The Council of Autism Service Providers

WHAT YOU NEED TO KNOW ABOUT AUTISM, HEALTH INSURANCE, AND MENTAL HEALTH PARITY LAW

Lorri Unumb, Esq.
CEO, The Council of Autism Service Providers
April 20, 2022

LORRI SHEALY UNUMB, ESQ.

The Unumb Center
FOR NEURODEVELOPMENT

AUTISM SPEAKS®

AUTISM ACADEMY OF SOUTH CAROLINA

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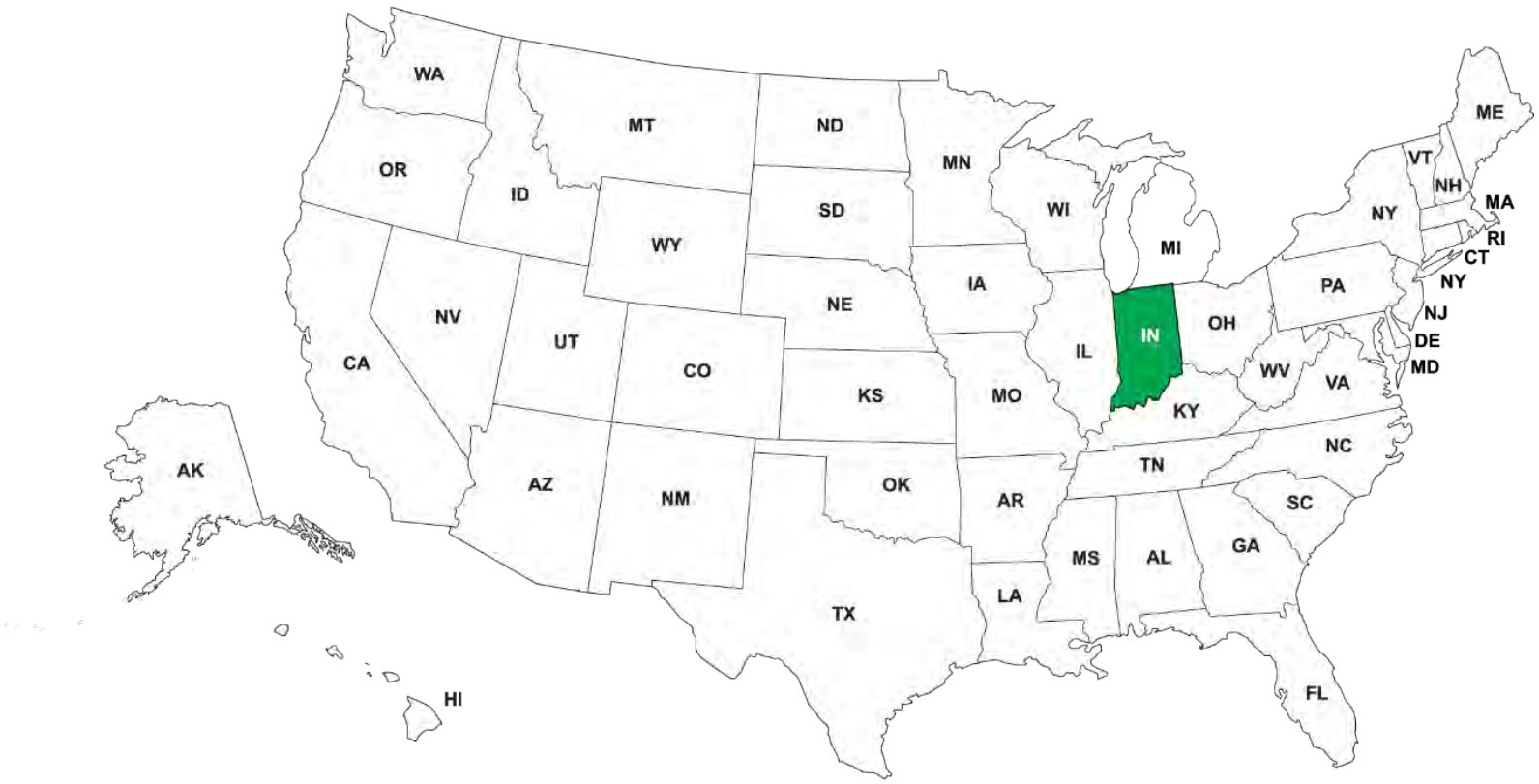
SOUTH CAROLINA Department OF Disabilities AND Special Needs

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Ryan, diagnosed at 22 months

2001 Snapshot



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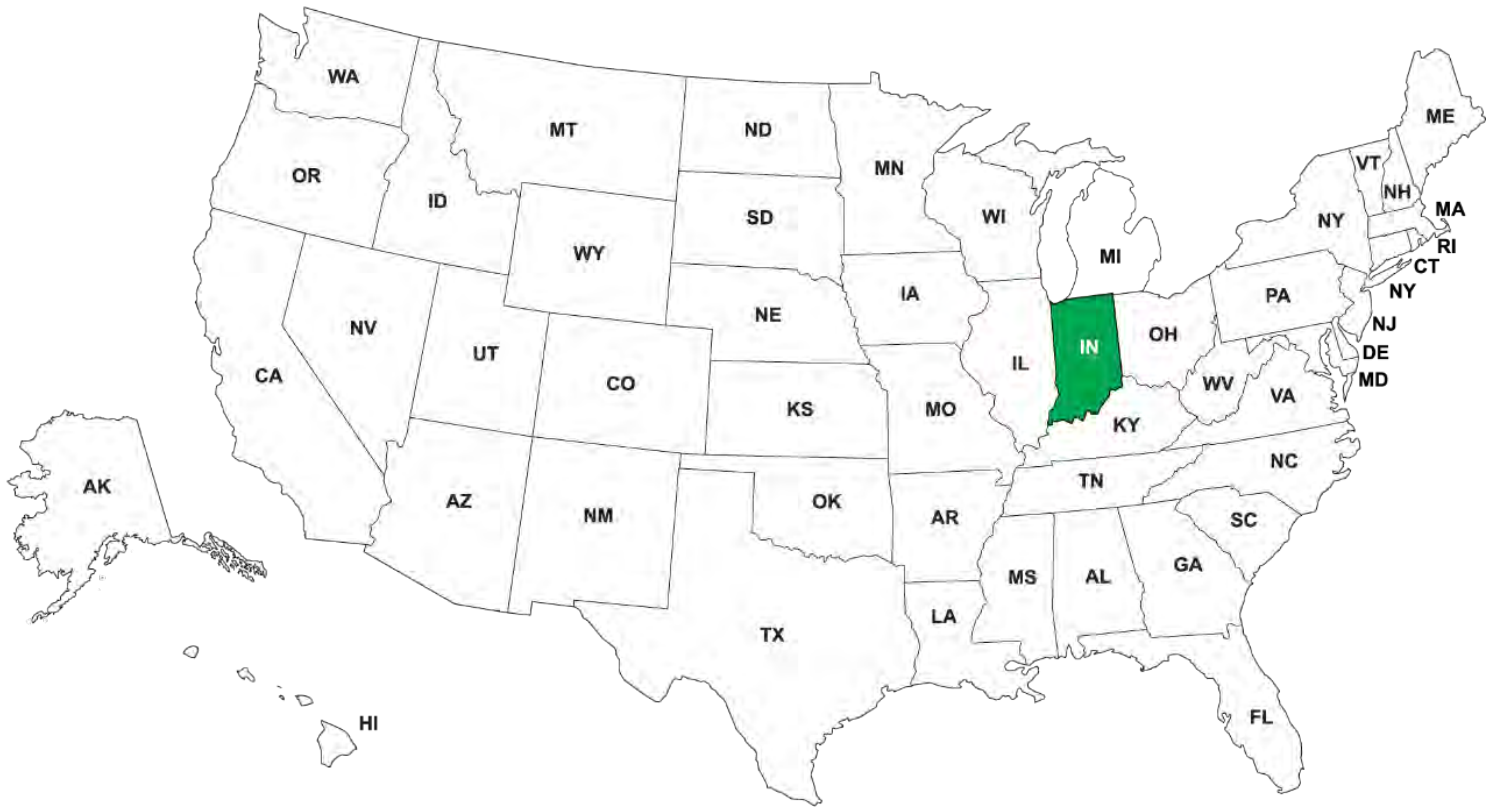
2002 Snapshot



