Wit v. United Behavioral Health and Other Parity Litigation

11-20-19

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- A recording will be posted online for download
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- Please type questions into the chat box during the presentation as there will be Q & A at the conclusion of the webinar

Speakers

Brian Hufford

Caroline Reynolds

Regional policy council

MHA

Wit v. United Behavioral Health and Other Pending Parity Litigation: What Will it Mean for People with Behavioral Health Needs?

Caroline Reynolds
Zuckerman Spaeder
November 20, 2019

Wit v. UBH: Overview

The Plaintiff Classes

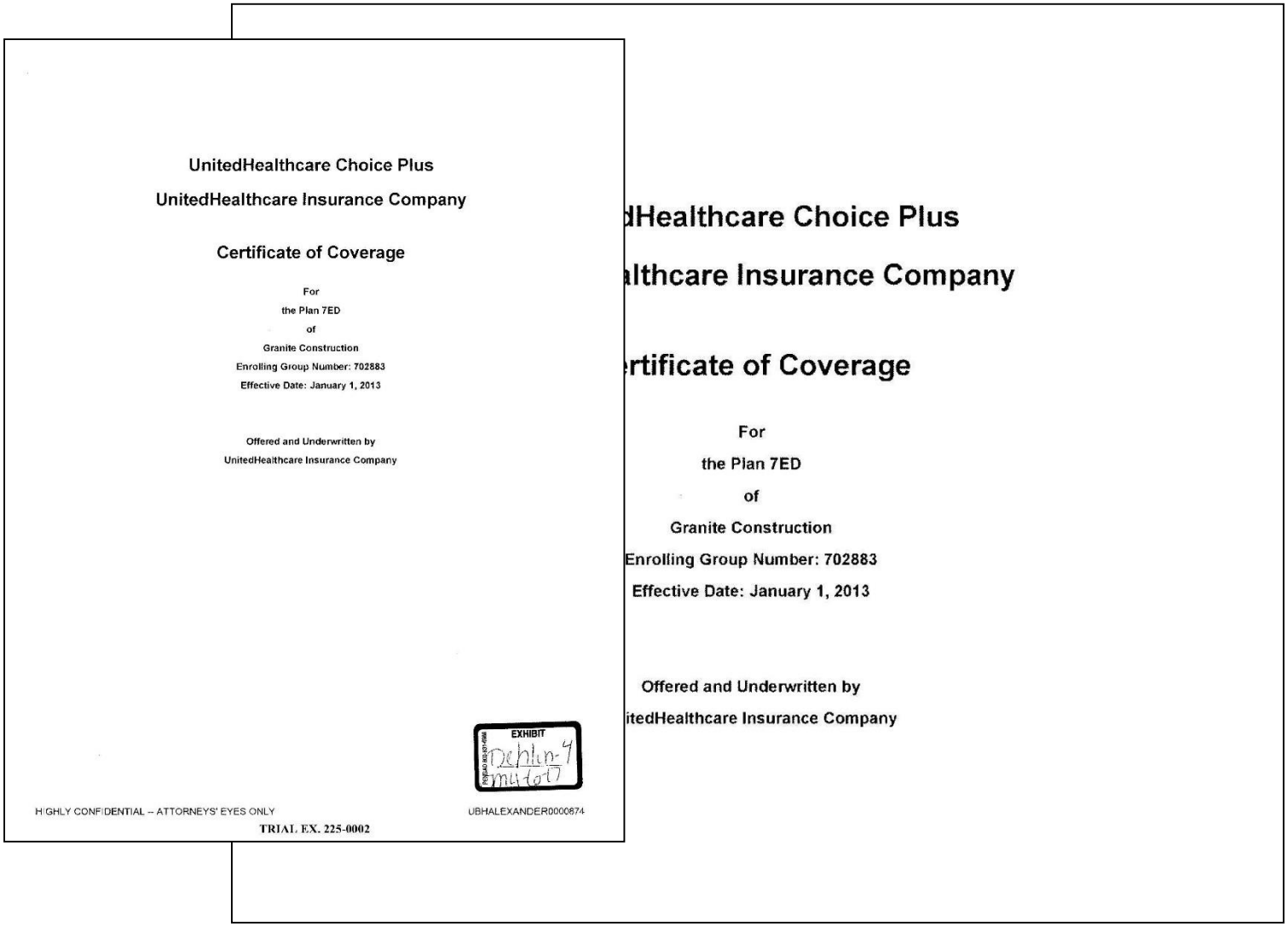
- 11 Named Plaintiffs
  - Adults/ Adolescents
  - MH/ SUD
  - RTC, IOP, OP
- More than 50,000 class members
- More than 67,000 claims for coverage

The Claims

The Claims

- Brought under the Employee Retirement Income Security Act ("ERISA")
  - Breach of Fiduciary Duty
  - Wrongful Denial of Claims
- Note: no claim asserted under the Parity Act

The Claims



UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For
the Plan 7ED
of
Granite Construction
Enrolling Group Number: 702883
Effective Date: January 1, 2013

Offered and Underwritten by
UnitedHealthcare Insurance Company

EXHIBIT
Dehlin-4
3/14/07

HIGHLY CONFIDENTIAL – ATTORNEYS' EYES ONLY

UBHALEXANDER0000674

TRIAL EX. 225-0002

dHealthcare Choice Plus

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rtificate of Coverage

For
the Plan 7ED
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Granite Construction
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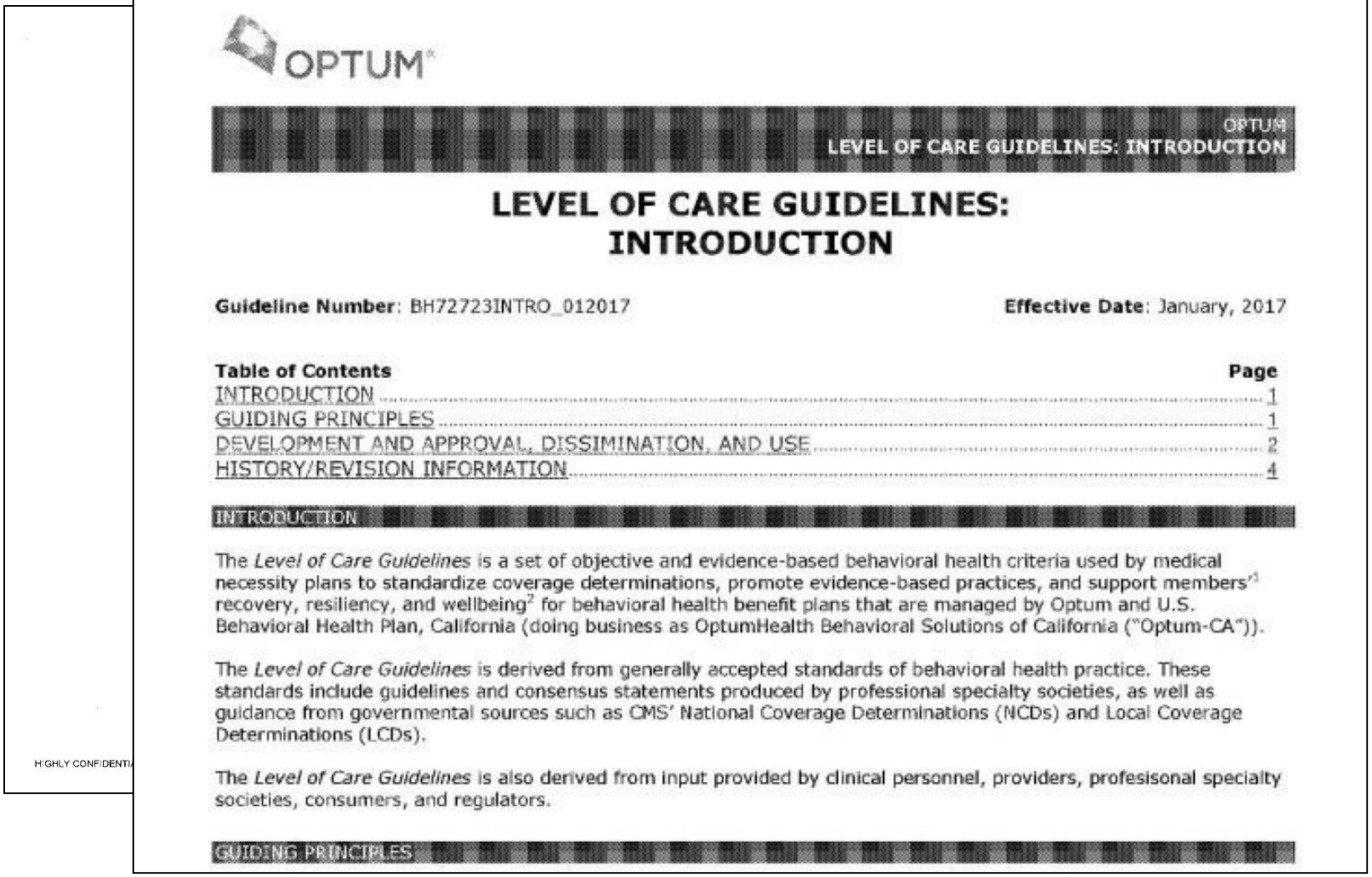
The Claims



