in *Nayab* was not disseminated. *See* 942 F.3d at 487 (plaintiff alleged that "a third-party obtain[ed] her credit report").

found insufficient. As Plaintiffs quote approvingly (at 39) from Justice Thomas's concurrence, *all* "fiduciary duties created by ERISA are owed to the plan, not [the beneficiaries]." 140 S. Ct. at 1623.

Thole also undercuts Plaintiffs' reliance (at 36-37) on trust law. The dissent in *Thole* invoked the same no-further-inquiry rule Plaintiffs invoke here, citing the same authorities, *e.g.*, *Michoud v. Girod*, 45 U.S. (4 How.) 503 (1846). *Thole*, 140 S. Ct. at 1629. But the majority found the trust-law analogy unpersuasive. *Id.* at 1619-20. Further, the no-inquiry rule concerns "'restor[ing]' [improperly transferred] assets 'to the trust fund.'" *Id.* at 1629 (Sotomayor, J., dissenting). It bears no resemblance to the procedural-error claims here with no link to plan assets. 2-ER-332.[4]

3. Plaintiffs' final argument—a newly minted "'informational' injury" theory—lacks any record support. Pls. Br. 38. Plaintiffs claim UBH's denial letters "misleadingly suggested that the Guidelines were plan terms" and that "the prescribed treatment was inconsistent with generally accepted standards." *Id*. But none of the denial letters characterize the guidelines as plan terms. *E.g.*, 15-ER-

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[4] This case likewise bears no resemblance to an action to rescind an insurance contract, *Allied Prof'ls Ins. Co. v. Anglesey*, 680 F. App'x 586, 587 (9th Cir. 2017), or for a declaration that the insurer need not pay benefits, *e.g.*, *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 243-44 (1937), or bear the cost of defending an insured, *e.g.*, *Maryland Cas. Co. v. Pac. Coal & Oil Co.*, 312 U.S. 270, 272 (1941). Those cases turn on the insurer's concrete interest in resolving coverage disputes before incurring costs based on the assumption of coverage.

3080-3124. And many denial letters never mention generally accepted standards. *E.g.*, 15-ER-3108-3115. The court's holding that the guidelines were not plan terms, *see* Pls. Br. 38, concerned a defense UBH raised below—not a representation that UBH made in its denial letters. 2-ER-253-254. Plaintiffs never argued, and the district court never found, that any denial letter was misleading, and there is no record to justify standing on that basis.

B. Plaintiffs' Arguments On Appeal Cannot Justify The District Court's No-Causation Reprocessing Remedy Under ERISA

Plaintiffs (at 44-50) portray UBH as seeking to deny any remedy for supposed flaws in UBH's guidelines. But as in *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455 (9th Cir. 1996), Plaintiffs could have obtained reprocessing through claims for "benefits due" under 29 U.S.C. § 1132(a)(1)(B) had they proven that guideline flaws actually caused the denials they challenge. No authority excuses this well-settled causation requirement.

1. Plaintiffs (at 21) wrongly frame the issue as whether reprocessing "requir[es] a judicial determination that benefits are owed." Instead, the issue is whether any ERISA violation *caused* a denial of benefits, not whether benefits ultimately are due. In *individual* cases—which account for *all* cited precedent on this issue—courts address causation by examining the specific administrative record before them. *E.g.*, *Saffle*, 85 F.3d at 457-58 (quoting denial of benefits "*because*" claimant "'could perform a substantial portion of [her] regular job'" (emphasis

added)); *McCartha v. Nat'l City Corp.*, 419 F.3d 437, 447 (6th Cir. 2005) (denying reprocessing because record reflected "two independent reasons for denying … benefits"); *Mitchell v. Blue Cross Blue Shield of N.D.*, 953 F.3d 529, 537 (8th Cir. 2020) (insurer denied benefits "based on" the specific interpretation challenged), *cited in* DOL Br. 22. Plaintiffs never square their theory that classwide reprocessing obviates causation analysis with the fact that the cases they cite *all* perform it. No cited case orders reprocessing *without* such analysis. And contrary to DOL's argument (at 24), the causation analysis these cases performed left meaningful work for the administrator on remand, and thus did not make remand a "dead letter."