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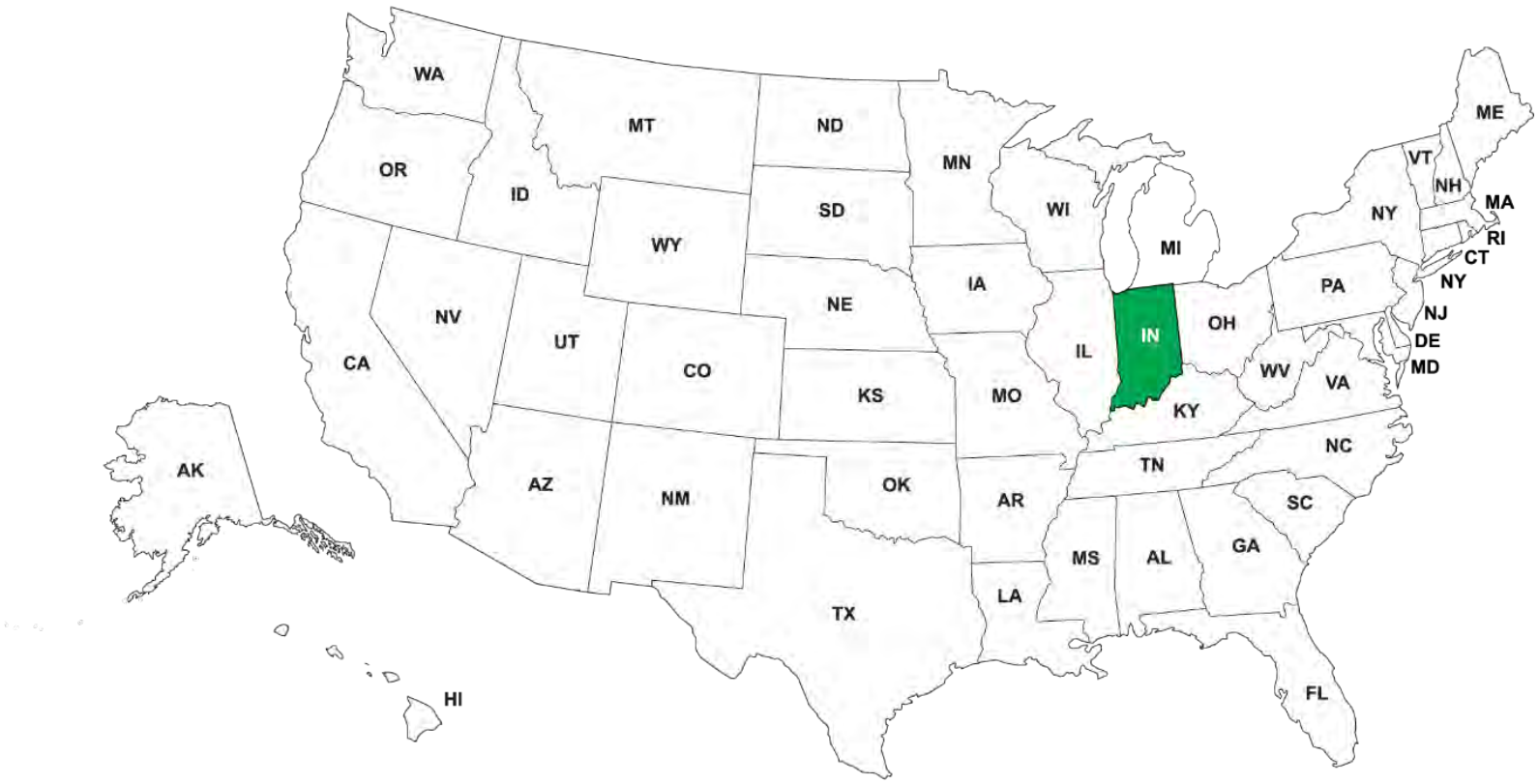

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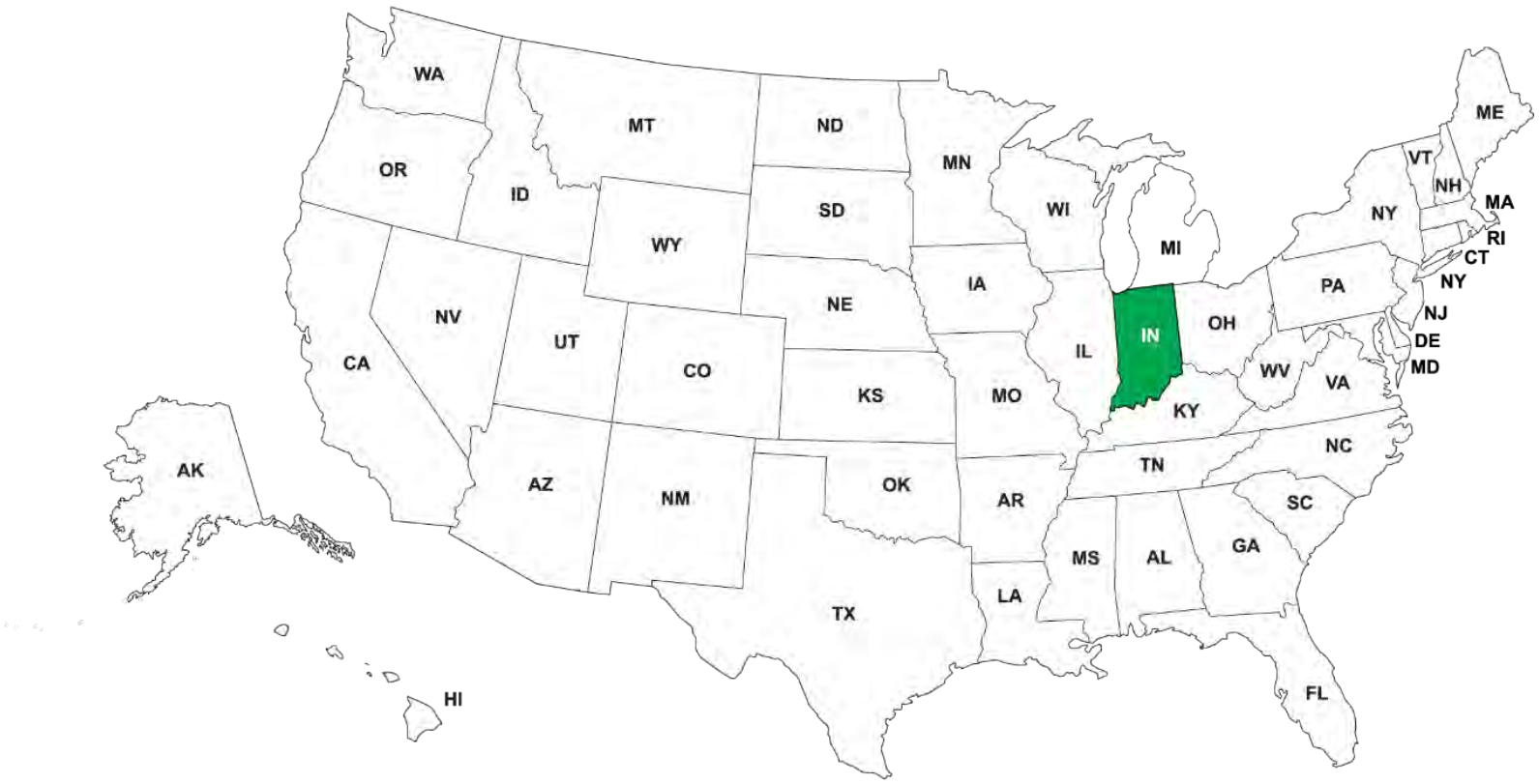
2004 Snapshot



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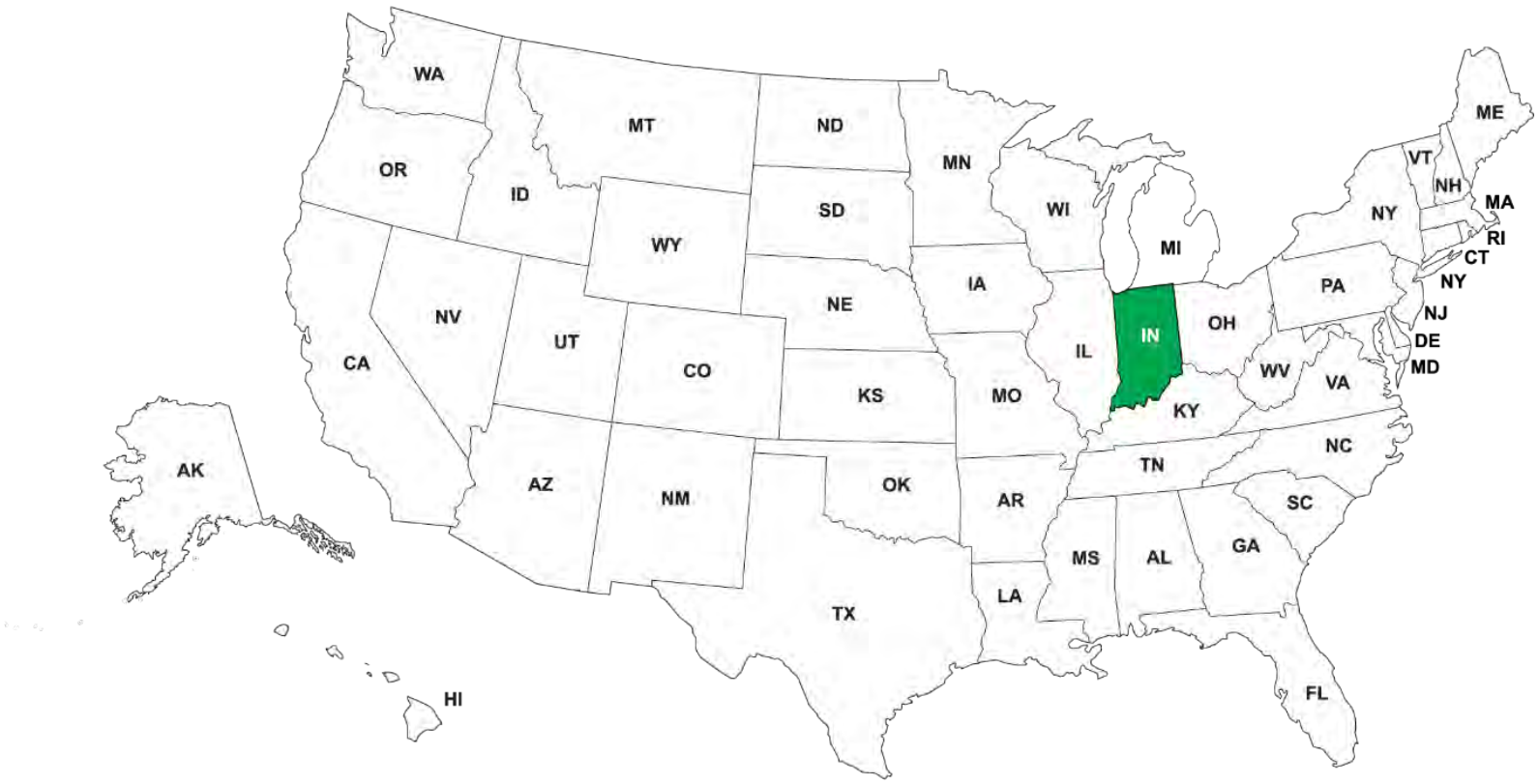
2005 Snapshot