OPTUM

LEVEL OF CARE GUIDELINES: INTRODUCTION

Guideline Number: BH72723INTRO_012017 **Effective Date**: January, 2017

Table of Contents **Page**

INTRODUCTION

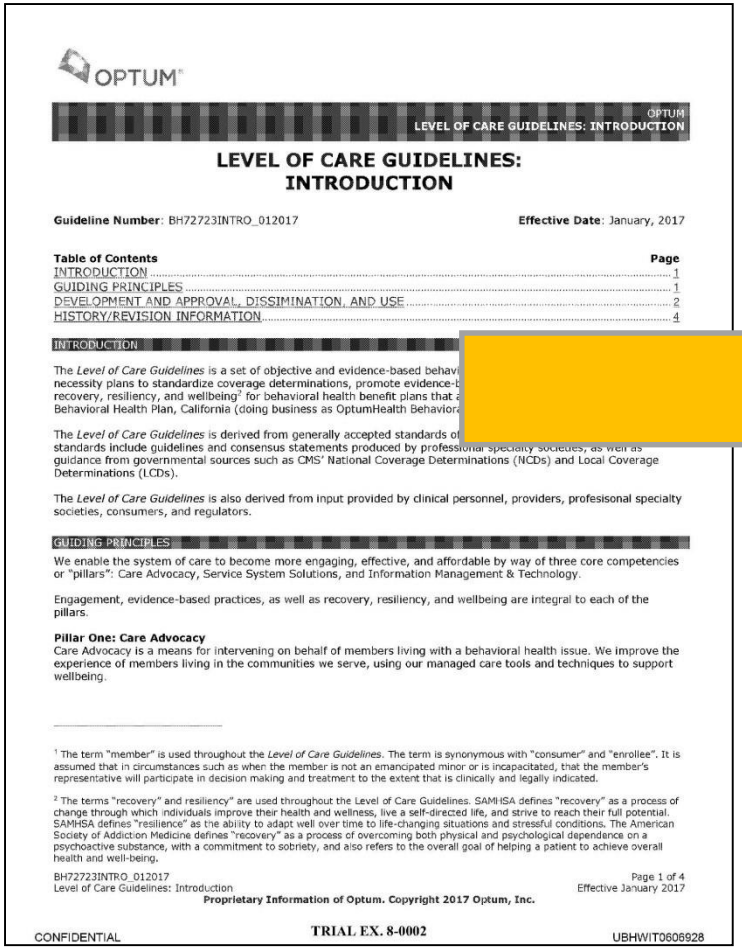
The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members'[1] recovery, resiliency, and wellbeing[2] for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

GUIDING PRINCIPLES

The Claims



OPTUM

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LEVEL OF CARE GUIDELINES: INTRODUCTION

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The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

GUIDING PRINCIPLES

We enable the system of care to become more engaging, effective, and affordable by way of three core competencies or "pillars": Care Advocacy, Service System Solutions, and Information Management & Technology.

Engagement, evidence-based practices, as well as recovery, resiliency, and wellbeing are integral to each of the pillars.

Pillar One: Care Advocacy
Care Advocacy is a means for intervening on behalf of members living with a behavioral health issue. We improve the experience of members living in the communities we serve, using our managed care tools and techniques to support wellbeing.

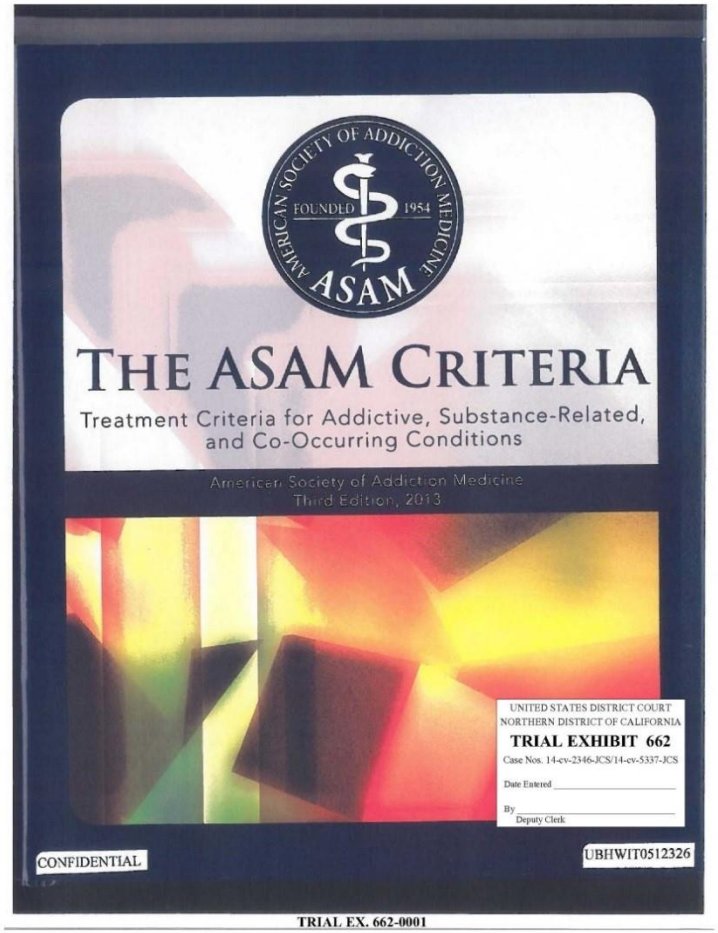
[1] The term "member" is used throughout the *Level of Care Guidelines*. The term is synonymous with "consumer" and "enrollee". It is assumed that in circumstances such as when the member is not an emancipated minor or is incapacitated, that the member's representative will participate in decision making and treatment to the extent that is clinically and legally indicated.

[2] The terms "recovery" and resiliency" are used throughout the Level of Care Guidelines. SAMHSA defines "recovery" as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines "resilience" as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines "recovery" as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

Coverage for
RTC
IOP
OP
under Plan terms

Generally Accepted Standards: The Evidence

The Evidence



"The ASAM Criteria are the most widely accepted articulation of the generally accepted standards of care for how to conduct a comprehensive multidimensional assessment of a patient with substance related disorder, translate that into patient treatment needs and match those needs to the appropriate level of care."

The Evidence

"The ASAM Criteria are really quite broadly considered to be an expression or a reflection or an articulation of the generally accepted standard of care. . . . [I]t's broadly accepted. . . by almost all experts in the field that I've encountered. "

The Evidence

"The ASAM Criteria are consistent with generally accepted standards of care."

The Evidence

LOCUS

LEVEL OF CARE UTILIZATION SYSTEM
FOR
PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS

March 20, 2009

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
TRIAL EXHIBIT 653
Case Nos. 14-cv-2346-JCS/14-cv-5337-JCS
Date Entered _____
By _____
Deputy Clerk

CONFIDENTIAL

TRIAL EX. 653-0001

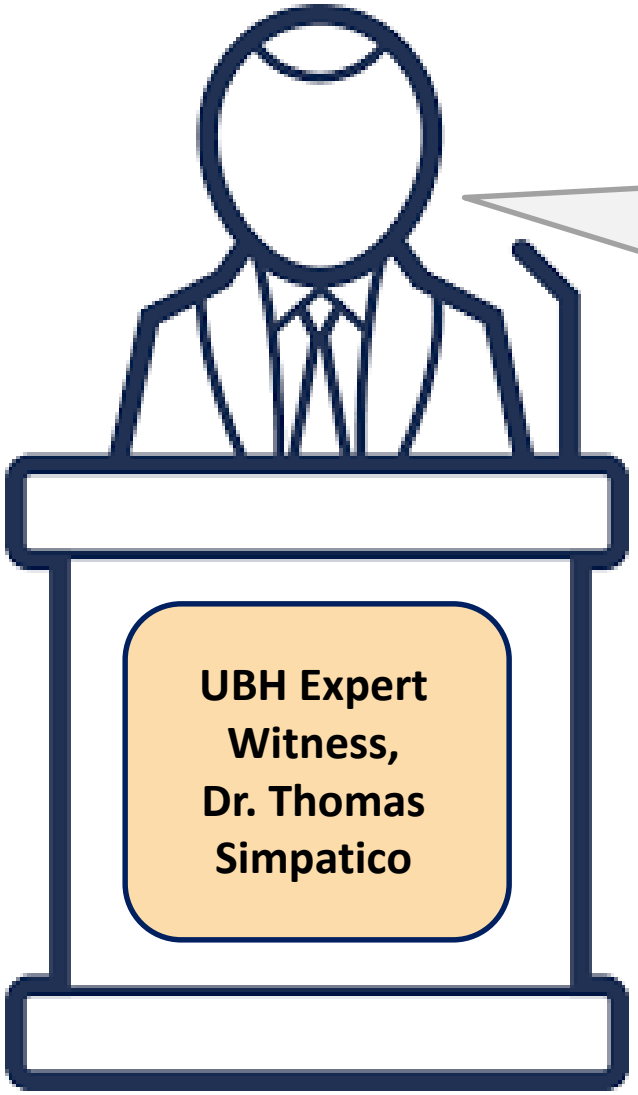
UBHWIT0102815

"The parties agree that LOCUS reflects generally accepted standards of care."

