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

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DAVID AND NATASHA WIT, ET AL.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, ET AL.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

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

BRIEF OF RHODE ISLAND, CONNECTICUT, AND ILLINOIS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND REHEARING EN BANC

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May 16, 2022

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INTERESTS OF AMICI CURIAE AND INTRODUCTION

Amici curiae States of Rhode Island, Connecticut, and Illinois submit this amicus brief in support of Plaintiffs-Appellees and their petition for panel rehearing and rehearing en banc. The Amici States' interests are implicated by this case and, more specifically, the panel decision, in a number of important ways.

As plaintiffs explain, Pet. at 3-6, a key issue in this case is whether United Behavioral Health ("UBH") violated Amici States' laws requiring insurers to adhere to the generally accepted level of care requirements—as set forth in criteria developed by the American Society for Addiction Medicine, known as the ASAM Criteria—when making substance use disorder coverage decisions. *E.g.* R.I. Gen. Laws § 27-38.2-1(g); 215 Ill. Comp. Stat. § 5/370c(b)(3); Conn. Gen. Stat. § 38a-591c(a)(3). After a full trial, the district court found, as a factual matter, not only that UBH had violated these laws, but also that it had lied to certain state regulators by reporting that UBH was applying the ASAM Criteria when it was not. *E.g.*, 2-ER-306-16; 1-ER-92. For example, the court found that UBH "materially mischaracterized" the guidelines in ways that UBH knew were "false." 2-ER-213-314; 2-ER-308-09 (¶153).

UBH did not contest these findings on appeal, nor did it present any specific arguments challenging the relief awarded to the class of individuals whose claims were based on those state laws (the "State Mandate Class"). UBH Br. at 43-58

(challenging findings related to the Plan Terms, not state law); Pls. Br. at 5 n.1. Nevertheless, the panel decision concludes by "reversing" the district court judgment—a conclusion that, if left intact, could preclude plaintiffs from obtaining the relief that was entered in favor of the State Mandate Class, even though that part of the judgment was not challenged by UBH on appeal. Amici States thus agree with plaintiffs that, at a minimum, this court should grant their petition for panel rehearing and clarify that the district court's decision with respect to the State Mandate Class—an uncontested issue on appeal—is affirmed.

In any event, Amici States agree with plaintiffs that the district court's findings related to their state laws were correct. Accordingly, to the extent the panel intended to reverse the district court's judgment on that basis, Amici States urge the court to grant plaintiffs' petition for rehearing to remedy that error. As explained in detail below, *see infra Section I*, Amici States bear the costs of mental health and substance use disorders that remain untreated as providers of last resort, through Medicaid expenditures, and in increased public safety costs. As such, Amici have each acted in their traditional regulatory sphere over the insurance industry to require insurers to provide meaningful coverage of mental health treatment and substance use disorder treatment. And, as the district court correctly concluded, UBH was not free to disregard these important state laws when developing and applying its guidelines to insured plans. 2-ER-306-16. To the extent the panel decision upends

those findings by reversing the district court's judgment in its entirety, it could undermine Amici States' efforts to ensure their citizens have access to treatment for substance use disorder and mental health conditions consistent with generally accepted standards of care, including the ASAM criteria.

Finally, Amici States agree with plaintiffs that, notwithstanding the resolution of the State Mandate Class, rehearing of the panel's decision is warranted because its conclusions as to the claims based on the UBH plans unduly restrict the substance use disorder coverage for our residents. Pet. 7-13. The human and financial toll of the opioid epidemic in 2017 alone reached 3,157 fatal opioid overdoses and $63.3 billion in costs among the three Amici States.[1] Throughout the pandemic and thereafter, mental illness generally, and in particular among adolescents, has been on the rise.[2] When insurers depart from these requirements, it leaves Amici States' populations vulnerable to the ravages of untreated and improperly treated disease. Amici States must pay again for the very treatment for which their insured populations have already purchased coverage—treatment of their mental health needs or substance use disorder to generally accepted standards of medical care.

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[1] Feijun Luo et al., CDC MORBIDITY AND MORTALITY WEEKLY REPORT, "State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose — United States, 2017," April 16, 2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7015a1.htm#T1_down.