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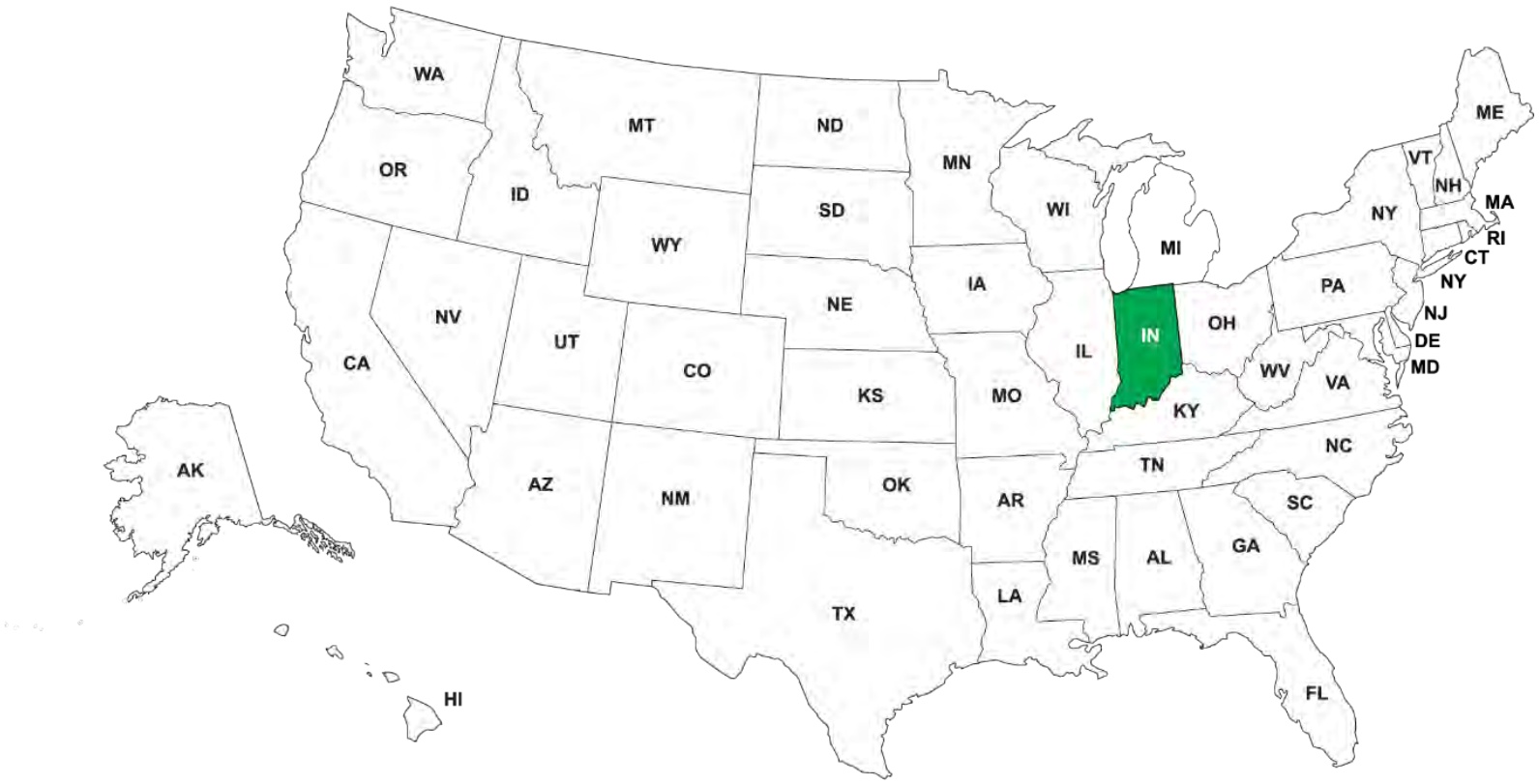
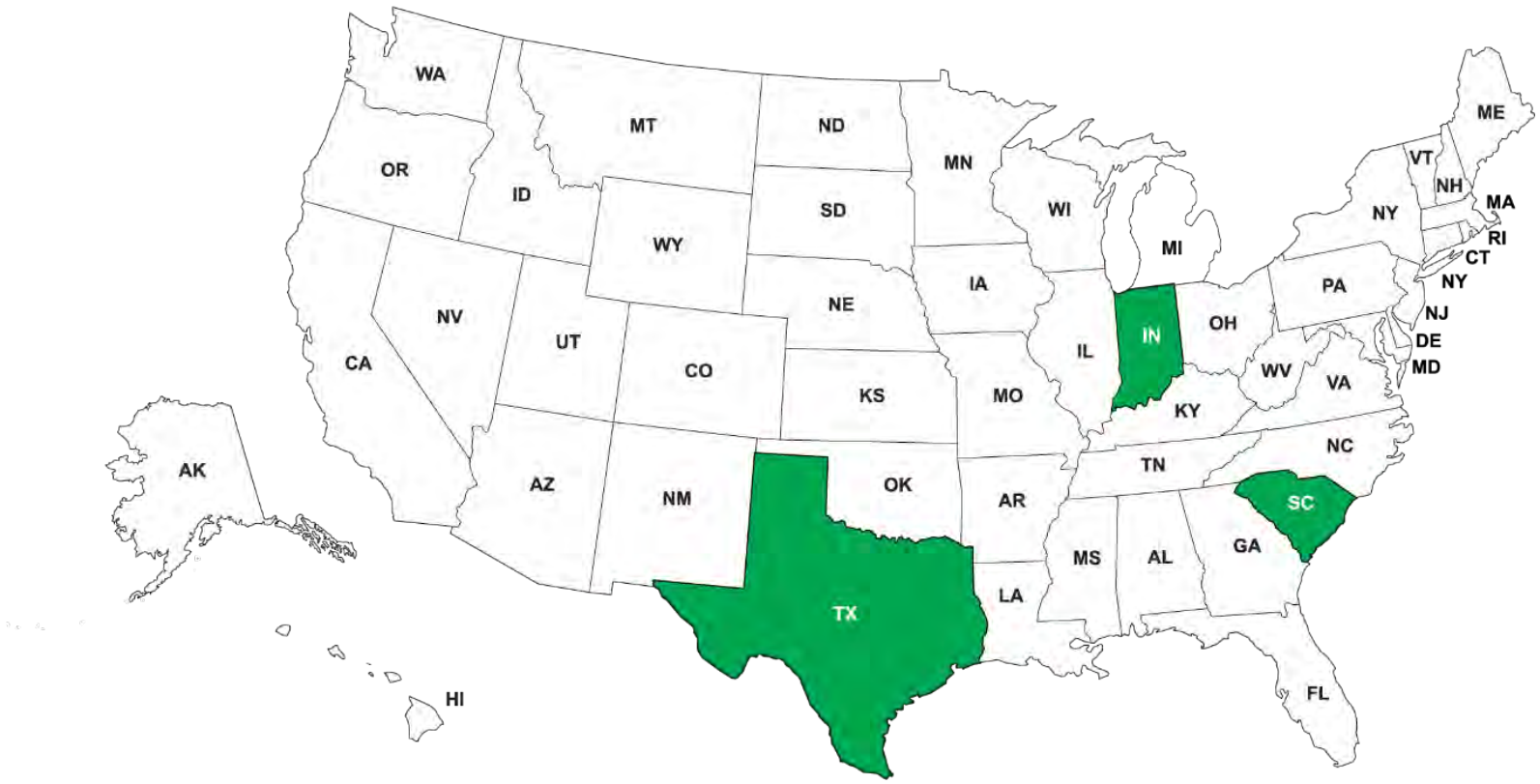
2006 Snapshot