The Evidence

"[The LOCUS is] a very useful, comprehensive, complex document because it includes a multi-faceted look at a complex problem in a complex way, six factors, and a way of trying to render those kinds of decisions relatively objective. . . ."

The Evidence



"[I]n meeting generally accepted standards of care. . . I would be reading the LOCUS. . . ."

The Evidence

CALOCUS

Version 1.5

Child and Adolescent Level of Care Utilization System

American Academy of Child and Adolescent Psychiatry
American Association of Community Psychiatrists

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
TRIAL EXHIBIT 644
Case Nos. 14-cv-2346-JCS/14-cv-5337-JCS
Date Entered _____
By _____ Deputy Clerk

Edited by:
Robert Klaehn, M.D., Kieran O'Malley, M.D., Tom Vaughan, M.D., Kristin Kroeger

FIDENTIAL TRIAL EX. 644-0001 UBHWIT0416594

CASII User's Manual

October, 2014 -- Version 4.0

d Adolescent Service Intensity Instrument

Academy of Child and Adolescent Psychiatry

ACKNOWLEDGMENTS

wing individuals for their contribution of time and expertise:

he instrument: Mark Chenven, M.D., Emilio Dominguez, M.D., Ted Fallon, Jr., M.D., me Hanson, M.D., William Heffron, M.D., Charlie Huffine, M.D., Robert Klaehn, an O'Malley, M.D., Andres Pumariega, M.D., Wes Sowers, M.D. Tom Vaughan, Jr., nd Al Zachik, M.D.

he training manual: Robert L. Klaehn, M.D., Kieran O'Malley, M.D., Kristin Kroeger .D.

evaluation of the instrument: Ted Fallon, Jr., M.D., Andres Pumariega, M.D.

: Debbie Carter, M.D., Mark Chenven, M.D., Ted Fallon, Jr., M.D., Gordon Hodas, arry Marx, M.D., Kaye McGinty, M.D., Peter Metz, M.D., Kieran O'Malley, M.D., cy Winters, M.D., Al Zachik, M.D.

nd Adolescent Psychiatry staff: Ron Szabat, J.D., LLM, Director of Government Jennifer Medicus, Assistant Director of Clinical Practice, Adriano Boccanelli, Clinical

eter Metz, M.D., Mark Chenven, M.D., Gordon Hodas, M.D., Robert Klaehn, M.D. Zachik, M.D.

strongly encouraged. Please call Adriano Boccanelli, at 800 333-7636 x137

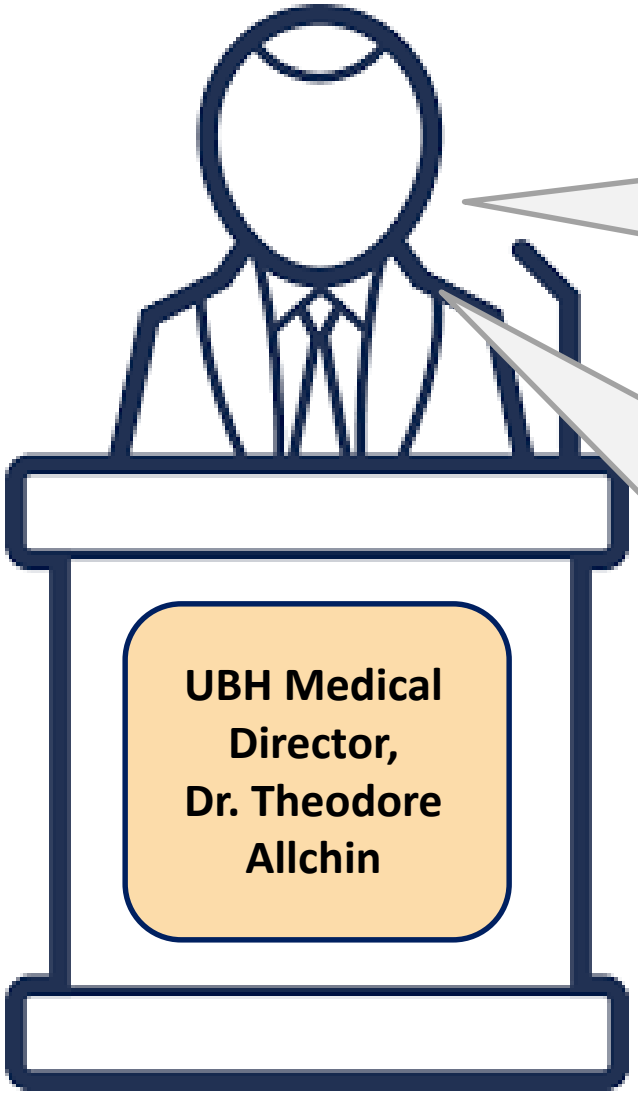
ter for Mental Health Services, Substance Abuse Mental Health Services Administration for funding the initial field testing and evaluation of the instrument.

Disclaimer: The American Academy of Child and Adolescent Psychiatry does not accept liability for clinical judgment and clinical decisions made while using this instrument.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
TRIAL EXHIBIT 645
Case Nos. 14-cv-2346-JCS/14-cv-5337-JCS
Date Entered _____

"There is no dispute that CALOCUS and CASII reflect generally accepted standards of care for determining the most appropriate level of care for children and adolescents."

The Evidence



Q. [I]s it fair to say that CALOCUS is a reflection of the generally accepted standards of care for kids?

A. Yes.

Q. Would you agree that both CALOCUS and CASII provide objective, data driven, evidence-based methodology. . . [f]or determining level of care or level of service specifically for children?

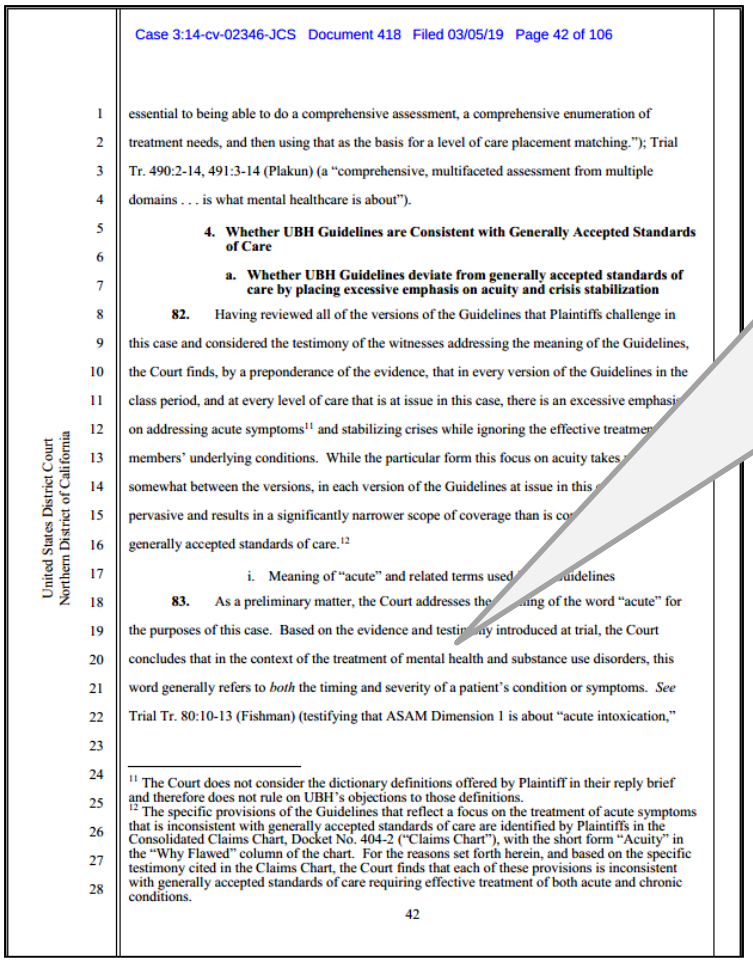
A. Yes.

The Court's Liability Ruling: Generally Accepted Standards

Generally- Accepted Standards

- Treat the **underlying condition**, not only current symptoms
- Treat **co-occurring** conditions
- Treat at the least intensive level of care that is **safe** and **effective**
- Err on the side of **caution**
- Effective treatment includes services to **maintain function**
- Determine **duration** based on individual needs
- Take unique needs of **children/ adolescents** into account
- Make level of care decisions based on a **multidimensional assessment**

Generally- Accepted Standards



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United States District Court
Northern District of California

essential to being able to do a comprehensive assessment, a comprehensive enumeration of treatment needs, and then using that as the basis for a level of care placement matching."); Trial Tr. 490:2-14, 491:3-14 (Plakun) (a "comprehensive, multifaceted assessment from multiple domains . . . is what mental healthcare is about").