[2] *See generally, e.g.*, Matt Richtel, *It's Life or Death: The Mental Health Crisis Among U.S. Teens*, N.Y. Times (April 23, 2022, https://www.nytimes.com/2022/04/23/health/mental-health-crisis-teens.html).

They must also bear the substantial medical and mental health costs associated with untreated and improperly treated conditions.

ARGUMENT

By reversing the district court's judgment in its entirety, the panel decision appears to overturn even the district court's judgment as to the State Mandate Class, as well as the underlying extensive factual findings showing that UBH's Guidelines violated state law. On appeal, UBH did not challenge any of these factual findings. And in its decision, the panel did not address the state-law claims at all. *Wit v. United Behavioral Health*, Nos. 20-17363 & 21-15193, slip op. (9th Cir. 2022). Instead, it focused on the issues presented by UBH: standing, class certification, and the meaning of the Plan terms. On the latter point, the panel held that the district court should have deferred to UBH's "discretionary authority" to interpret plan terms. Slip op. at 6-7. Acknowledging that the Plans "exclude[d] coverage for treatment inconsistent" with generally accepted standards of care, the panel then concluded that the Plans did not "mandate coverage for all treatment that is consistent" with generally accepted standards of care. *Id*. This reasoning—which is focused on the Plans—does not relate to the State Mandate Class or its claims. Accordingly, to the extent the panel did not intend to reverse on the state-law grounds that were not presented to it, it should grant the petition for panel rehearing and clarify that the district court's decision with respect to the State Mandate Class is affirmed.

If the decision were left intact, it could run roughshod over Amici States' laws. Indeed, under Connecticut, Illinois and Rhode Island law, the criteria used to make decisions on medical necessity for substance use disorder treatment must be consistent with ASAM criteria. Conn. Gen. Stat. § 38a-591c(a)(3) ("For any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (A) [the ASAM Criteria];" or criteria similar to the ASAM Criteria that has been approved by state regulators); 215 Ill. Comp. Stat. § 5/370c(b)(3) ("Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders."); R.I. Gen. Laws § 27-38.2-1(g) ("Payors shall rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment.")

Additionally, the decision has broader implications for our residents. Among other flaws, the panel decision blesses imposition of treatment limitations not stated in the plan but applied ad hoc by insurers, even when those treatment limitations are undisclosed to plan participants and undiscoverable by regulators reviewing plans for compliance, and even when those treatment limitations admittedly depart from generally accepted standards of care and state law. Because substance use and

behavioral health is of utmost importance to the states, and UBH is governed by state law and state regulation as well as ERISA, the panel decision should be reconsidered.

I. The Amici States Enacted Insurance Statutes and Regulations To Address The Behavioral Health and Substance Use Disorder Treatment Crisis.

Substance use disorder causes incredible costs in dollars and human suffering. Throughout some of the very time periods UBH was using impermissible criteria to deny treatment claims, the opioid epidemic was spreading. From 2011 to 2020 Rhode Island saw a 108% increase in overdose fatalities. [3] Rhode Island's annual accidental drug overdoses increased from 190 in 2011 to 397 in 2020.[4] And in Illinois, nearly 18,000 people died from an opioid overdose between 1999 and 2017.[5] In 2017, opioid overdoses killed 2,202 people in Illinois, a more than 100% increase

[3] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death Files 1999-2020 on CDC WONDER Online Database, released in 2021, http://wonder.cdc.gov/mcd-icd10.html (Last accessed May 6, 2022): overdose fatalities, excluding murders.

[4] *Id.*

[5] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, http://wonder.cdc.gov/mcd-icd10.html (Last accessed March 12, 2019).

compared to 2013.[6] In Connecticut, there was a 340% increase in overdose fatalities from 2011 to 2020, from 402 overdose deaths in 2011 to 1369 deaths in 2020.[7]

In response to this crisis, States enacted laws requiring compliance with the ASAM Criteria for substance use treatment coverage, as well as parity in mental health coverage standards with medical/surgical standards. For example, during this period of increasing opioid overdoses, Rhode Island extended insurance coverage for lifesaving substance use disorder treatment. At the hearing for the bill mandating adherence to the ASAM Criteria, there was testimony that "over 250 individuals [were] denied prior authorization for inpatient treatment in the past year. These individuals had a prior clinical assessment based on ASAM criteria. There was no clinical reason to deny admission."[8] The Hospital Association of Rhode Island also submitted testimony that it had experience with claims being denied even after medical necessity findings, resulting in patients ultimately receiving lower levels of

[6] Illinois Department of Public Health, Drug Overdose Deaths by Sex, Age Group, Race/Ethnicity and County, Illinois Residents, 2013-2018, March 8, 2010, http://www.dph.illinois.gov/sites/default/files/publications/Drug-Overdose-Deaths-Aug2018.pdf (Last accessed March 26, 2019).