Recognizing this causation requirement, DOL acknowledges that "[i]f … UBH justified … benefit denials for reasons truly independent from [its] Guidelines," then remand "may be inappropriate as to that subset of claims, unless the court rejects those independent grounds." DOL Br. 26. Plaintiffs likewise concede (at 48) that under *Huntsinger v. Shaw Group, Inc.*, 268 F. App'x 518 (9th Cir. 2008), remand is "futile"—and thus unavailable—if the administrator has given "undisputedly dispositive" independent reasons for denying benefits.

The same is also true when the independent ground is disputed: As in *Vizcaino v. Microsoft Corp.*, courts review the record, identify the grounds the denial was "based upon," and address *all* such grounds before granting relief. 120 F.3d 1006, 1013 (9th Cir. 1997). Plaintiffs note (at 48-49) that *Vizcaino* remanded for

consideration of other alternative grounds for affirmance *not* previously considered by the administrator, but the court did so only after rejecting each independent ground that the administrator *did* consider. *Id*. Plaintiffs cite no precedent for remanding coverage denials to an administrator without first considering each stated ground for denying benefits.

2. Requiring proof of causation does not mean beneficiaries "can sue only to recover money" for "out-of-pocket payments." Pls. Br. 45. ERISA provides a range of remedies for different injuries, but each requires some type of causation. Beneficiaries who actively seek treatment for which coverage was wrongly denied, for example, have claims for "benefits due" under 29 U.S.C. § 1132(a)(1)(B). But here the claims were denied years ago. Class members no longer purport to seek the same treatment. Under these circumstances, they have no redressable injury unless they received the treatment at their own expense. Whatever the injury, they must prove causation. *See supra*, at 12-14.

ERISA also provides for forward-looking declaratory relief to "clarify … rights to future benefits." 29 U.S.C. § 1132(a)(1)(B). But reprocessing concerns only *past* benefits. Similarly, current plan members can sue to "enforce" their "rights under the terms of the plan," *id.*, through "'an injunction against … refusal to pay benefits,'" Pls. Br. 46. But Plaintiffs do not seek that type of injunction, and their

only pertinent, plan-conferred right is to receive covered benefits, which they cannot establish merely by showing that the guidelines were flawed. UBH Br. 40.

Finally, ERISA provides for "appropriate equitable relief" to address certain violations, such as fiduciary breaches. 29 U.S.C. § 1132(a)(3). But claims under Section 1132(a)(3) require more than just proof that the defendant "violated the plans and its fiduciary duties." Pls. Br. 45. Plaintiffs must prove that the violation caused harm and equitable relief is appropriate. UBH Br. 36-40. Equitable relief is *not* appropriate for claim-processing violations because Section 1132(a)(1)(B) provides an adequate legal remedy whenever the violation caused the denial of benefits. *Id.* at 36-38; *see Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). Plaintiffs never rebut these arguments. Their novel reprocessing claims are thus unavailable under ERISA.

C. Plaintiffs' Attempts To Defend Class Certification In The Absence Of Causation Fail

Plaintiffs' unprecedented facial challenge casts aside the requirements for individual ERISA claims. Even Plaintiffs' *amici* do not support Plaintiffs' assertion (at 51) that "each class member" has an individual claim. *See* DOL Br. 26 (suggesting remand "may be inappropriate" for coverage requests denied on valid "independent grounds"). Because "[c]lass actions are merely a procedural tool" that under the Rules Enabling Act must "'leav[e] the parties' legal rights and duties intact,'" *Olean*, 993 F.3d at 787, the district court's embrace of classwide remand-and-reprocessing

for members who could not establish individual claims was error. *See* Chamber Br. 18-21.

It is too late for Plaintiffs to disclaim (at 54) their contention that their solution to Rule 23's limits is "novel." As the district court recognized, *Plaintiffs*—not UBH—have "always said[] this is a facial challenge" to UBH's guidelines. 11-ER-2346:4; *see also*, *e.g.*, 2-ER-239, 451. In seeking attorneys' fees below, Plaintiffs told the court they had "pioneered a rare and important ERISA case theory." 1-FER-4. Such novel devices for purported classwide proof must be "carefully scrutinized" for "'[a]ctual, not presumed, conformance' with Rule 23[]" and the Rules Enabling Act. *Olean*, 993 F.3d at 787.