2007 Snapshot

3



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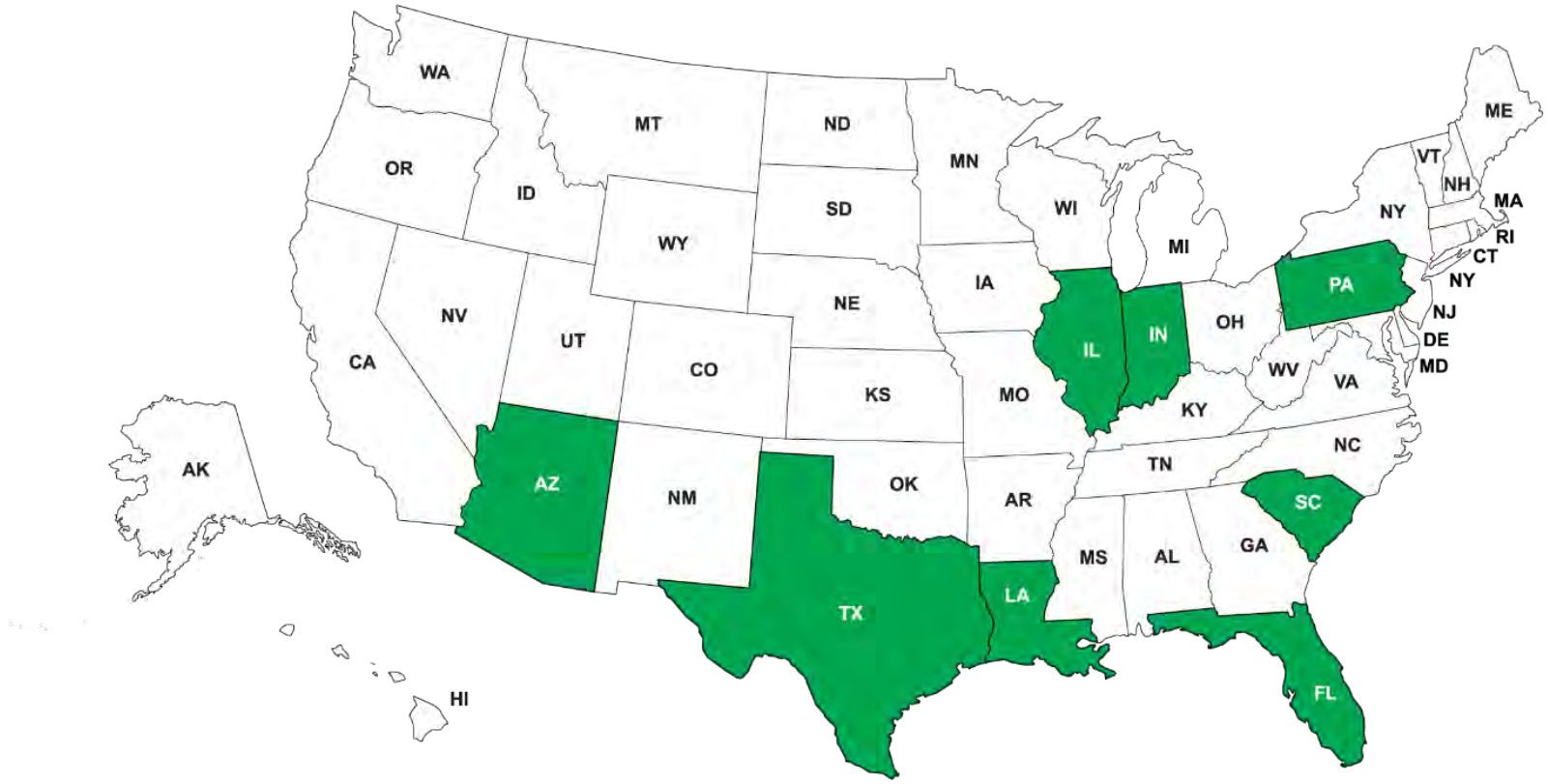
2008 Snapshot



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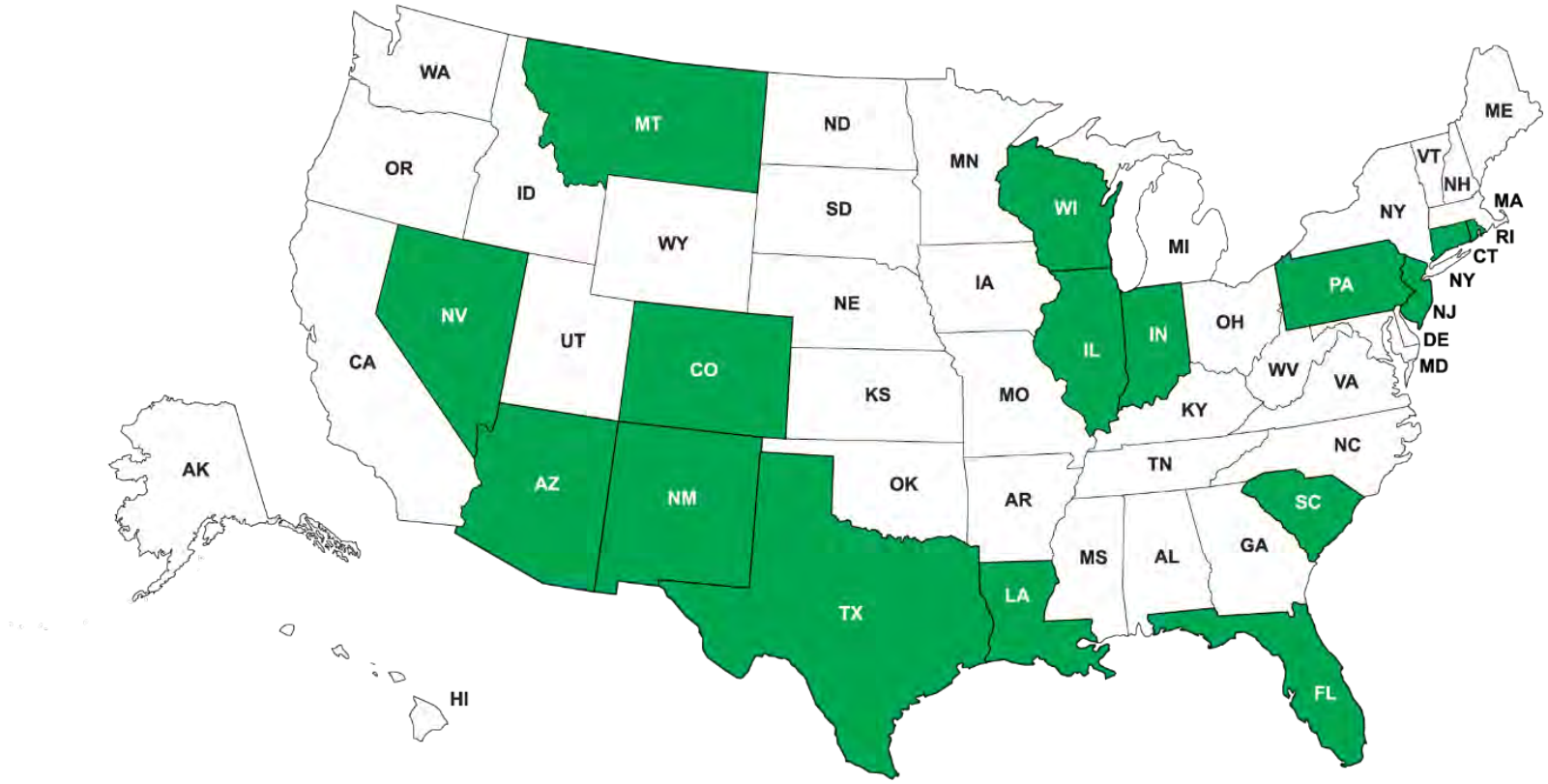

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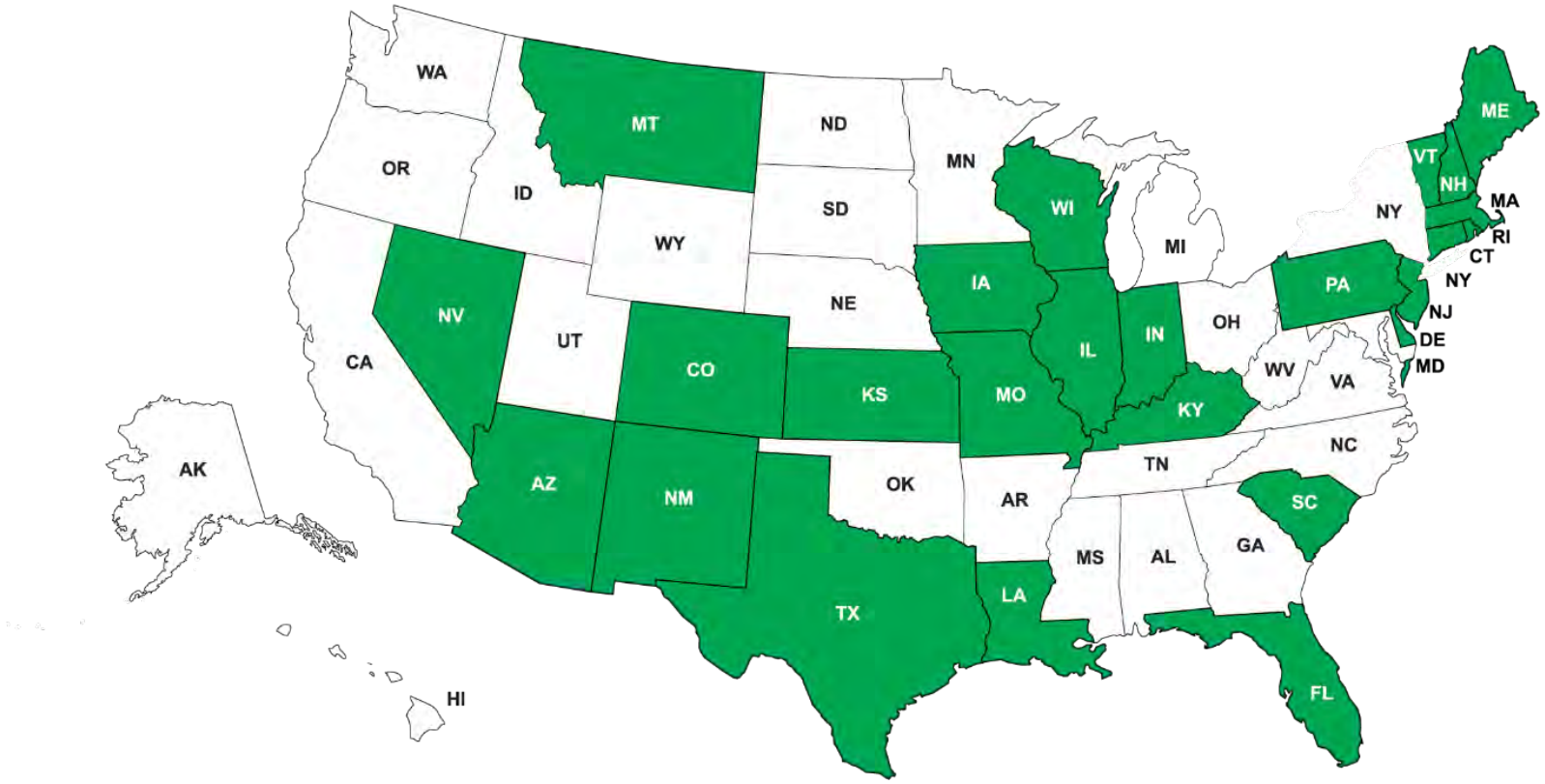