[7] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, http://wonder.cdc.gov/mcd-icd10.html (Last accessed May 6, 2022): overdose fatalities, excluding murders.

[8] Hearing on H-5837 Before the H. Comm. on Corps., 2015 Leg. (R.I. Apr. 7, 2015) (written testimony of David Spencer, Executive Director of the Drug and Alcohol Treatment Association of Rhode Island). Reproduced at Appendix 3-4.

care.[9] Half of the reported cases belonged to UBH.[10] It was specifically to address these denials of care that the General Assembly required that insurers "rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment." R.I. Gen. Laws § 27-38.2-1(g).

Illinois has also taken increasingly specific legislative steps to address the problem of insurers improperly denying medically necessary treatment. Effective August 18, 2011, Illinois law required that "[m]edical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine." 215 Ill. Comp. Stat. § 5/370c(b)(3). Additionally, in 2015, the Illinois legislature amended this statutory requirement by adding that "[n]o additional criteria may be used to make medical necessity determinations for substance use disorders." *Id.*

Last year, Illinois enacted the Generally Accepted Standards of Behavioral Health Care Act of 2021, (Public Act 102-0579; 215 ILCS 5/370c, effective date August 25, 2021), which amends the Illinois Insurance Code, among other ways, to

[9] Hearing on H-5837 Before the H. Comm. on Corps., 2015 Leg. (R.I. Apr. 7, 2015) (letter by Michael R. Souza, President of the Hospital Association of Rhode Island). Reproduced at Appendix 5-7.
[10] *Id.* (32 cases out of 65).

require commercial insurers, health insurance marketplace plans and Medicaid managed care organizations to:

- cover medically necessary treatment of mental health and substance use disorders;
- base any medical necessity determination or the utilization review criteria on current generally accepted standards for the treatment of mental health and substance abuse disorders; and
- conduct utilization review of covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance abuse disorders in children, adolescents, and adults, applying exclusively the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

Insurers may not apply different, additional, conflicting, or more restrictive utilization review criteria compared to the criteria and guidelines set forth in the treatment criteria. Further, benefits or coverage for medically necessary services cannot be restricted on the basis that such services should be or could be covered by a public entitlement program.

Connecticut also has a long-standing history of addressing inappropriate insurance company denials in this area. Since 2013, Connecticut has required insurers to use the ASAM Criteria or criteria that is consistent with ASAM that have been approved by the Connecticut Insurance Department if insurers conduct utilization review of substance use disorder treatment. Conn. Gen. Stat. § 38a-

591c(3). In 2019, Connecticut strengthened coverage for substance abuse services and enacted further parity protections regarding nonquantitative treatment limitations in individual and group policies. Conn. Gen. Stat. § §§ 38a-488c; 38a-488d; 38a-514c; 38a-514d.

Although ERISA generally preempts state law related to employer benefit plans, it contains a savings clause permitting states to retain their authority over insurers. 29 U.S.C. § 1144(b)(2)(A). Core to this retained authority are requirements that insurers insure "against additional risks," "offer their insureds additional benefits," and adopt procedures that "affect the likelihood that a disputed claim will ultimately be deemed valid." *Sgro v. Danone Waters of N. Am., Inc.,* 532 F.3d 940, 943–44 (9th Cir. 2008); *see also Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 361 (2002) (state law allowing insured to request independent clinical review of benefits denial saved from preemption); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 730, 758 (1985) (state law requiring coverage for mental health saved from preemption).