Plaintiffs cannot persuasively dispute that if this Court reverses the ruling that Plaintiffs need not prove causation—the centerpiece of the decision to certify the class action for reprocessing under Rule 23(b)(3), UBH Br. 15-16—the classes must be decertified.[5] A court "abuse[s] its discretion," Pls. Br. 51, when its class-certification decision rests on "an error of law," *Koon v. United States*, 518 U.S. 81, 100

[5] The district court correctly recognized that reprocessing could not occur under Rule 23(b)(2) because it involves "individualized inquiries." 1-ER-135. Plaintiffs' contrary argument in a footnote (at 52 n.17) flouts the holding of *Wal-Mart Stores, Inc. v. Dukes*, that "claims for *individualized* relief"—"injunctive" or otherwise—"do not satisfy" Rule 23(b)(2). 564 U.S. 338, 360 (2011); *see also AA Suncoast Chiropractic Clinic, P.A. v. Progressive Am. Ins. Co.*, 938 F.3d 1170, 1175 (11th Cir. 2019) (finding Rule 23(b)(2) inappropriate for "reprocess[ing]" claims).

(1996). The district court found that "Plaintiffs' claims would fail for lack of causation" if it were required. 1-ER-77. Decertifying the class is actually *more* favorable to class members than the alternative—maintaining the class action and granting judgment against *all* class members for failing to prove causation. UBH Br. 25 n.1.

II. Plaintiffs Overlook The District Court's Fundamental Legal Errors In Evaluating UBH's Guidelines

Independently, the district court's merits rulings included legal errors that infected all aspects of this class action. Those rulings rest on false premises that Plaintiffs (at 55-61) hardly defend in their brief responses to UBH's thorough critiques.

Plaintiffs stake their defense on clear-error review of district court "findings," but the case they cite for that standard, *Plumber, Steamfitter & Shipfitter Industry Pension Plan & Trust v. Siemens Building Technologies Inc*., 228 F.3d 964 (9th Cir. 2000), did not involve deferential abuse-of-discretion review of discretionary coverage decisions. It was unrelated to eligibility for benefits: Plan trustees sought to audit a plan sponsor, who disputed that the audit had a "legitimate purpose." *Id.* at 966. Under settled precedent that Plaintiffs ignore, "'[w]here an ERISA Plan grants discretionary authority to determine eligibility for benefits,'" the district court reviews the administrator's determination "'for abuse of discretion,'" and this Court reviews the "application of this standard … de novo." *Lehman v. Nelson*, 943 F.3d 891, 897 (9th Cir. 2019). Regardless, under any standard, the district court's abuse-

of-discretion ruling fails because it rests on critical legal errors that fundamentally distorted the court's conclusions.

A. Plaintiffs Offer No Basis For Requiring UBH's Guidelines To Exclusively Track Generally Accepted Standards

Plaintiffs (at 55) repeat their assertion that UBH's guidelines were "require[d] [to] adher[e] to generally accepted standards of care." Plaintiffs still identify *no* provision in *any* plan imposing that requirement, and they ignore the provisions refuting this assertion. UBH Br. 46-50.

Plaintiffs' entire case rests on a single plan requirement—necessary but not sufficient for coverage—stating that treatment inconsistent with generally accepted standards is not covered. The problem is that they (and the district court) transformed this requirement into an affirmative coverage grant—*i.e.*, that treatments consistent with generally accepted standards *must in all events* be covered. Only by distorting the relevant plan terms did the court wrongly become focused on whether UBH's guidelines tracked generally accepted standards. Judging UBH's guidelines against standards they were not required to track set UBH up for failure and tainted every subsequent ruling that the guidelines were flawed.

UBH did *not* employ the challenged guidelines solely "to determine whether that [one] requirement was satisfied." Pls. Br. 7. As the guidelines themselves state, UBH used the CDGs to "assis[t] in interpreting [UBH's] plans," not any one specific term, *e.g.*, 12-ER-2555, and used the LOCGs to address "medica[l] necess[ity]," *e.g.*,

7-ER-1314:8-1318:20—a requirement shaped not just by generally accepted standards, but by various other requirements and exclusions that also required clinical judgment, UBH Br. 11, 46-48. Standardizing those clinical determinations through guidelines is not only expressly allowed by the plans (and good practice), UBH Br. 49; it is *required* by "[f]ederal laws and regulations," ABHW Br. 7-10. Restricting UBH's ability to take into account various clinical considerations and coverage requirements, not just generally accepted standards, wrongly deprived UBH of an "essential too[l]" to ensure consistent and effective care. *Id*. at 2.