4. Whether UBH Guidelines are Consistent with Generally Accepted Standards of Care

a. Whether UBH Guidelines deviate from generally accepted standards of care by placing excessive emphasis on acuity and crisis stabilization

82. Having reviewed all of the versions of the Guidelines that Plaintiffs challenge in this case and considered the testimony of the witnesses addressing the meaning of the Guidelines, the Court finds, by a preponderance of the evidence, that in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms[11] and stabilizing crises while ignoring the effective treatment members' underlying conditions. While the particular form this focus on acuity takes somewhat between the versions, in each version of the Guidelines at issue in this pervasive and results in a significantly narrower scope of coverage than is co generally accepted standards of care.[12]

i. Meaning of "acute" and related terms used uidelines

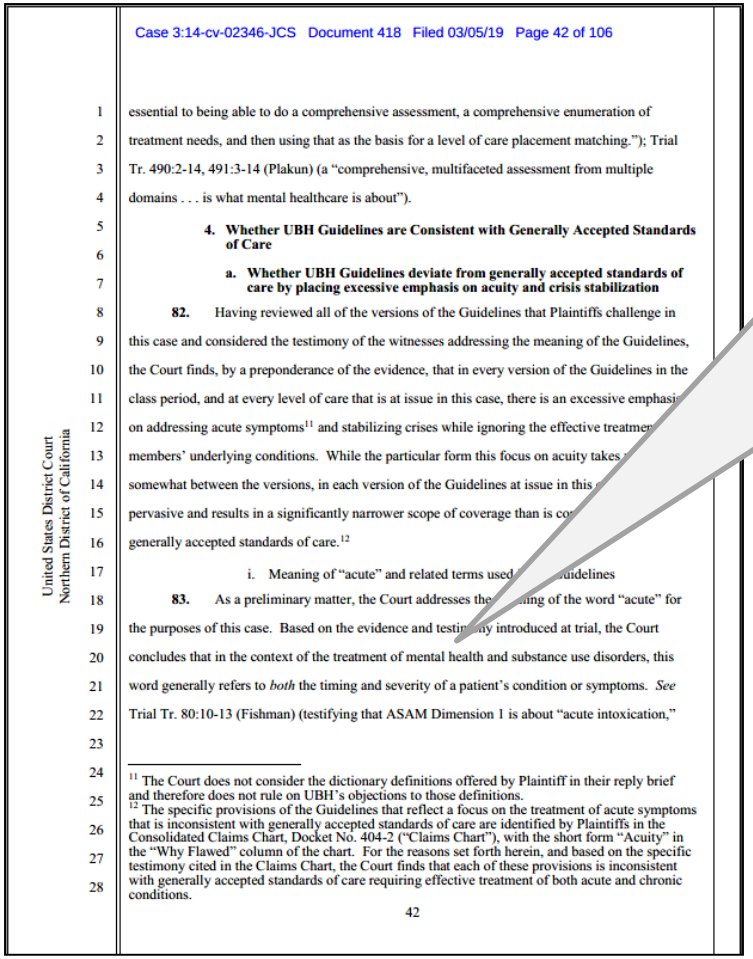
83. As a preliminary matter, the Court addresses the ing of the word "acute" for the purposes of this case. Based on the evidence and testi y introduced at trial, the Court concludes that in the context of the treatment of mental health and substance use disorders, this word generally refers to *both* the timing and severity of a patient's condition or symptoms. *See* Trial Tr. 80:10-13 (Fishman) (testifying that ASAM Dimension 1 is about "acute intoxication,"

[11] The Court does not consider the dictionary definitions offered by Plaintiff in their reply brief and therefore does not rule on UBH's objections to those definitions.
[12] The specific provisions of the Guidelines that reflect a focus on the treatment of acute symptoms that is inconsistent with generally accepted standards of care are identified by Plaintiffs in the Consolidated Claims Chart, Docket No. 404-2 ("Claims Chart"), with the short form "Acuity" in the "Why Flawed" column of the chart. For the reasons set forth herein, and based on the specific testimony cited in the Claims Chart, the Court finds that each of these provisions is inconsistent with generally accepted standards of care requiring effective treatment of both acute and chronic conditions.

42

"[I]n every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an **excessive emphasis on addressing acute symptoms** and stabilizing crises while ignoring the effective treatment of members' underlying conditions."

Generally- Accepted Standards



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Northern District of California

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42

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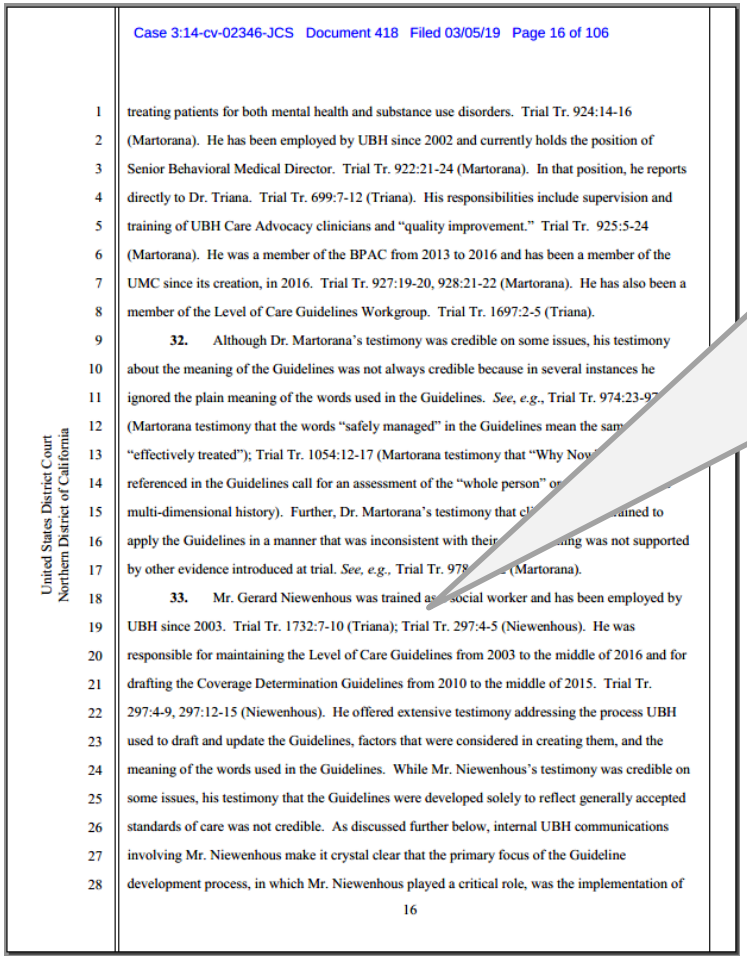
The Court's Liability Ruling: Conflict of Interest

Conflict of Interest



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treating patients for both mental health and substance use disorders. Trial Tr. 924:14-16 (Martorana). He has been employed by UBH since 2002 and currently holds the position of Senior Behavioral Medical Director. Trial Tr. 922:21-24 (Martorana). In that position, he reports directly to Dr. Triana. Trial Tr. 699:7-12 (Triana). His responsibilities include supervision and training of UBH Care Advocacy clinicians and "quality improvement." Trial Tr. 925:5-24 (Martorana). He was a member of the BPAC from 2013 to 2016 and has been a member of the UMC since its creation, in 2016. Trial Tr. 927:19-20, 928:21-22 (Martorana). He has also been a member of the Level of Care Guidelines Workgroup. Trial Tr. 1697:2-5 (Triana).

32. Although Dr. Martorana's testimony was credible on some issues, his testimony about the meaning of the Guidelines was not always credible because in several instances he ignored the plain meaning of the words used in the Guidelines. *See, e.g.*, Trial Tr. 974:23-97 (Martorana testimony that the words "safely managed" in the Guidelines mean the sam "effectively treated"); Trial Tr. 1054:12-17 (Martorana testimony that "Why Now referenced in the Guidelines call for an assessment of the "whole person" or multi-dimensional history). Further, Dr. Martorana's testimony that cl ained to apply the Guidelines in a manner that was inconsistent with their ing was not supported by other evidence introduced at trial. *See, e.g.*, Trial Tr. 978 (Martorana).

33. Mr. Gerard Niewenhous was trained as ocial worker and has been employed by UBH since 2003. Trial Tr. 1732:7-10 (Triana); Trial Tr. 297:4-5 (Niewenhous). He was responsible for maintaining the Level of Care Guidelines from 2003 to the middle of 2016 and for drafting the Coverage Determination Guidelines from 2010 to the middle of 2015. Trial Tr. 297:4-9, 297:12-15 (Niewenhous). He offered extensive testimony addressing the process UBH used to draft and update the Guidelines, factors that were considered in creating them, and the meaning of the words used in the Guidelines. While Mr. Niewenhous's testimony was credible on some issues, his testimony that the Guidelines were developed solely to reflect generally accepted standards of care was not credible. As discussed further below, internal UBH communications involving Mr. Niewenhous make it crystal clear that the primary focus of the Guideline development process, in which Mr. Niewenhous played a critical role, was the implementation of a