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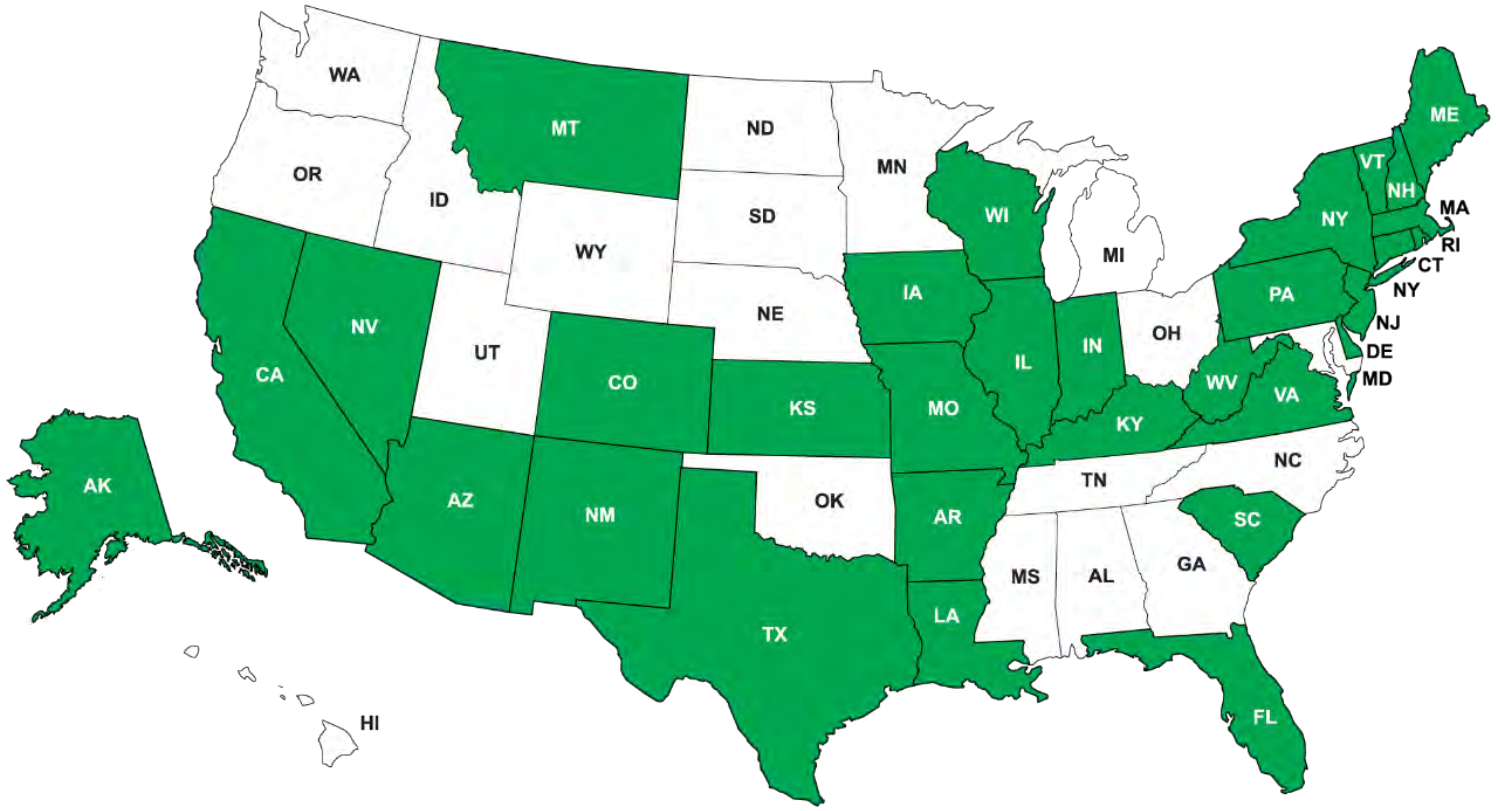