B. Plaintiffs' "Preponderance" Standard Denies UBH The Deference They Concede UBH Is Due

Even if the guidelines were otherwise required to track generally accepted standards, Plaintiffs concede (at 19, 25) that UBH's clinical judgments are entitled to "appropriate deference" and reviewed for "abuse of discretion." But Plaintiffs never square that requirement with the preponderance-of-the-evidence standard the district court applied in deciding for itself which "standards are generally accepted," and whether the guidelines comported with those standards. 1-ER-261.

Plaintiffs instead suggest (at 56) that there is some difference between abuse-of-discretion review (which they agree applies) and the "substantial evidence" standard it incorporates (which they dispute). There is no such difference. "[I]n their application to the requirement of factual support the substantial evidence test and the arbitrary or capricious test are one and the same." *Ass'n of Data Processing Serv.*

Orgs., Inc. v. Bd. Of Governors of Fed. Reserve Sys., 745 F.2d 677, 683 (D.C. Cir. 1984) (Scalia, J.). An ERISA administrator has not "abused its discretion" where its decision rests on "substantial evidence." *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1179 (9th Cir. 2005).

Plaintiffs argue (at 57-58) that substantial evidence review is inapplicable because "there is no administrative record" on the guidelines' consistency with generally accepted standards. But as Plaintiffs recognize (at 58 n.18), the administrative record is simply "the record before the Plan administrator" when it made the pertinent decision, *Snow v. Standard Ins. Co.*, 87 F.3d 327, 332 (9th Cir. 1996)—here, to "promulgat[e] [the] guidelines," Pls. Br. 22. That record was produced in discovery and presented at trial. The guidelines listed their "references," *e.g.*, 12-ER-2499, 2506, 2518-2519, and the comments received in developing them were admitted as exhibits, UBH Br. 52-54. Plaintiffs' decision to ignore that record and focus on other evidence at trial—*e.g.*, testimony by hired experts, whose opinions were never presented to UBH until this litigation—does not change the applicable legal standard.

Plaintiffs argue (at 56-57) that UBH invited this error by using the word "preponderance" in its post-trial brief. But UBH's actual statement—that Plaintiffs had to prove "by a preponderance" that "UBH *abused its discretion*," 1-SER-271 (emphasis added)—was not an invitation to abandon abuse-of-discretion review. UBH was clear that under the "abuse of discretion" standard and "'substantial evidence'"

review, "[t]he Court may not merely substitute its view" for UBH's clinical judgment. 1-SER-269-70. UBH never suggested that the court should decide *which standards are generally accepted* by a preponderance of the evidence.

2. Because "the trial court base[d] its findings upon a mistaken impression of applicable legal principles," this Court "is not bound by the clearly erroneous standard." *Inwood*, 456 U.S. at 855 n.15. This Court's review is *de novo*. *Lehman*, 943 F.3d at 897. Under the correct standard, the guidelines should be upheld based on the substantial evidence that they were reasonable.

Plaintiffs' citations identify only two commenters—Gerald Shulman and Dr. Axelson—who criticized UBH's guidelines during their development, out of dozens who commented. Pls. Br. 59 (citing 2-ER-307-309, 321-22; 10-ER-2162:3-2163:15; 10-ER-2195:15-2196:10). The comments date from 2013 and 2015-2016, respectively, and thus are outside the record applicable to earlier guidelines. Given the numerous expert commenters who *approved* UBH's guidelines during the same period, UBH Br. 52-54, UBH was free—in its plan-conferred discretion—to disagree with Shulman and Axelson. Plaintiffs complain that commenters were not explicitly "asked" to apply generally accepted standards, but UBH's questions—seeking "[p]rovider input" on whether any "criteria" should be "added or deleted," 12-ER-2695—plainly called for medical judgment, as commenters clearly understood, *e.g.*, 7-ER-1460:15-1462:14 (discussing comments that UBH adopted). Since even "a

single persuasive medical opinion" supporting the guidelines suffices to affirm—regardless of "contrary" evidence, *Boyd*, 410 F.3d at 1178—the guidelines should be upheld.