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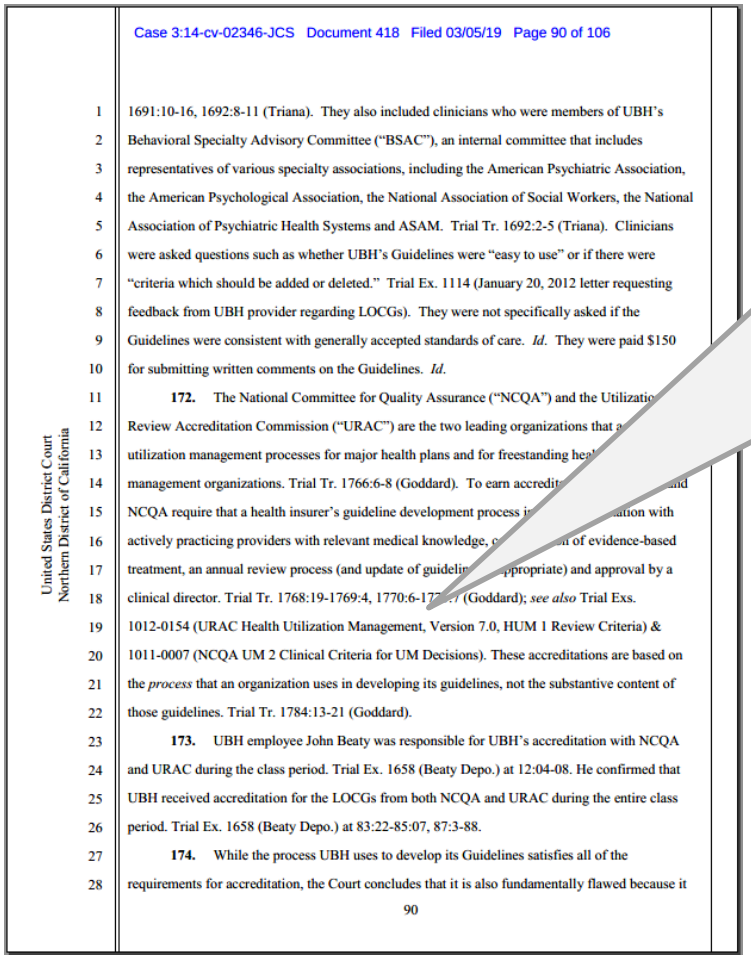
"[I]nternal UBH communications. . . make it crystal clear that the **primary focus** on the Guideline development process. . . was the implementation of a 'utilization management' model that **keeps benefit expenses down** by placing a heavy emphasis on crisis stabilization and an insufficient emphasis on the effective treatment of co-occurring and chronic conditions."

Conflict of Interest



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Northern District of California

1691:10-16, 1692:8-11 (Triana). They also included clinicians who were members of UBH's Behavioral Specialty Advisory Committee ("BSAC"), an internal committee that includes representatives of various specialty associations, including the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, the National Association of Psychiatric Health Systems and ASAM. Trial Tr. 1692:2-5 (Triana). Clinicians were asked questions such as whether UBH's Guidelines were "easy to use" or if there were "criteria which should be added or deleted." Trial Ex. 1114 (January 20, 2012 letter requesting feedback from UBH provider regarding LOCGs). They were not specifically asked if the Guidelines were consistent with generally accepted standards of care. *Id*. They were paid $150 for submitting written comments on the Guidelines. *Id*.

172. The National Committee for Quality Assurance ("NCQA") and the Utilizatio Review Accreditation Commission ("URAC") are the two leading organizations that a utilization management processes for major health plans and for freestanding hea management organizations. Trial Tr. 1766:6-8 (Goddard). To earn accredit nd NCQA require that a health insurer's guideline development process i ation with actively practicing providers with relevant medical knowledge, c n of evidence-based treatment, an annual review process (and update of guideli ppropriate) and approval by a clinical director. Trial Tr. 1768:19-1769:4, 1770:6-17 (Goddard); *see also* Trial Exs. 1012-0154 (URAC Health Utilization Management, Version 7.0, HUM 1 Review Criteria) & 1011-0007 (NCQA UM 2 Clinical Criteria for UM Decisions). These accreditations are based on the *process* that an organization uses in developing its guidelines, not the substantive content of those guidelines. Trial Tr. 1784:13-21 (Goddard).

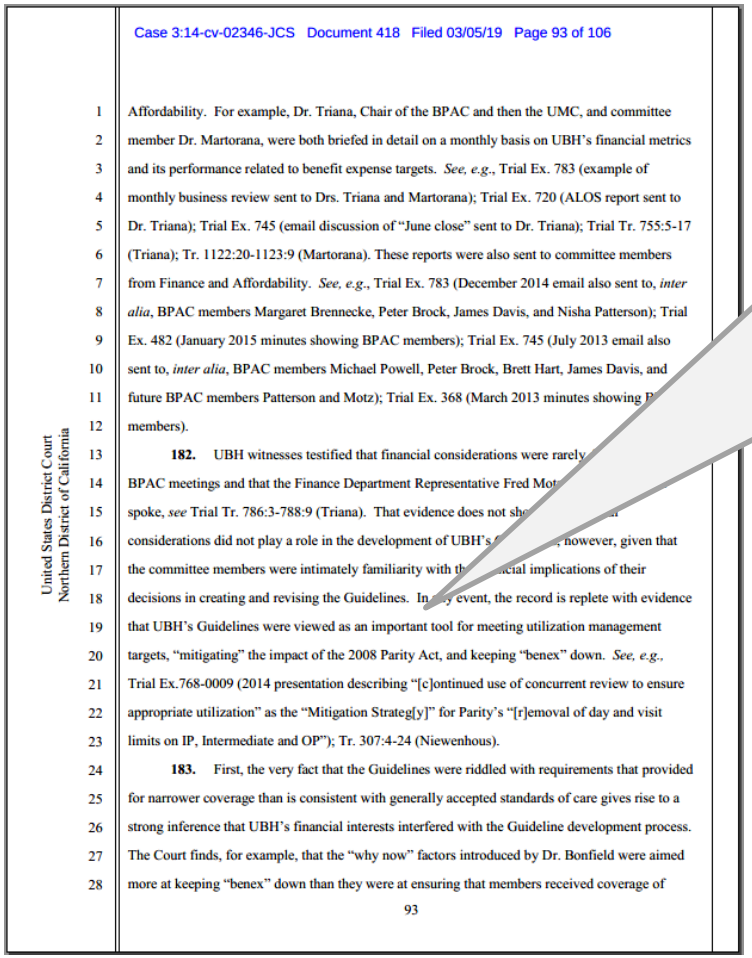
173. UBH employee John Beaty was responsible for UBH's accreditation with NCQA and URAC during the class period. Trial Ex. 1658 (Beaty Depo.) at 12:04-08. He confirmed that UBH received accreditation for the LOCGs from both NCQA and URAC during the entire class period. Trial Ex. 1658 (Beaty Depo.) at 83:22-85:07, 87:3-88.

174. While the process UBH uses to develop its Guidelines satisfies all of the requirements for accreditation, the Court concludes that it is also fundamentally flawed because it

90

The Court found that the process UBH followed to develop its Guidelines was "fundamentally flawed because it [was] **tainted by UBH's financial interests**."

Conflict of Interest



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Affordability. For example, Dr. Triana, Chair of the BPAC and then the UMC, and committee member Dr. Martorana, were both briefed in detail on a monthly basis on UBH's financial metrics and its performance related to benefit expense targets. *See, e.g.*, Trial Ex. 783 (example of monthly business review sent to Drs. Triana and Martorana); Trial Ex. 720 (ALOS report sent to Dr. Triana); Trial Ex. 745 (email discussion of "June close" sent to Dr. Triana); Trial Tr. 755:5-17 (Triana); Tr. 1122:20-1123:9 (Martorana). These reports were also sent to committee members from Finance and Affordability. *See, e.g.*, Trial Ex. 783 (December 2014 email also sent to, *inter alia*, BPAC members Margaret Brennecke, Peter Brock, James Davis, and Nisha Patterson); Trial Ex. 482 (January 2015 minutes showing BPAC members); Trial Ex. 745 (July 2013 email also sent to, *inter alia*, BPAC members Michael Powell, Peter Brock, Brett Hart, James Davis, and future BPAC members Patterson and Motz); Trial Ex. 368 (March 2013 minutes showing P members).

182. UBH witnesses testified that financial considerations were rarely BPAC meetings and that the Finance Department Representative Fred Mot spoke, *see* Trial Tr. 786:3-788:9 (Triana). That evidence does not sh considerations did not play a role in the development of UBH's , however, given that the committee members were intimately familiarity with th cial implications of their decisions in creating and revising the Guidelines. In y event, the record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, "mitigating" the impact of the 2008 Parity Act, and keeping "benex" down. *See, e.g.*, Trial Ex.768-0009 (2014 presentation describing "[c]ontinued use of concurrent review to ensure appropriate utilization" as the "Mitigation Strateg[y]" for Parity's "[r]emoval of day and visit limits on IP, Intermediate and OP"); Tr. 307:4-24 (Niewenhous).