As discussed, the Amici States have all chosen to exercise this traditional authority to prohibit UBH's very actions in this case—denying coverage for mental health and substance use disorder treatment through the use of overly restrictive clinical criteria. *See, e.g.,* R.I. Gen. Laws § 27-38.2-1(d) (requiring that any nonquantitative treatment limitations be applied consistent with parity

requirements); Conn. Gen. Stat. § 38a-488c (parity required for individual policies); § 38a-514c (parity required for group policies). Amici States each require insured plans to use the ASAM Criteria, or criteria consistent with it, in making substance use disorder treatment decisions. R.I. Gen. Laws § 27-38.2-1(g); 215 Ill. Comp. Stat. § 5/370c(b)(3); Conn. Gen. Stat. § 38a-591c(a)(3). These provisions are examples of state insurance regulation that ensure a basic level of coverage is provided to Amici state residents who purchase fully insured plans.

State regulators take action to ensure that insureds in their states are adequately protected when they purchase health coverage. Rhode Island's Office of the Health Insurance Commissioner ("OHIC") is, among other things, required to ensure behavioral health care receives treatment on par with somatic healthcare. *E.g.*, R.I. Gen. Laws § 42-14.5-3(p).

OHIC examined United Healthcare's use of UBH in 2020 as part of a larger suite of market conduct reviews aimed at evaluating behavioral health parity requirements.[11] With respect to UBH, its related company "failed to use clinically appropriate utilization review criteria for behavioral health services" in violation of Rhode Island law and regulation.[12] OHIC also found that UBH's utilization criteria

[11] *See* OHIC, "Market Conduct Examinations," https://ohic.ri.gov/regulations-and-enforcement-actions/market-conduct-examinations.

[12] OHIC 2014-3, *In Re: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations: Examination Report of United Healthcare Insurance Company and United Healthcare of New*

for behavioral health "were not based on objective, measurable, clinical criteria," violating Rhode Island law.[13] United Healthcare was ordered to pay both a separate state fine of $350,000 and a $2.85 million contribution to a community fund to improve behavioral health infrastructure. In a related but separate matter, OHIC has also investigated the same conduct at issue in the State Mandate class claims here—UBH's refusal to apply ASAM criteria to its clinical review of substance abuse treatment. On March 4, 2022, OHIC issued a Consent Agreement and Order against United Healthcare Insurance Co., United Healthcare of New England, and UBH, finding that from July 10, 2015 through January 30, 2019, the respondents had failed to use the ASAM criteria as required by R.I. Gen. Laws § 27-38.2-1(g).[14] OHIC ordered remediation of both UBH's practices and the individual treatment of specific claims along with an administrative penalty of one hundred thousand dollars ($100,000) to the State of Rhode Island.

The Illinois Department of Insurance (DOI) utilizes market conduct examinations to verify a health insurer's compliance with mental health and substance use disorder coverage and parity laws contained in Sections 356z.14,

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England, Inc. in accordance with R.I.G.L. § 27-13.1-5(b), at 13, https://ohic.ri.gov/documents/2020/March/United/UHC%20MCE_033020_WEBSITE.pdf.

[13] *Id.*

[14] *In The Matter Of: UnitedHealthcare Insurance Co., UnitedHealthcare of New England, and United Behavioral Health (Respondents),* OHIC No. SC-2019-01.

356z.23, 370c, and 370c.1 of the Illinois Insurance Code and DOI regulations.[15] The scope of the examination includes, but is not limited to, coverage and benefit determinations as they pertain to parity in mental health and substance use disorder benefits within the company's health insurance business.[16] The objective of the examinations is to evaluate if the company managed those benefits no less favorably than medical or surgical benefits.[17]

Since 2019, the DOI has conducted five (5) market conduct examinations regarding compliance with mental health and substance use disorder coverage and parity laws.[18] The DOI found multiple violations related to the failure of the insurance companies to utilize the ASAM Criteria, including UnitedHealth Group, which paid $550,000 for violations including failing to use ASAM guidelines, requiring prior authorization from the company before a provider can prescribe the patient Buprenorphine to help fight substance use disorder, and requiring prior authorization for prescribing certain ADHD medications.[19]

Connecticut's Department of Insurance also conducts market conduct examinations to enforce insurer's compliance with Connecticut statutes protecting

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[15] IDOI-HFS-Annual-Report-Compliance-Mental-Health-and-Substance-Coverage-and-Parity-Laws-08-2020.pdf (illinois.gov), p. 4.
[16] *Id.*
[17] *Id.*
[18] *Id.* at 6.
[19] *Id.* at 8.