C. UBH Had No Structural Conflict Of Interest In Administering Self-Funded Plans

Plaintiffs likewise fail to show that the court's "structural conflict of interest" finding justified its "skepticism" of the guidelines as to self-funded plans. 2-ER-330-332. Plaintiffs do not even address this Court's precedents holding that claims administrators of self-funded ERISA plans have no conflict because they do not bear the costs of paying claims. UBH Br. 55. Nor do they cite authority supporting their theory (at 60) that those claims administrators lose their plan-conferred deference when they apply a "single" policy to "both fully-insured and self-funded plans." Adopting that theory, contrary to binding precedent, would vitiate the deference owed to plan administrators' discretionary interpretations under, *e.g.*, *Conkright v. Frommert*, 559 U.S. 506, 512 (2010), since administering both insured and self-funded plans is commonplace. It would also threaten to sidetrack many ERISA cases

involving self-funded plans with satellite inquiries into whether the policy or practice at issue also applies to insured plans not involved in the case. Plaintiffs cite *no* case from *any* jurisdiction applying their preferred rule.[6]

Plaintiffs' argument (at 60-61) that economic considerations "actually influenced" UBH's decisions misconstrues the applicable standard. As UBH maintained throughout this litigation, such a finding is necessary but not sufficient to apply skeptical review, because precedent requires *both* a cognizable "structural conflict of interest" *and* "that the conflict actually influenced [the administrator's] decision." 1-SER-276-277; *see Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 968 (9th Cir. 2006) (requiring a "structural" conflict).

Nothing in ERISA prohibits economic considerations. To the contrary, "'guard[ing] the assets of the [Plan] from improper claims'" is part of an administrator's fiduciary duty, *Boyd*, 410 F.3d at 1178, and many plans required UBH to consider cost-effectiveness of treatments, *see* 7-ER-1312:7-1313:19; 13-ER-2767; 12-ER-2640-2641. None of the three instances in which UBH allegedly considered financial consequences in addressing specific changes was improper or had anything to do with Plaintiffs' challenges to the guidelines. Nor do these isolated instances

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[6] Plaintiffs' argument about the percentage of UBH's "revenue" from fully-insured plans, Pls. Br. 10-11, is irrelevant, and ignores the higher expenses offsetting that revenue because (unlike under self-funded plans), UBH bears the cost of paying benefits, 2-ER-252.

show that UBH's overall development of the guidelines was tainted by a conflict of interest. UBH Br. 56-57. There was thus no basis for the district court's skepticism of the guidelines.

D. Plaintiffs Ignore How UBH's Clinicians Apply The Guidelines In Practice

Plaintiffs offer just one sentence (at 61) defending the district court's erroneous refusal to consider how UBH's guidelines were applied. The issue is not, as Plaintiffs contend (at 13), whether UBH's clinicians could "'ignore'" the guidelines. It is whether the guidelines should be read out of context, as Plaintiffs' facial challenge demands, or pragmatically assessed accounting for their practical application. ERISA requires the latter on abuse-of-discretion review, because courts are "ill equipped" to interpret medical guidelines and thus "have no warrant" to second-guess how UBH's trained clinicians interpreted them. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832, 834 (2003).

Plaintiffs mischaracterize the statement by UBH's expert that "[a]ny practitioner worth their salt" would not follow UBH's guidelines "as a script." 8-ER-1696:13-1697:3. The expert was not "admitt[ing]" that "UBH's guidelines were far too restrictive." Pls. Br. 1. Instead, he stated that he would read the guidelines "in the context of other information"—such as the "APA Clinical Practice Guidelines"—that UBH "specifically instructed" clinician reviewers to consider in applying the guidelines. 8-ER-1697:5-1698:20. By substituting the court's own legalistic

reading of the guidelines for the only record evidence concerning how they were applied, the district court further erred.

III. Plaintiffs Have No Valid Excuse For Absent Class Members' Failure To Exhaust Administrative Remedies

A. Plaintiffs have no answer to the numerous authorities—*e.g.*, *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99 (2013)—requiring courts to enforce plan-imposed limitations on the right to sue. UBH Br. 60-62. Plaintiffs never even mention these cases, which foreclose the district court's judge-made exception to the plan-imposed exhaustion requirement for absent class members. Nor do Plaintiffs mention the Rules Enabling Act, which bars class members who failed to exhaust from expanding their right to relief—and nullifying UBH's plan-conferred rights—by joining with the named plaintiffs through the procedural device of a class action. *Id.* at 61.