183. First, the very fact that the Guidelines were riddled with requirements that provided for narrower coverage than is consistent with generally accepted standards of care gives rise to a strong inference that UBH's financial interests interfered with the Guideline development process. The Court finds, for example, that the "why now" factors introduced by Dr. Bonfield were aimed more at keeping "benex" down than they were at ensuring that members received coverage of

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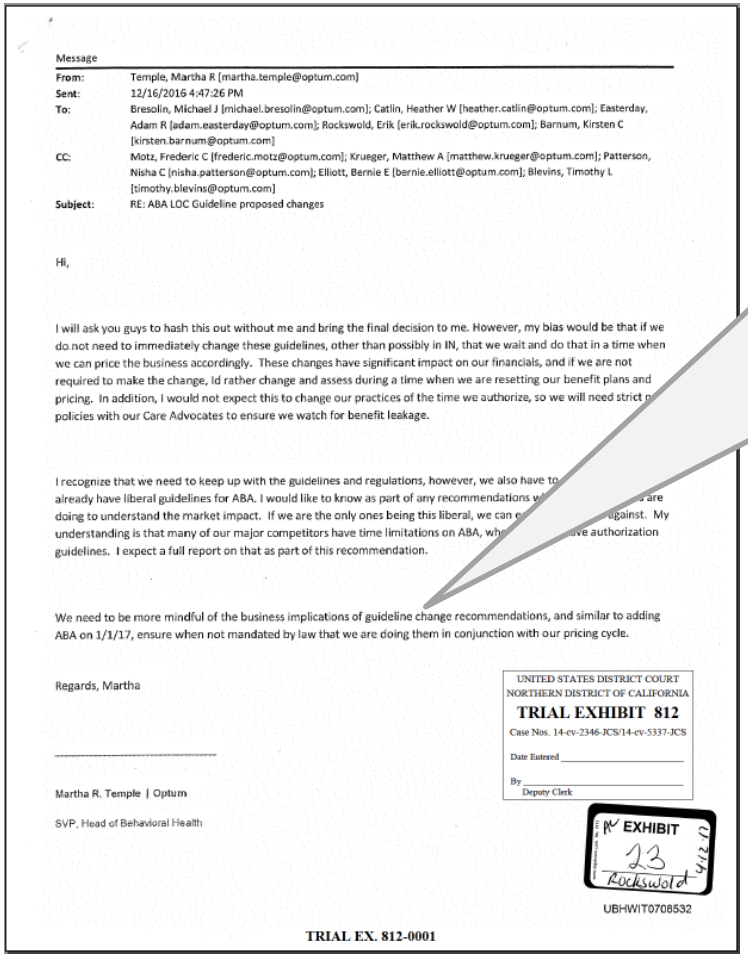
"The record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, 'mitigating' the impact of the 2008 Parity Act, and **keeping 'benex' down**."

Conflict of Interest



Message

From: Temple, Martha R [martha.temple@optum.com]
Sent: 12/16/2016 4:47:26 PM
To: Bresolin, Michael J [michael.bresolin@optum.com]; Catlin, Heather W [heather.catlin@optum.com]; Easterday, Adam R [adam.easterday@optum.com]; Rockswold, Erik [erik.rockswold@optum.com]; Barnum, Kirsten C [kirsten.barnum@optum.com]
CC: Motz, Frederic C [frederic.motz@optum.com]; Krueger, Matthew A [matthew.krueger@optum.com]; Patterson, Nisha C [nisha.patterson@optum.com]; Elliott, Bernie E [bernie.elliott@optum.com]; Blevins, Timothy L [timothy.blevins@optum.com]
Subject: RE: ABA LOC Guideline proposed changes

Hi,

I will ask you guys to hash this out without me and bring the final decision to me. However, my bias would be that if we do not need to immediately change these guidelines, other than possibly in IN, that we wait and do that in a time when we can price the business accordingly. These changes have significant impact on our financials, and if we are not required to make the change, Id rather change and assess during a time when we are resetting our benefit plans and pricing. In addition, I would not expect this to change our practices of the time we authorize, so we will need strict n policies with our Care Advocates to ensure we watch for benefit leakage.

I recognize that we need to keep up with the guidelines and regulations, however, we also have to already have liberal guidelines for ABA. I would like to know as part of any recommendations w are doing to understand the market impact. If we are the only ones being this liberal, we can e against. My understanding is that many of our major competitors have time limitations on ABA, wh ve authorization guidelines. I expect a full report on that as part of this recommendation.

We need to be more mindful of the business implications of guideline change recommendations, and similar to adding ABA on 1/1/17, ensure when not mandated by law that we are doing them in conjunction with our pricing cycle.

Regards, Martha

Martha R. Temple | Optum

SVP, Head of Behavioral Health

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
TRIAL EXHIBIT 812
Case Nos. 14-cv-2346-JCS/14-cv-5337-JCS
Date Entered _____
By _____
Deputy Clerk

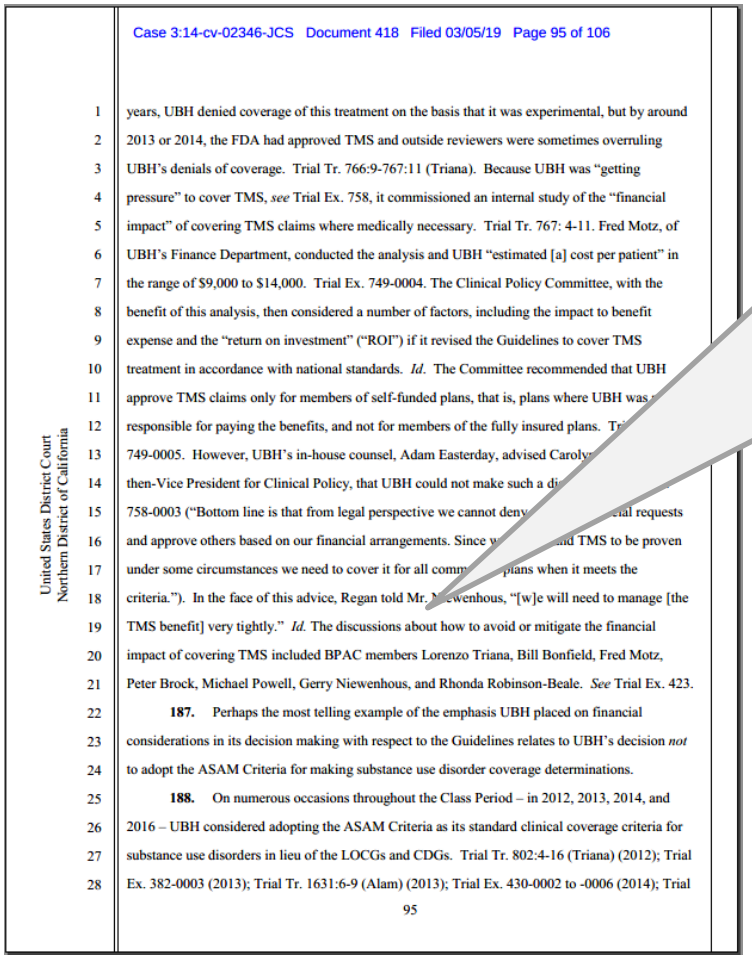
MV EXHIBIT 23 Rockswold 4-12-17

UBHWIT0708532

TRIAL EX. 812-0001

"[w]e need to be more mindful of the business implications of guideline change recommendations."

Conflict of Interest



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Northern District of California

years, UBH denied coverage of this treatment on the basis that it was experimental, but by around 2013 or 2014, the FDA had approved TMS and outside reviewers were sometimes overruling UBH's denials of coverage. Trial Tr. 766:9-767:11 (Triana). Because UBH was "getting pressure" to cover TMS, *see* Trial Ex. 758, it commissioned an internal study of the "financial impact" of covering TMS claims where medically necessary. Trial Tr. 767: 4-11. Fred Motz, of UBH's Finance Department, conducted the analysis and UBH "estimated [a] cost per patient" in the range of $9,000 to $14,000. Trial Ex. 749-0004. The Clinical Policy Committee, with the benefit of this analysis, then considered a number of factors, including the impact to benefit expense and the "return on investment" ("ROI") if it revised the Guidelines to cover TMS treatment in accordance with national standards. *Id.* The Committee recommended that UBH approve TMS claims only for members of self-funded plans, that is, plans where UBH was responsible for paying the benefits, and not for members of the fully insured plans. Tr... 749-0005. However, UBH's in-house counsel, Adam Easterday, advised Carol... then-Vice President for Clinical Policy, that UBH could not make such a di... 758-0003 ("Bottom line is that from legal perspective we cannot deny ...ial requests and approve others based on our financial arrangements. Since w... ...d TMS to be proven under some circumstances we need to cover it for all comm... ...plans when it meets the criteria."). In the face of this advice, Regan told Mr. N...ewenhous, "[w]e will need to manage [the TMS benefit] very tightly." *Id.* The discussions about how to avoid or mitigate the financial impact of covering TMS included BPAC members Lorenzo Triana, Bill Bonfield, Fred Motz, Peter Brock, Michael Powell, Gerry Niewenhous, and Rhonda Robinson-Beale. *See* Trial Ex. 423.

187. Perhaps the most telling example of the emphasis UBH placed on financial considerations in its decision making with respect to the Guidelines relates to UBH's decision *not* to adopt the ASAM Criteria for making substance use disorder coverage determinations.

188. On numerous occasions throughout the Class Period – in 2012, 2013, 2014, and 2016 – UBH considered adopting the ASAM Criteria as its standard clinical coverage criteria for substance use disorders in lieu of the LOCGs and CDGs. Trial Tr. 802:4-16 (Triana) (2012); Trial Ex. 382-0003 (2013); Trial Tr. 1631:6-9 (Alam) (2013); Trial Ex. 430-0002 to -0006 (2014); Trial

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"[w]e will need to manage [the TMS benefit] very tightly."

Conflict of Interest

ASAM GUIDELINE DECISION

Adopt or Abandon ?