insurance consumers. From August 2019 to July 2020, Connecticut conducted an examination of the mental health parity practices of United HealthCare Insurance Company, Oxford Health Insurance, Inc. and Oxford HealthPlans(CT), Inc. ("the Companies") for claim year 2017.[20] Connecticut similarly found that there were violations of parity requirements, including the failure to demonstrate that nonquantitative treatment limitations for behavioral health and substance abuse were on par with similar limitations for medical and surgical care, and that the former appeared to have resulted in inferior treatment outcomes for patients as well as lower reimbursements to mental health and substance abuse providers.[21] Connecticut entered into a consent agreement with the Companies, alleging that United Behavioral Health (used by the Companies) misrepresented to the Department its use of the ASAM Criteria or equivalent guidelines and did not comply with its duty to use the appropriate review criteria.[22] As a result, the Companies were ordered to pay $575,000 in penalties, $500,000 to mental health nonprofits, and to take corrective action, including a remediation plan for claims that may have been denied under improper standards.[23]

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[20] Connecticut Insurance Department, Market Conduct Report (July 2020), https://www.catalog.state.ct.us/cid/portalApps/images/reports/10795276.pdf.
[21] *Id.* at 37-38.
[22] *Id.* at 43.
[23] *Id.*

II. The District Court's Decision That UBH Failed to Comply with State Insurance Statutes Was Correct.

After a ten-day bench trial, the district court below found, as a factual matter, that UBH had "denied mental health and substance use disorder treatment coverage to tens of thousands of class members using internal guidelines that were inconsistent with the terms of the class members' health insurance plans." 1-ER-92; *see also* 2-ER-229 to -334. The court held that UBH had applied pervasively flawed clinical criteria that departed substantially from the ASAM criteria for substance use disorder and from generally accepted standards of care for mental health treatment over years, meaning (i) UBH had violated state law requirements; and (ii) that policyholders residing in Amici States have not had adequate access to treatment for their substance abuse disorders and other behavioral health needs. The district court's findings confirmed that UBH violated state law in administering the plans. Specifically, the district court found that "ASAM is a recognized source of generally accepted standards of care," and "UBH's Guidelines deviated from these standards in a multitude of ways." 2-ER-306 to -07, ¶154. Indeed, UBH conceded below that its Guidelines did not comply with ASAM levels 3.1, 3.3 or 3.5, specific requirements governing the standards for various levels of clinically managed residential treatment. 2-ER-309, ¶154.

The district court made extensive factual findings and concluded that UBH's Guidelines violated "the laws of Illinois, Connecticut, Rhode Island, and Texas." 2-

ER-310 to 316, ¶¶157-167. The court also found that UBH deliberately made false statements to Connecticut's insurance regulators, representing that its Guidelines included admission criteria consistent with multiple ASAM residential rehabilitation levels of care, when they did not. 2-ER-313 to -14, ¶162. Additionally, the court found that despite "the clear consensus among UBH's addiction specialists that the ASAM Criteria were preferable to UBH's own Guidelines from a clinical standpoint, UBH consistently refused to replace its standard Guidelines with ASAM Criteria. 2-ER-324-25, ¶189.

These decisions, which were uncontested by UBH on appeal, were correct. Indeed, UBH's failure to adhere to state legal requirements has cost it hundreds of thousands of dollars in fines and increased scrutiny by state regulators, as described above. Applying self-serving and defective clinical criteria that is directly contrary to state law for insured plans cannot be within the reasonable exercise of a claims administrator's discretion. The Amici States' insureds who have coverage under UBH fully insured plans are entitled to their benefit determinations made using the ASAM Criteria or its equivalent.

While the classes below were certified with regard to the ASAM criteria state mandates, there are many other important substance use disorder and mental health treatment mandates in state law, including specific state parity requirements. For example, Rhode Island mandates coverage of "[m]edication-assisted treatment or

medication-assisted maintenance services of substance use disorders" and "evidence-based, non-opioid treatment for pain" such as "medically necessary chiropractic care and osteopathic manipulative treatment . . ." R.I. Gen. Laws § 27-38.2-1 (f), (g). Illinois, as discussed above, requires generally accepted standards of care for all behavioral healthcare. 215 Ill. Comp. Stat. § 5/370c. And Connecticut specifies other industry-specific treatment guidelines for child and adolescent psychiatry and adult mental health treatment which bind insurer utilization review. Conn. Gen. Stat. § 38a-591c(4), (5).