Plaintiffs also make no effort to distinguish decisions enforcing ERISA exhaustion requirements against classes in which some members had exhausted. UBH Br. 60. Instead, they dismiss these cases (at 68) as unprincipled, ignoring the sound reasoning (under *Heimeshoff* and the Rules Enabling Act) that compels their outcomes.

Indeed, the only Ninth Circuit case Plaintiffs cite (at 67) does not even mention (or involve) a class action, let alone Plaintiffs' proposed rule. *See Diaz v. United*

Agric. Emp. Welfare Benefit Plan, 50 F.3d 1478, 1483 (9th Cir. 1995). And Plaintiffs' other key authority—*In re Household International Tax Reduction Plan*, 441 F.3d 500 (7th Cir. 2006)—expressly contemplates the critical distinction between judge-made prudential exhaustion requirements (which admit judge-made exceptions) and plan-imposed requirements (which do not). UBH Br. 61-62. Plaintiffs cite cases that excuse *prudential* exhaustion requirements based on *prudential* concerns. *E.g.*, *Laurenzano v. Blue Cross & Blue Shield*, 134 F. Supp. 2d 189, 210-11 (D. Mass. 2001) (invoking "judicial economy"). But the only case they cite addressing a *plan-imposed* exhaustion requirement—*Noren v. Jefferson Pilot Financial Insurance Co.*—held that this requirement was *not* excused. 378 F. App'x 696, 697-98 (9th Cir. 2010).

Plaintiffs also cite (at 63-64) two additional decisions they claim applied judge-made exceptions to plans that required exhaustion. But neither plan involved such a requirement. Instead, they set deadlines to appeal or else "waiv[e]" the "right to reconsideration" by the plan, which triggered the judge-made *prudential* exhaustion requirement. *Amato v. Bernard*, 618 F.2d 559, 562 n.1 (9th Cir. 1980) (any appeal "shall be filed … within sixty days"); *accord Counts v. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105 (11th Cir. 1997). Here, by contrast, the plans expressly impose litigation consequences for failure to exhaust—stating, for example, that members "cannot bring any legal action" without "complet[ing] all the steps in

the appeal process," 2-ER-326; 13-ER-2728—that courts must enforce "as written," *Heimeshoff*, 571 U.S. at 108. Further neither case ultimately excused exhaustion, and neither addressed Plaintiffs' argument that only named plaintiffs need to exhaust. The district court's holding thus lacks support in either precedent or principle.

B. The district court's "futility" exception fails both because it cannot override plan terms requiring exhaustion, and because there is no basis for finding futility here.

Plaintiffs characterize futility (at 62) as a broadly applicable "common law doctrine," but courts may not "appl[y] federal common law doctrines to alter ERISA plans[']… clear and unambiguous" terms, *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 n.4 (11th Cir. 2010). Unlike under state law, Pls. Br. 65—where courts vary in their "'insist[ence] on strict compliance'" with contractual requirements in different contexts, *Wolff & Munier, Inc. v. Whiting-Turner Contracting Co.*, 946 F.2d 1003, 1009 (2d Cir. 1991)—ERISA requires courts to "enforc[e] plan terms as written," without judge-made exceptions, *Heimeshoff*, 571 U.S. at 108.

Plaintiffs also analogize to cases addressing due process, *see McBride Cotton & Cattle Corp. v. Veneman*, 290 F.3d 973, 976 (9th Cir. 2002); *Bowen v. City of N.Y.*, 476 U.S. 467, 474 (1986); *Glover v. St. Louis-S.F. Ry. Co.*, 393 U.S. 324, 327 (1969), and the Labor-Management Reporting and Disclosure Act ("LMRDA"), *see Parish v. Legion*, 450 F.2d 821 (9th Cir. 1971). Exhaustion principles are weaker

"when constitutional questions are in issue" because "the availability of judicial review is presumed." *Califano v. Sanders*, 430 U.S. 99, 109 (1977). *McBride* thus confirms that courts typically *do* "require [exhaustion] unless the suit alleges a constitutional claim"—*and* meets additional requirements that Plaintiffs have never attempted to satisfy here. 290 F.3d at 980.