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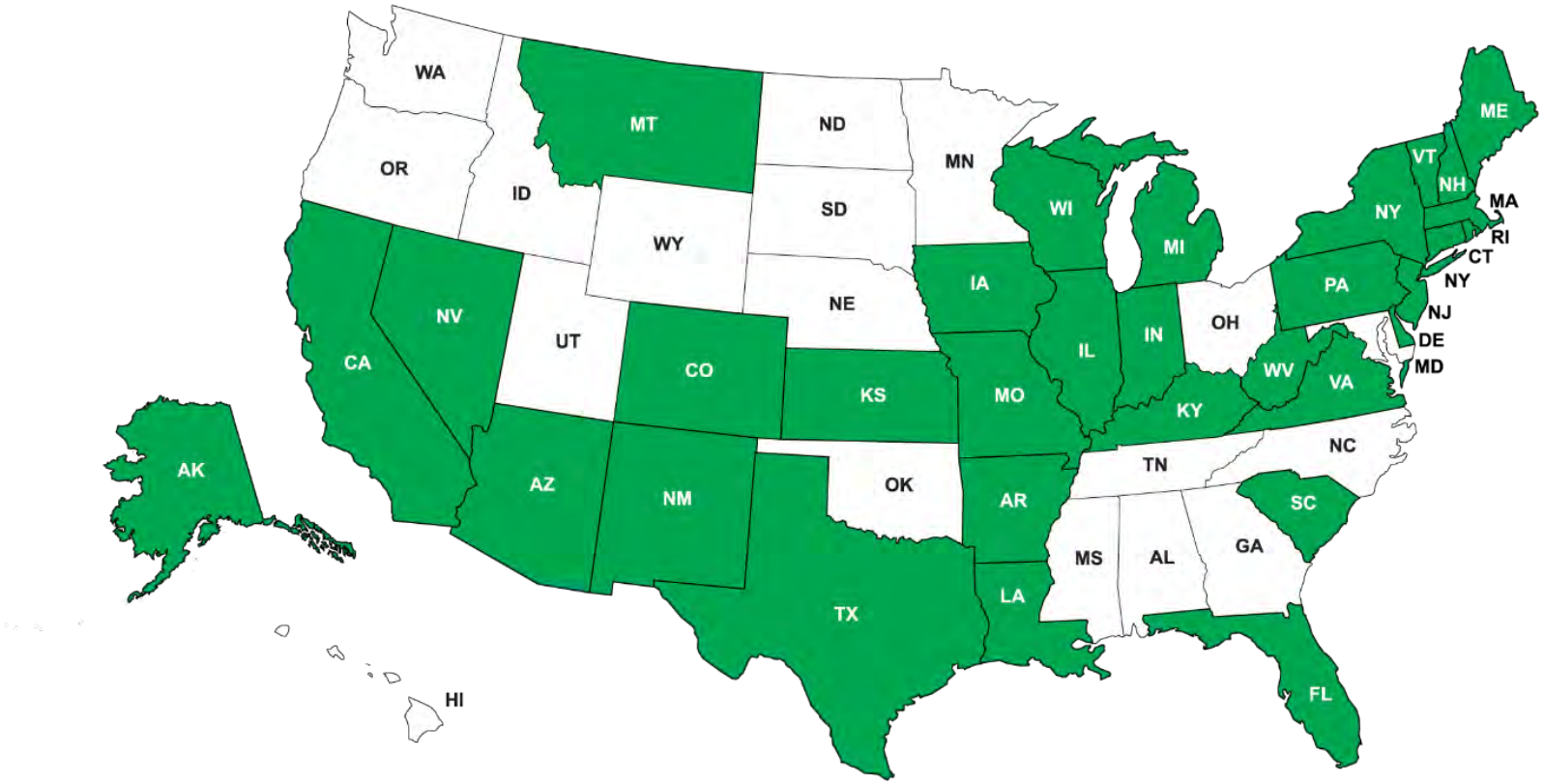
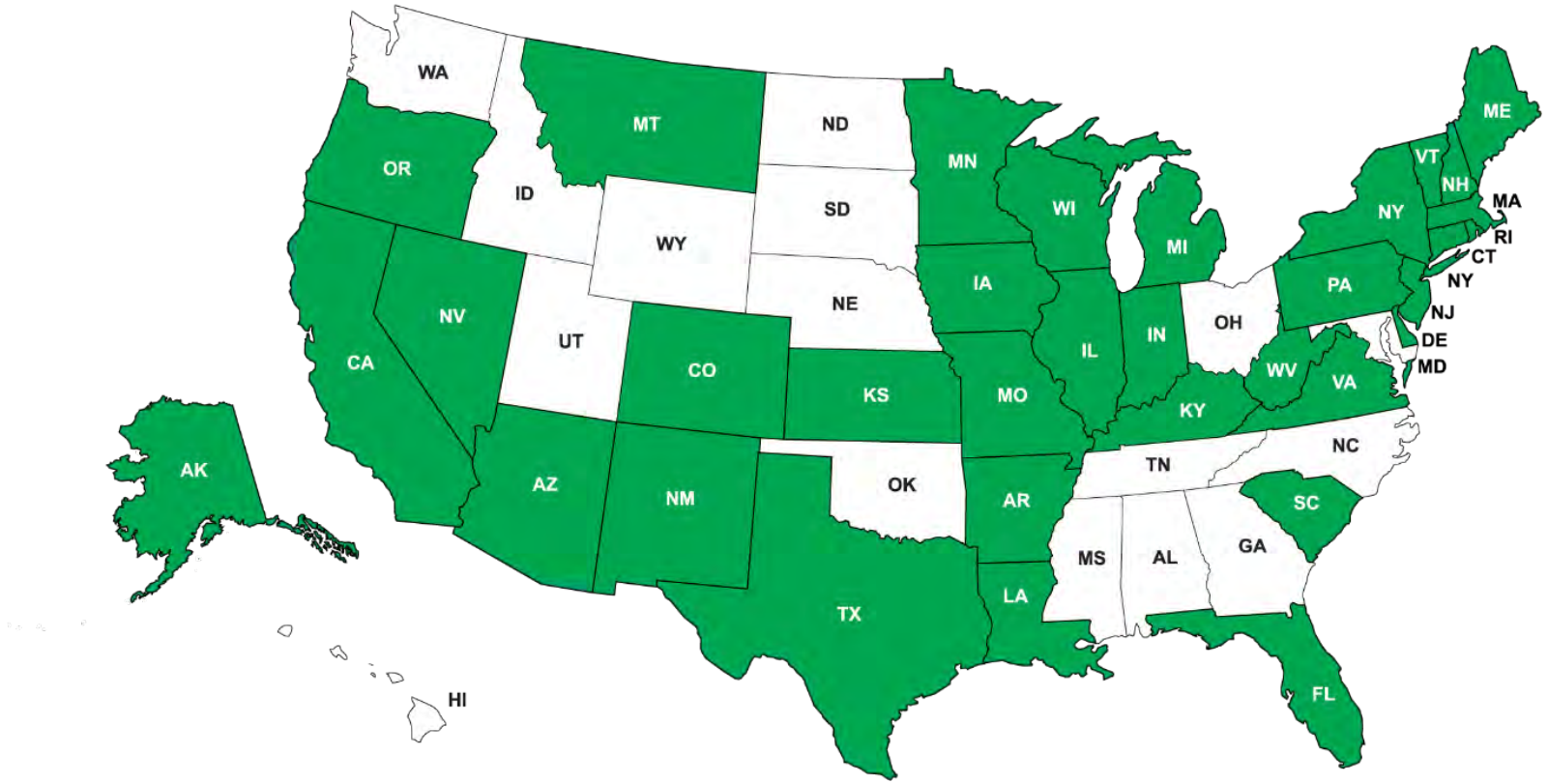


2013 Snapshot



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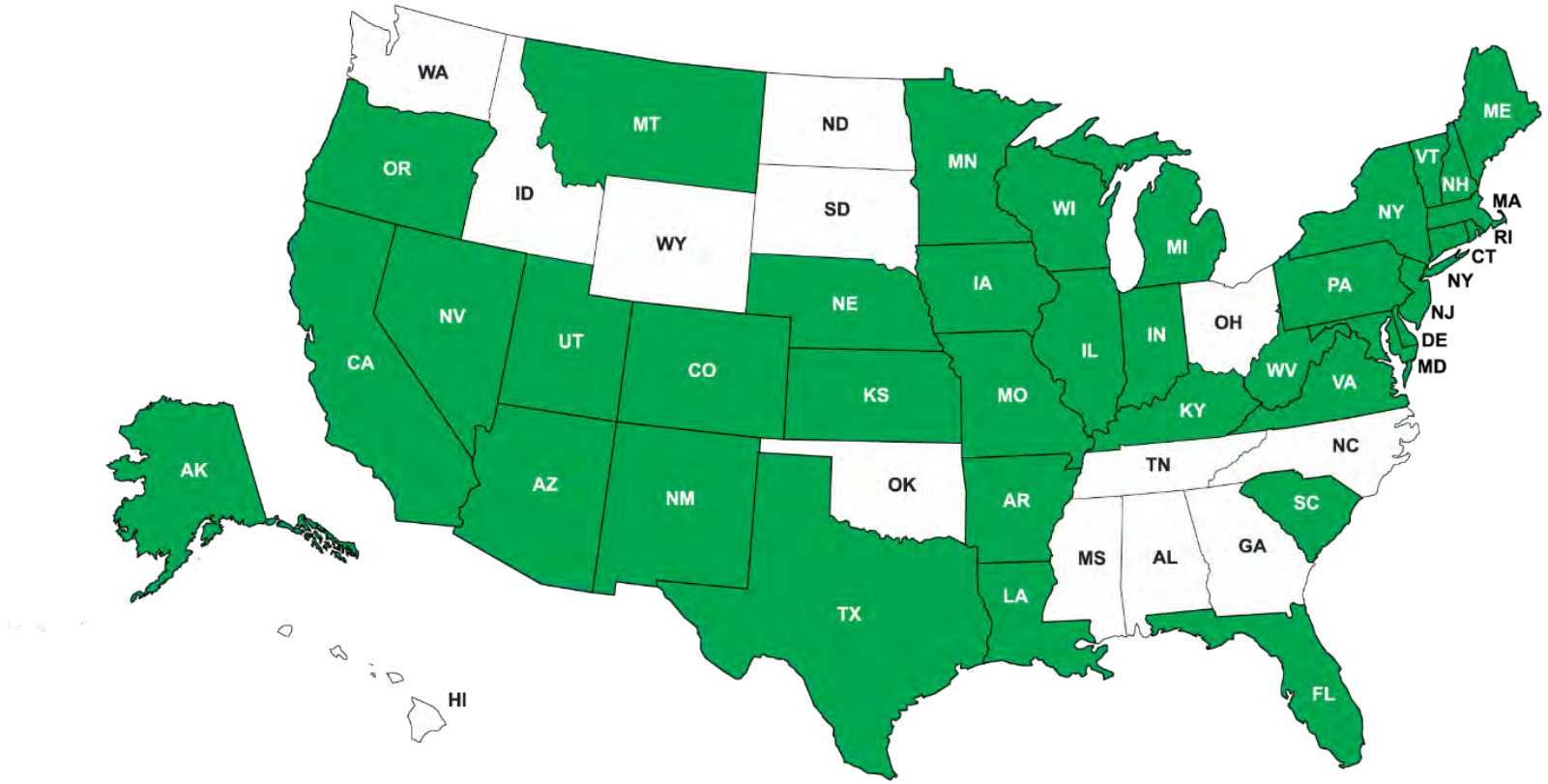
2014 Snapshot