These mandates too must be offered to insureds in fully insured plans and permitting an insurer to impose clinical criteria inconsistent with state law and generally accepted standards of care creates an uphill battle for regulators, who can only uncover these state law violations upon resource-intensive investigations. If the district court judgment were reversed, it could foreclose an important adjunctive avenue for the insureds directly injured by application of these complex (and deceptive) clinical criteria to pursue relief directly under ERISA when it appears state law has been violated.

Amici States have been fighting on behalf of the people within their borders with substance use disorders and mental health needs to provide life-saving care at a time when these conditions are a constant and growing threat to public health. Alongside traditional provision of public health services, Amici States have worked

to create insurance regulatory frameworks to make sure that insureds in their states have access to necessary treatment. These frameworks are enforced by state regulators, but the claims of those directly affected under ERISA are important adjunctive enforcement tools. The panel therefore decided an issue of exceptional importance with potential to adversely affect the health and well-being of insureds in Amici States.

CONCLUSION

Because state law required compliance with the ASAM Criteria, and UBH concedes that it failed to comply with those criteria, affirmance at least as to the State Mandate class was warranted. Because the panel decision appears to overturn the entirety of the judgment, the Amici States respectfully request that the petition for rehearing be granted to clarify that this uncontested issue was not reversed by the panel decision. Alternatively, if the panel intended to reach the district court's findings as to the State Mandate class, Amici States agree with plaintiffs that such a decision was incorrect and should be reconsidered. Finally, for the reasons explained above and those set forth by plaintiffs, the Amici States urge this Court to grant rehearing on the claims arising under the UBH Plans.

May 16, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of May 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

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This brief contains 4,048 **words**, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

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- ○ complies with the length limit designated by court order dated _____.
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Signature s/Maria R. Lenz **Date** May 16, 2022

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APPENDIX

RHODE ISLAND HOUSE OF REPRESENTATIVES
2015

REPORT OF THE COMMITTEE ON CORPORATIONS

6-23-2015
DATE

Bill Number: H-5537 Principal Sponsor Representative Slater

Short Title:

To the Speaker of the House

On a Motion by Representative: Marcello, seconded by Representative Nardolillo,
the Committee, by a vote of 13 to 0, agreed to
recommend to the House the following action on the above referenced bill: H-5537

- ☐ Passage
- ☑ Passage of the bill as amended or in substitution form H-5537 Sub A
- ☐ No passage
- ☐ Without recommendation
- ☐ Held for further study

Member	*Yea*	*Nay*	*Absent*	*Abstain*
Brian Patrick Kennedy - Chair	☑	☐	☐	☐
William W. O'Brien - Vice Chair	☐	☐	☑	☐
Mary Messier - Secretary	☑	☐	☐	☐
Stephen Casey	☑	☐	☐	☐
Raymond H. Johnston	☑	☐	☐	☐
Katherine Kazarian	☑	☐	☐	☐
Charlene Lima	☐	☐	☑	☐
Michael Marcello	☑	☐	☐	☐
Kenneth Marshall	☐	☐	☑	☐
Michael Morin	☑	☐	☐	☐
Robert Nardolillo III	☑	☐	☐	☐
Jared Nunes	☑	☐	☐	☐
Jeremiah O'Grady	☑	☐	☐	☐
Robert Phillips	☑	☐	☐	☐
Sherry Roberts	☐	☐	☑	☐
Joseph Trillo	☑	☐	☐	☐
Anastasia Williams	☑	☐	☐	☐
TOTALS	13 (Y)	0 (N)	4 (AB)	0 (AN)

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Gold-Bill file

Respectfully Submitted:

Chair Vice Chair Secretary

RHODE ISLAND GENERAL ASSEMBLY

House of Representatives

COMMITTEE ON CORPORATIONS

BILL # H – 5837 **DATE: April 7, 2015**

TITLE: Provide coverage for seven (7) days of residential or inpatient services for opioid treatment to be included within the appropriate classification.