Exhaustion principles are likewise weaker under the LMRDA because that statute "grant[s] authority to the courts" to excuse exhaustion on "futil[ity]" grounds by expressly prohibiting unreasonable contractual limitations on union members' rights to sue. *Ornellas v. Oakley*, 618 F.2d 1351, 1354 (9th Cir. 1980). By omitting any analogous provision under ERISA, *see Amato*, 618 F.2d at 566 & n.6, Congress made clear that courts lack comparable authority to excuse ERISA plan requirements.

Regardless, Plaintiffs' staggering premise—that pursuing administrative remedies would have been futile for *every class member*—is wrong. Plaintiffs (at 62) hide behind the standard of review for factual findings, but the facts that defeat futility are undisputed. The district court recognized that when members appealed coverage requests denied under UBH's guidelines, UBH sometimes awarded full coverage. 1-ER-195. Indeed, this happened 15-20% of the time. 9-ER-1960:15-1961:1. Under the correct legal standard, therefore, exhaustion is not futile because

thousands of members could have "receiv[ed] all the relief [they are] entitled to under the Plan," without "judicial intervention." *Amato*, 618 F.2d at 567-68.[7] Holding otherwise was an error of *law*, not fact.

C. Plaintiffs are left with alternate grounds for affirmance that did not persuade the district court. 2-ER-328.[8] Plaintiffs argue (at 69) that they were not required to exhaust their "statutory" claims (*e.g.*, under Section 1132(a)(3)) because the exhaustion requirement only applies to claims for benefits under Section 1132(a)(1)(B). But Plaintiffs' own authorities recognize that Plaintiffs cannot "justif[y] … a total failure to pursue … internal appeal[s]" by "attach[ing] a 'statutory violation' sticker" to "claims for plan benefits." *Diaz*, 50 F.3d at 1484. This Court sometimes has not required exhaustion where the plaintiff sought relief outside of ERISA, *Fujikawa v. Gushiken*, 823 F.2d 1341, 1345 (9th Cir. 1987) (LMRA claim);

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[7] Plaintiffs' speculation (at 62 n.19) that UBH would not have amended its guidelines is the sort of "bare assertio[n]" that cannot support a finding of futility. *Diaz*, 50 F.3d at 1485. Unlike in *Fallick v. Nationwide Mutual Insurance Co.*, where the plan rebuffed the plaintiffs' "repeate[d]" challenges to its policies, 162 F.3d 410, 414-17 (6th Cir. 1998), no class member claims to have challenged the guidelines before this litigation, and there is no evidence that UBH would have stood by its determinations had Plaintiffs presented credible proof that the guidelines were medically inappropriate as applied. Unlike in *Hitchcock v. Cumberland University 403(b) DC Plan*, moreover, Plaintiffs are not challenging the "legality" of plan terms—which *cannot* lawfully be challenged through an administrative appeal, 851 F.3d 552, 560 (6th Cir. 2017).

[8] Plaintiffs' "informational injury" argument fails for the reasons explained *supra*, at 11-12.

did not challenge claim-processing decisions, *Amaro v. Cont'l Can Co.*, 724 F.2d 747, 751-52 (9th Cir. 1984) (ERISA retaliation); or sought forward-looking injunctive relief, *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282 (9th Cir. 2014). But when a "statutory claim is no more than a 'disguised' benefit claim," exhaustion applies with equal force. *Id*. at 1294. Otherwise, exhaustion would be a paper tiger, since (as the Supreme Court has made clear) review of discretionary decisions *always* involves a "'fiduciary'" component that can be recast as a Section 1132(a)(3) claim. *Conkright*, 559 U.S. at 512.

CONCLUSION

If Plaintiffs had brought individual ERISA claims without obtaining or actively seeking the treatment denied, without exhausting their administrative remedies, without disputing that substantial evidence supported the denial, or without even alleging that UBH's guidelines caused the denial, their claims would quickly have been dismissed. The Rules Enabling Act requires the same result in a class action. Accepting Plaintiffs' approach would alter the standard not only in class actions but in individual ERISA cases, unraveling ERISA's carefully reticulated scheme. Because that is not the law, UBH respectfully requests that the Court reverse or vacate the judgment and remand with instructions to dismiss the case for lack of standing or, alternatively, decertify the classes and enter judgment for UBH.

Dated: June 2, 2021

Respectfully submitted.

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