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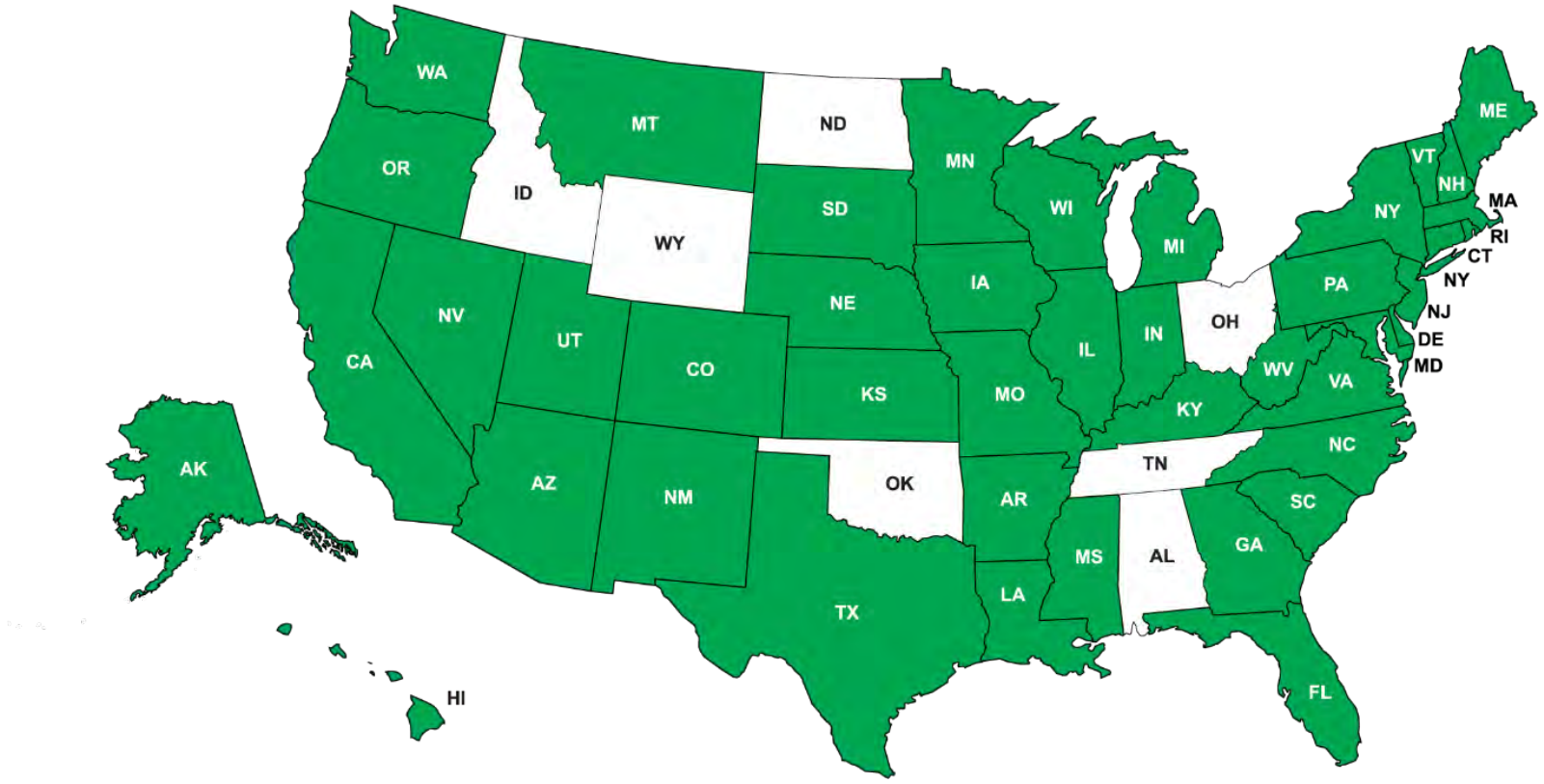
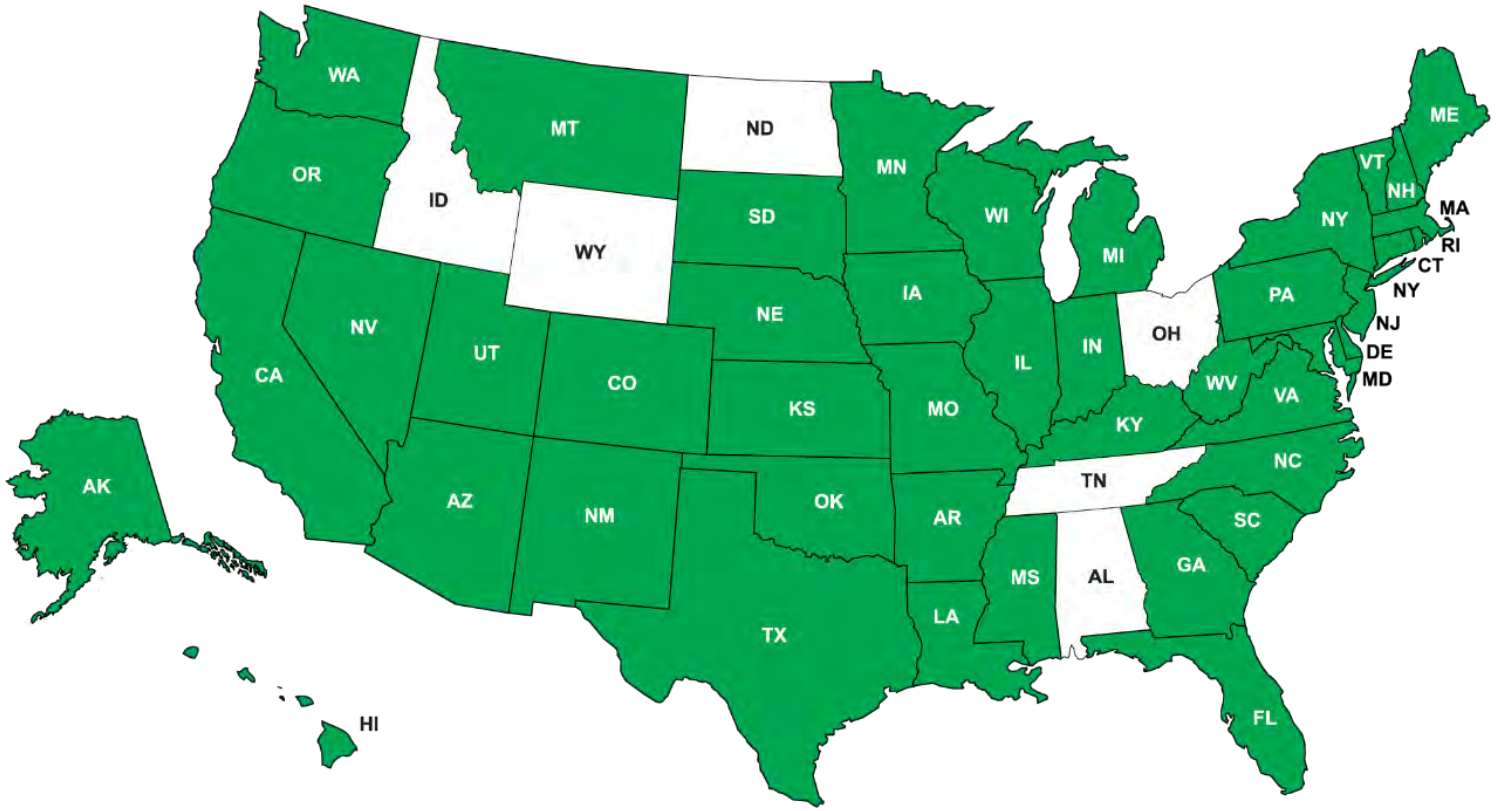
2015 Snapshot



2016 Snapshot



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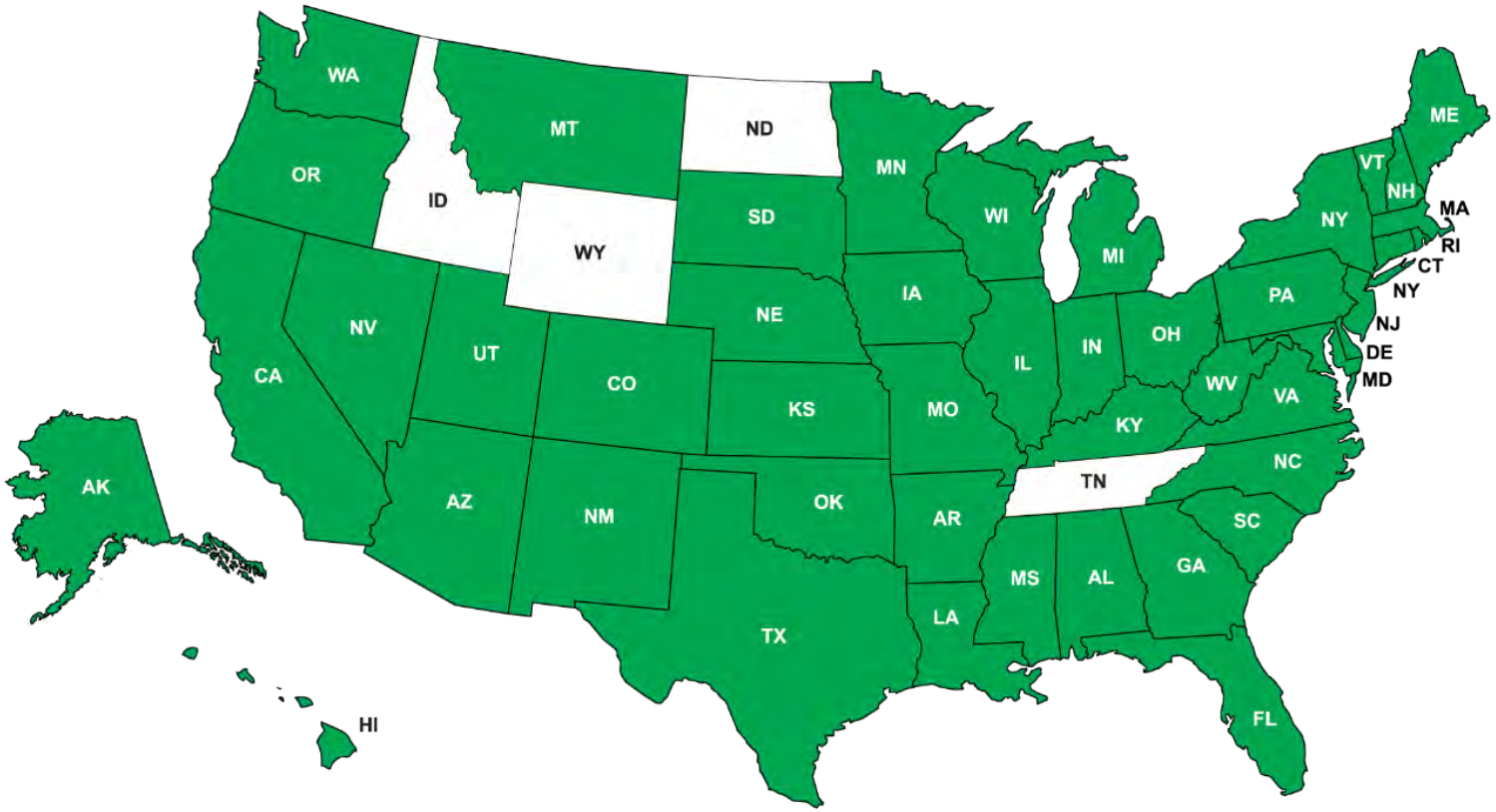
2017 Snapshot