SPONSOR: Representative Serpa

NAME/Represent	Contact Info	PRO	CON
David Spencer	DATA	✓	✓
John Tasson	Pharmacy Assoc	✓	
Mike Ryan	RI Council of Community Mental Health Orgs.	✓	
Shawn Donahue	Blue Cross Blue Shield RI		✓
Cecelia Pelkey	Hospital Assn of RI	5	
Steve Peloquin	RI Medical Soc	X	
Elizabeth Sievers	UHC		✓
Terry Martiello	AIDP		✓

Drug and Alcohol Treatment
Association of Rhode Island
Representing Treatment and Prevention Providers

Testimony for H-5837

- My name is David Spencer, I'm Executive Director of the Drug and Alcohol Treatment Association of RI.

- We represent nearly 30 agencies which provide a wide range of mental health and substance abuse treatment and prevention services in this state.

- We strongly support H-5837 – which would provide at least 7 days of residential or inpatient SA treatment services.

- As you all know, Rhode Island is experiencing a serious drug overdose problem. There have been many individuals and organizations involved in attempting to address this problem. BHDDH, the Health Department and the Governor's office have all been actively involved.

- In addition, we now have Recovery coaches in nearly all of the hospital emergency rooms to help when someone who overdoses is brought in.

- We need all the help we can get to help save lives and to assist individuals getting the help they need.

- This bill H-5837 - will do that

- Recently I conducted a survey of our treatment programs to determine if there were problems with getting approvals for drug detoxification and residential services.

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- I was shocked to fund that with just a handful of programs – we had over 250 individuals being denied prior authorization for inpatient treatment in the past year.

- These individuals had a prior clinical assessment based on ASAM criteria. There was no clinical reason to deny admission.

- Massachusetts just passed similar legislation and its currently being considered in other states. The federal government is also currently considering similar legislation.

Thank you for the opportunity to testify on this important issue.

David Spencer, MBA, MPA
Executive Director

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HARI **The Hospital Association of Rhode Island**
100 Midway Road – Suite 21
Cranston, Rhode Island 02920
(401) 946-7887

April 7, 2015

The Honorable Brian Patrick Kennedy
Chairman, House Corporations Committee
State House, Room 328
82 Smith Street
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members **support** bill H.5387 by Representative Patricia Serpa. The referenced legislation seeks to provide coverage for seven days of residential or inpatient treatment for opioid treatment.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids. We have been working with the Rhode Island Department of Health and provider community partners to reduce the misuse and abuse of opioids and other prescription drugs in our state. While the efforts have been having some success, there is still a great need to also connect individuals with necessary treatment, when needed.

Our members have strongly supported insurance coverage for anti-opioid and anti-opiate drugs, as well as drugs used for the treatment of substance use disorders. We believe this legislation is a necessary next step in supporting Rhode Islanders in need. Insurance coverage for seven days of residential or inpatient treatment for opioid addiction is needed to further address the serious rise of opioid addiction and overdoses facing our state.

We welcome the opportunity to work with you, Representative Serpa, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President

Below is a list of denials that were reported though there have been more. In all these cases medical necessity was reported during the Utilization review process and was still denied and received Lower Level of Care.

April 2015

BCBS	Denied detox – received Resi LOC

March 2015

2 BCBS	Both cases denied Detox received PHP LOC
2 UBH Exp	Both cases denied Detox received IOP LOC
1 – UBH	Denied Detox received PHP LOC
1 – NHP	

February 2015

2 – UBH Exp	Both cases denied Detox received IOP LOC
2 - UBH	

January 2015

- 3 – UBH
- 1 – UBH Exp

December 2014

- 6 – UBH
- 1 – UBH Exp
- 1 – Aetna
- 4 – NHP
- 1 – NHP Exp
- 3 – BCBS
- 1 – Empire BCBS - Detox Denied based on MD recommendation of Out Patient Detox

November 2014

- 6 – UBH
- 1 – UBH Exp
- 4 – NHP
- 3 – BCBS

October 2014

- 6 – UBH
- 1 – UBH Exp
- 2 – BCBS
- 5 – NHP
- 3 – NHP Exp
- 2 – Tufts

September 2014

3 – BCBS
4 – NHP
2 – NHP Exp
4 – UBH
2 – UBH Exp

August 2014

7 – UBH
4 – BCBS
2 – UBH Exp
4 – NHP
1 – NHP Exp

July 2014

7 – UBH
3 - BCBS