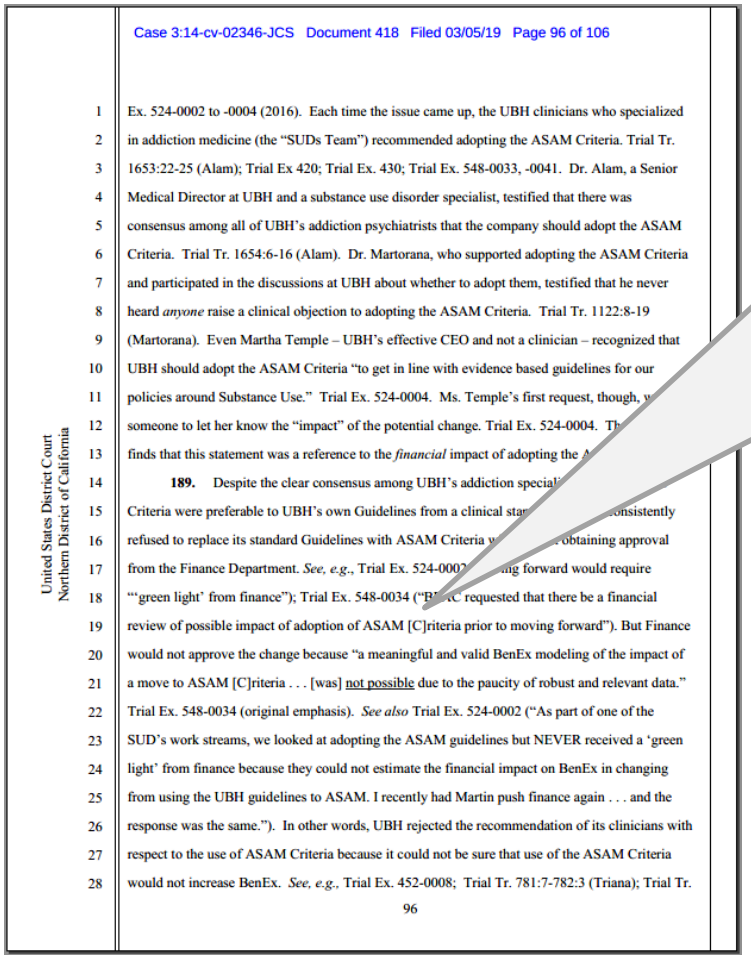
OPTUMHealth™

SUDS

TRIAL EX. 548-0032

Proprietary and Confidential. Do not distribute. 1

Conflict of Interest



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Ex. 524-0002 to -0004 (2016). Each time the issue came up, the UBH clinicians who specialized in addiction medicine (the "SUDs Team") recommended adopting the ASAM Criteria. Trial Tr. 1653:22-25 (Alam); Trial Ex 420; Trial Ex. 430; Trial Ex. 548-0033, -0041. Dr. Alam, a Senior Medical Director at UBH and a substance use disorder specialist, testified that there was consensus among all of UBH's addiction psychiatrists that the company should adopt the ASAM Criteria. Trial Tr. 1654:6-16 (Alam). Dr. Martorana, who supported adopting the ASAM Criteria and participated in the discussions at UBH about whether to adopt them, testified that he never heard *anyone* raise a clinical objection to adopting the ASAM Criteria. Trial Tr. 1122:8-19 (Martorana). Even Martha Temple – UBH's effective CEO and not a clinician – recognized that UBH should adopt the ASAM Criteria "to get in line with evidence based guidelines for our policies around Substance Use." Trial Ex. 524-0004. Ms. Temple's first request, though, w
someone to let her know the "impact" of the potential change. Trial Ex. 524-0004. Th
finds that this statement was a reference to the *financial* impact of adopting the A

189. Despite the clear consensus among UBH's addiction speciali
Criteria were preferable to UBH's own Guidelines from a clinical sta
onsistently refused to replace its standard Guidelines with ASAM Criteria w
obtaining approval from the Finance Department. *See, e.g.*, Trial Ex. 524-000
ng forward would require "'green light' from finance"); Trial Ex. 548-0034 ("P
C requested that there be a financial review of possible impact of adoption of ASAM [C]riteria prior to moving forward"). But Finance would not approve the change because "a meaningful and valid BenEx modeling of the impact of a move to ASAM [C]riteria . . . [was] not possible due to the paucity of robust and relevant data." Trial Ex. 548-0034 (original emphasis). *See also* Trial Ex. 524-0002 ("As part of one of the SUD's work streams, we looked at adopting the ASAM guidelines but NEVER received a 'green light' from finance because they could not estimate the financial impact on BenEx in changing from using the UBH guidelines to ASAM. I recently had Martin push finance again . . . and the response was the same."). In other words, UBH rejected the recommendation of its clinicians with respect to the use of ASAM Criteria because it could not be sure that use of the ASAM Criteria would not increase BenEx. *See, e.g.*, Trial Ex. 452-0008; Trial Tr. 781:7-782:3 (Triana); Trial Tr.

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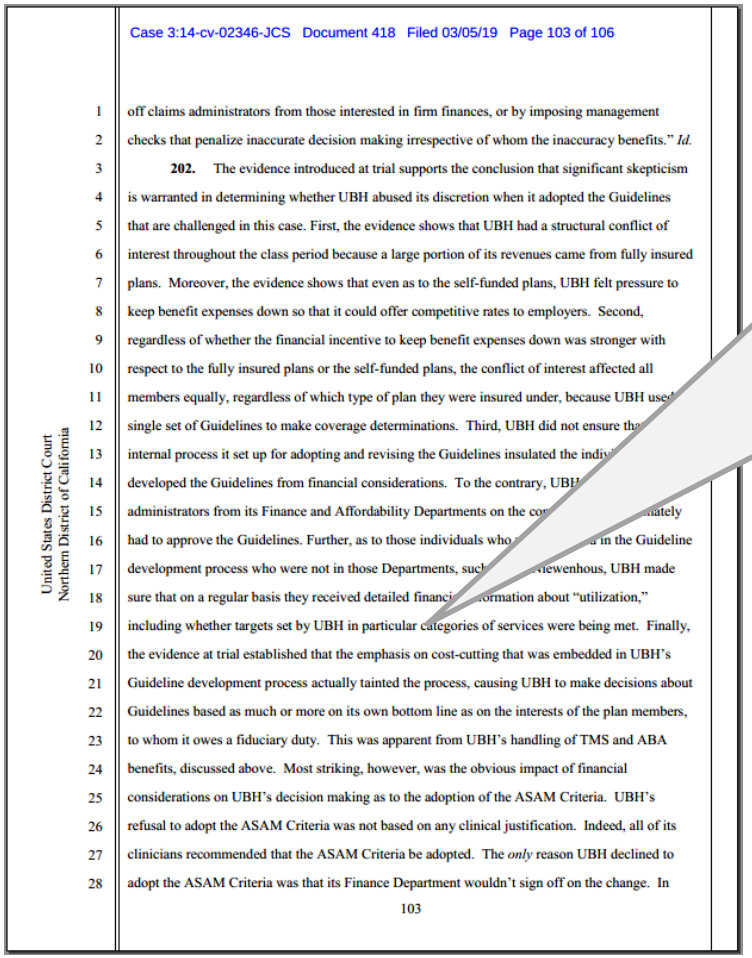
"In other words, UBH rejected the recommendation of its clinicians with respect to the use of ASAM Criteria because **it could not be sure that use of the ASAM Criteria would not increase BenEx**."

Conflict of Interest



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off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." *Id.*

202. The evidence introduced at trial supports the conclusion that significant skepticism is warranted in determining whether UBH abused its discretion when it adopted the Guidelines that are challenged in this case. First, the evidence shows that UBH had a structural conflict of interest throughout the class period because a large portion of its revenues came from fully insured plans. Moreover, the evidence shows that even as to the self-funded plans, UBH felt pressure to keep benefit expenses down so that it could offer competitive rates to employers. Second, regardless of whether the financial incentive to keep benefit expenses down was stronger with respect to the fully insured plans or the self-funded plans, the conflict of interest affected all members equally, regardless of which type of plan they were insured under, because UBH used a single set of Guidelines to make coverage determinations. Third, UBH did not ensure that the internal process it set up for adopting and revising the Guidelines insulated the individuals who developed the Guidelines from financial considerations. To the contrary, UBH had administrators from its Finance and Affordability Departments on the committee that ultimately had to approve the Guidelines. Further, as to those individuals who participated in the Guideline development process who were not in those Departments, such as Niewenhous, UBH made sure that on a regular basis they received detailed financial information about "utilization," including whether targets set by UBH in particular categories of services were being met. Finally, the evidence at trial established that the emphasis on cost-cutting that was embedded in UBH's Guideline development process actually tainted the process, causing UBH to make decisions about Guidelines based as much or more on its own bottom line as on the interests of the plan members, to whom it owes a fiduciary duty. This was apparent from UBH's handling of TMS and ABA benefits, discussed above. Most striking, however, was the obvious impact of financial considerations on UBH's decision making as to the adoption of the ASAM Criteria. UBH's refusal to adopt the ASAM Criteria was not based on any clinical justification. Indeed, all of its clinicians recommended that the ASAM Criteria be adopted. The *only* reason UBH declined to adopt the ASAM Criteria was that its Finance Department wouldn't sign off on the change. In

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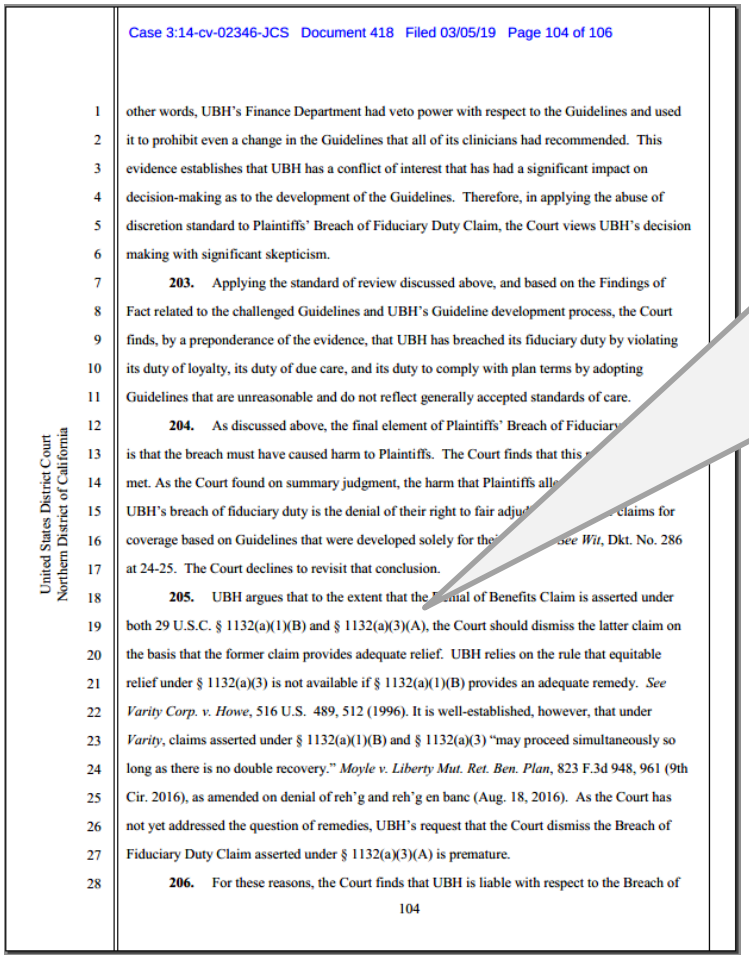
"The *only* reason UBH declined to adopt the ASAM Criteria was that its Finance Department wouldn't sign off on the change."

The Court's Liability Ruling: Conclusions of Law

Conclusions of Law



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other words, UBH's Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change in the Guidelines that all of its clinicians had recommended. This evidence establishes that UBH has a conflict of interest that has had a significant impact on decision-making as to the development of the Guidelines. Therefore, in applying the abuse of discretion standard to Plaintiffs' Breach of Fiduciary Duty Claim, the Court views UBH's decision making with significant skepticism.

203. Applying the standard of review discussed above, and based on the Findings of Fact related to the challenged Guidelines and UBH's Guideline development process, the Court finds, by a preponderance of the evidence, that UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care, and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care.

204. As discussed above, the final element of Plaintiffs' Breach of Fiduciary
is that the breach must have caused harm to Plaintiffs. The Court finds that this
met. As the Court found on summary judgment, the harm that Plaintiffs all
UBH's breach of fiduciary duty is the denial of their right to fair adju claims for
coverage based on Guidelines that were developed solely for the *See Wit*, Dkt. No. 286 at 24-25. The Court declines to revisit that conclusion.

205. UBH argues that to the extent that the nial of Benefits Claim is asserted under both 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(3)(A), the Court should dismiss the latter claim on the basis that the former claim provides adequate relief. UBH relies on the rule that equitable relief under § 1132(a)(3) is not available if § 1132(a)(1)(B) provides an adequate remedy. *See Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). It is well-established, however, that under *Varity*, claims asserted under § 1132(a)(1)(B) and § 1132(a)(3) "may proceed simultaneously so long as there is no double recovery." *Moyle v. Liberty Mut. Ret. Ben. Plan*, 823 F.3d 948, 961 (9th Cir. 2016), as amended on denial of reh'g and reh'g en banc (Aug. 18, 2016). As the Court has not yet addressed the question of remedies, UBH's request that the Court dismiss the Breach of Fiduciary Duty Claim asserted under § 1132(a)(3)(A) is premature.

206. For these reasons, the Court finds that UBH is liable with respect to the Breach of

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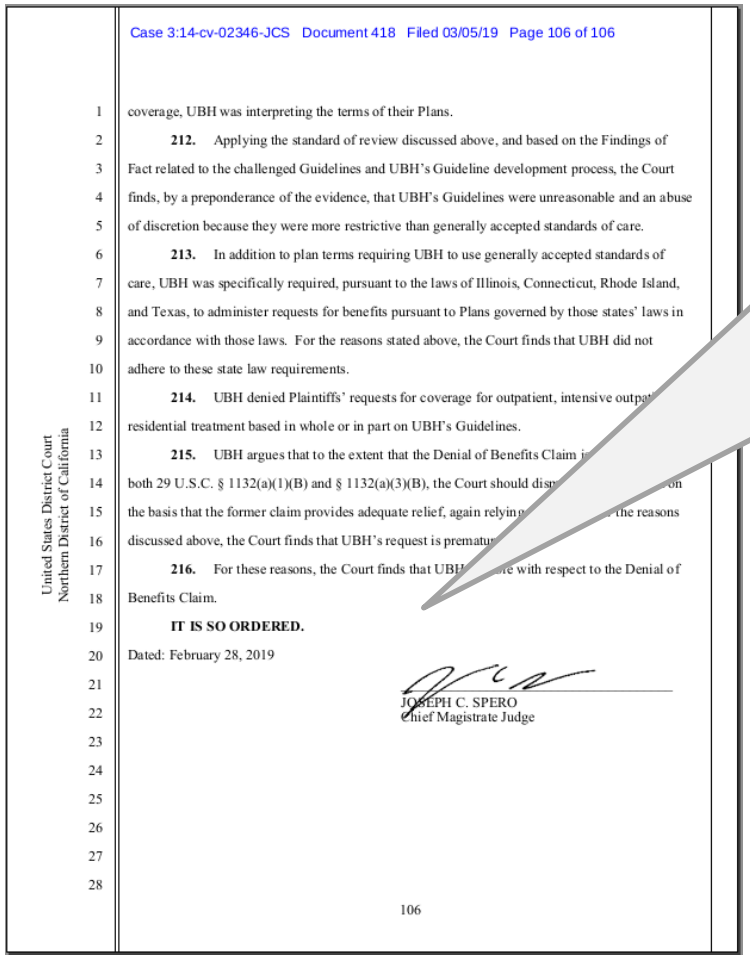
"UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care, and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care."

Conclusions of Law



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coverage, UBH was interpreting the terms of their Plans.

212. Applying the standard of review discussed above, and based on the Findings of Fact related to the challenged Guidelines and UBH's Guideline development process, the Court finds, by a preponderance of the evidence, that UBH's Guidelines were unreasonable and an abuse of discretion because they were more restrictive than generally accepted standards of care.

213. In addition to plan terms requiring UBH to use generally accepted standards of care, UBH was specifically required, pursuant to the laws of Illinois, Connecticut, Rhode Island, and Texas, to administer requests for benefits pursuant to Plans governed by those states' laws in accordance with those laws. For the reasons stated above, the Court finds that UBH did not adhere to these state law requirements.

214. UBH denied Plaintiffs' requests for coverage for outpatient, intensive outpat residential treatment based in whole or in part on UBH's Guidelines.

215. UBH argues that to the extent that the Denial of Benefits Claim i both 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(3)(B), the Court should dis on the basis that the former claim provides adequate relief, again relyin the reasons discussed above, the Court finds that UBH's request is prematu

216. For these reasons, the Court finds that UBH re with respect to the Denial of Benefits Claim.

IT IS SO ORDERED.

Dated: February 28, 2019

JOSEPH C. SPERO
Chief Magistrate Judge

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"UBH's Guidelines were unreasonable and an abuse of discretion because they were more restrictive than generally accepted standards of care."

What Does it Mean?

- **Judicial findings on generally accepted standards of care**
  - Apply across-the-board
  - Can be cited when discussing coverage with other insurers or payors, not only UBH

- **Beginnings of change**
  - UBH abandoning its proprietary Guidelines in favor of the standards Plaintiffs proposed
  - Vigilance/ oversight still needed

- **Road map for future cases**

Other Pending Cases

More cases challenging restrictive proprietary coverage guidelines:

- Tomlinson v. United Behavioral Health (N.D. Cal.)
- Berceanu v. UMR, Inc. (W.D. Wis.)
- Hering v. New Directions Behavioral Health, LLC (M.D. Fla.)
- Smith v. Healthcare Services Corp. and MCG, Inc. (N.D. Ill.)

Parity challenge to exclusion of Intensive Behavioral Therapy:

- Doe v. United Behavioral Health (N.D. Cal.)

Parity challenges to discriminatory reimbursement rates:

- Smith v. United Healthcare Insurance Co. and UBH (N.D. Cal.)
- Doe v. United Health Group, UHIC, Oxford Health Plans (E.D.N.Y.)

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- Smith v. Intermountain Healthcare, Inc. and SelectHealth, Inc. (D. Utah)

Thank You for Listening