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2018 Snapshot

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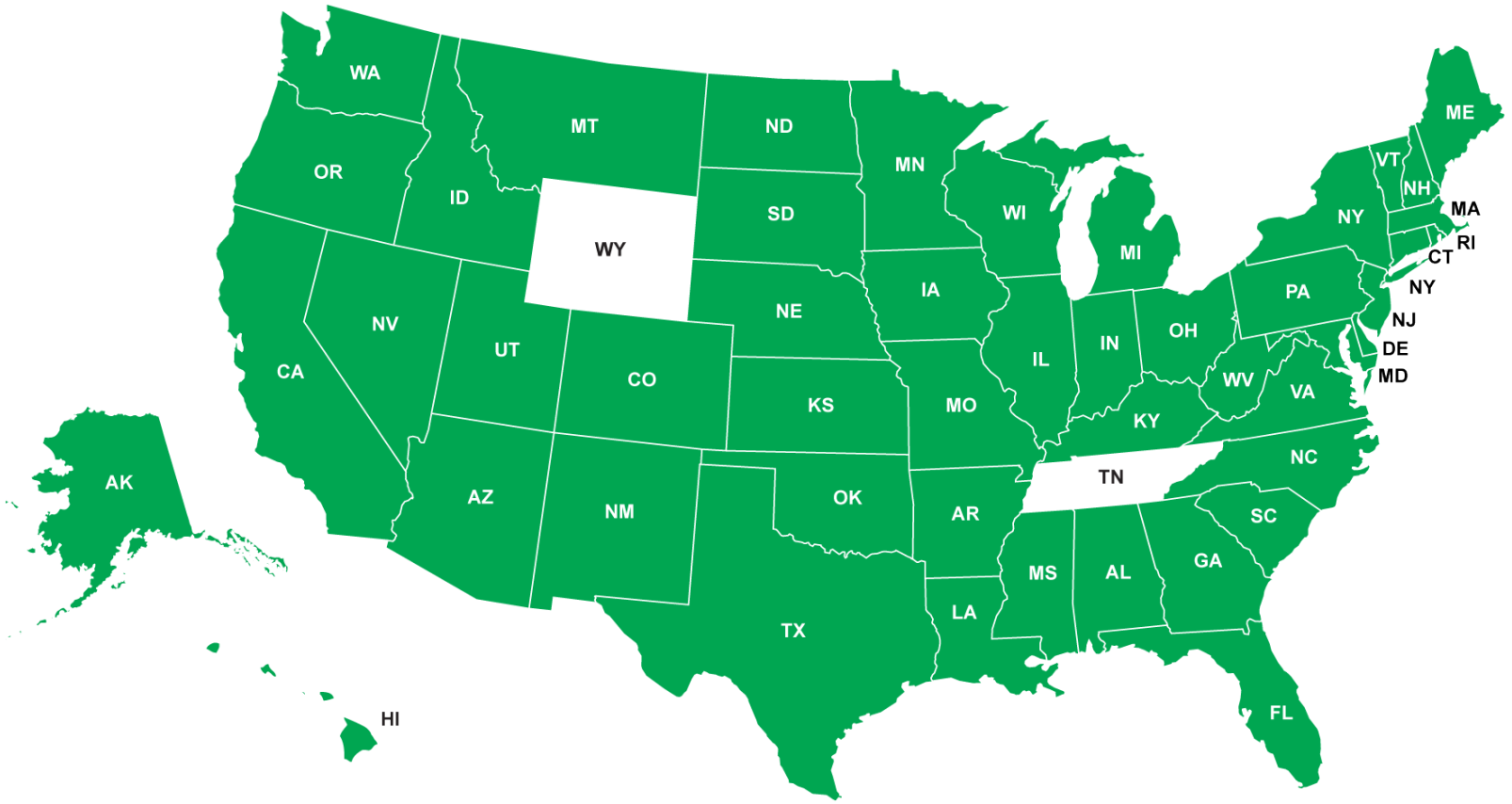

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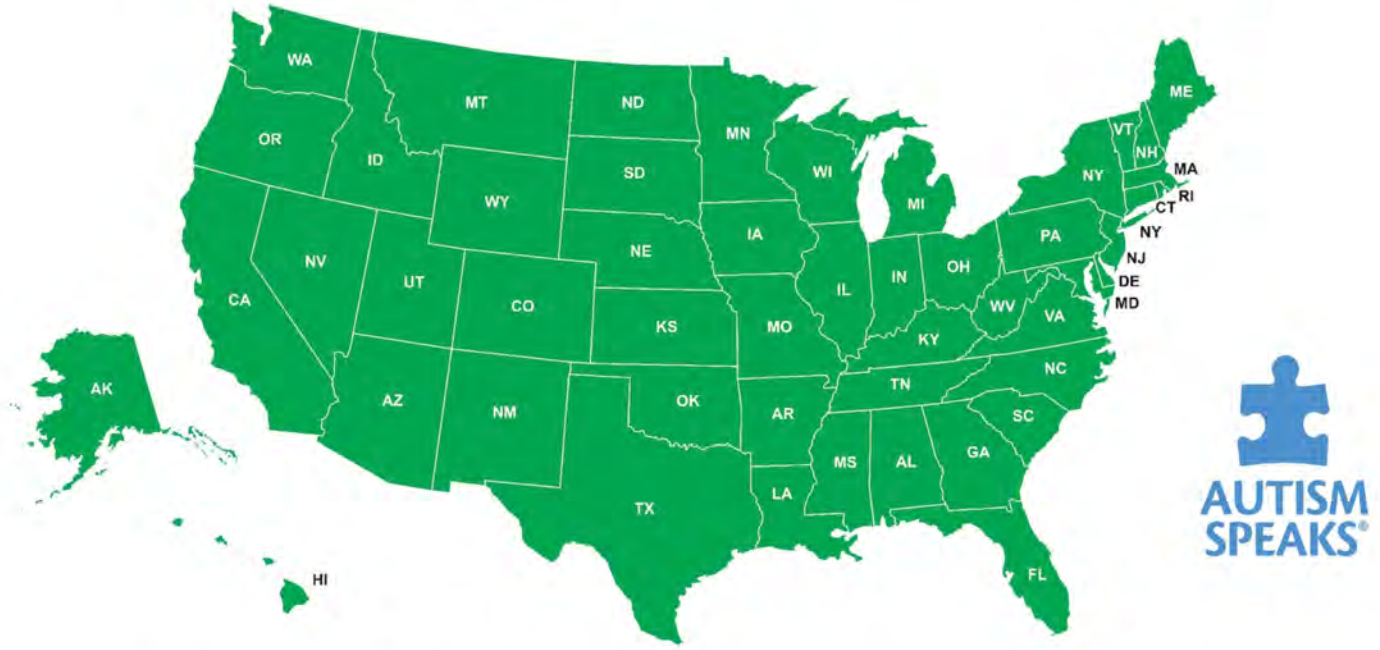
Autism Insurance Reform in 50 States



AUTISM SPEAKS®

2001 - Indiana	2009 - Connecticut	2010 - Missouri	2012 - Alaska	2015 - Georgia
2007 - South Carolina	2009 - Wisconsin	2010 - New Hampshire	2012 - Delaware	2015 - Hawaii
2007 - Texas	2009 - Montana	2010 - Massachusetts	2013 - Minnesota	2015 - North Carolina
2008 - Arizona	2009 - New Jersey	2011 - Arkansas	2013 - Oregon	2016 - Oklahoma
2008 - Florida	2009 - New Mexico	2011 - West Virginia	2014 - Maryland	2017 - Ohio
2008 - Louisiana	2010 - Maine	2011 - Virginia	2014 - Nebraska	2017 - Alabama
2008 - Pennsylvania	2010 - Kentucky	2011 - Rhode Island	2014 - Utah	2018 - Idaho
2008 - Illinois	2010 - Kansas	2011 - California	2014 - Washington	2018 - North Dakota
2009 - Colorado	2010 - Iowa	2011 - New York	2015 - South Dakota	2019 - Wyoming
2009 - Nevada	2010 - Vermont	2012 - Michigan	2015 - Mississippi	**2019 - Tennessee**

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Health Insurance and Autism

Is there coverage?

Is the coverage sufficient?

Are insurance plans providing the coverage in a fair and comprehensive way?

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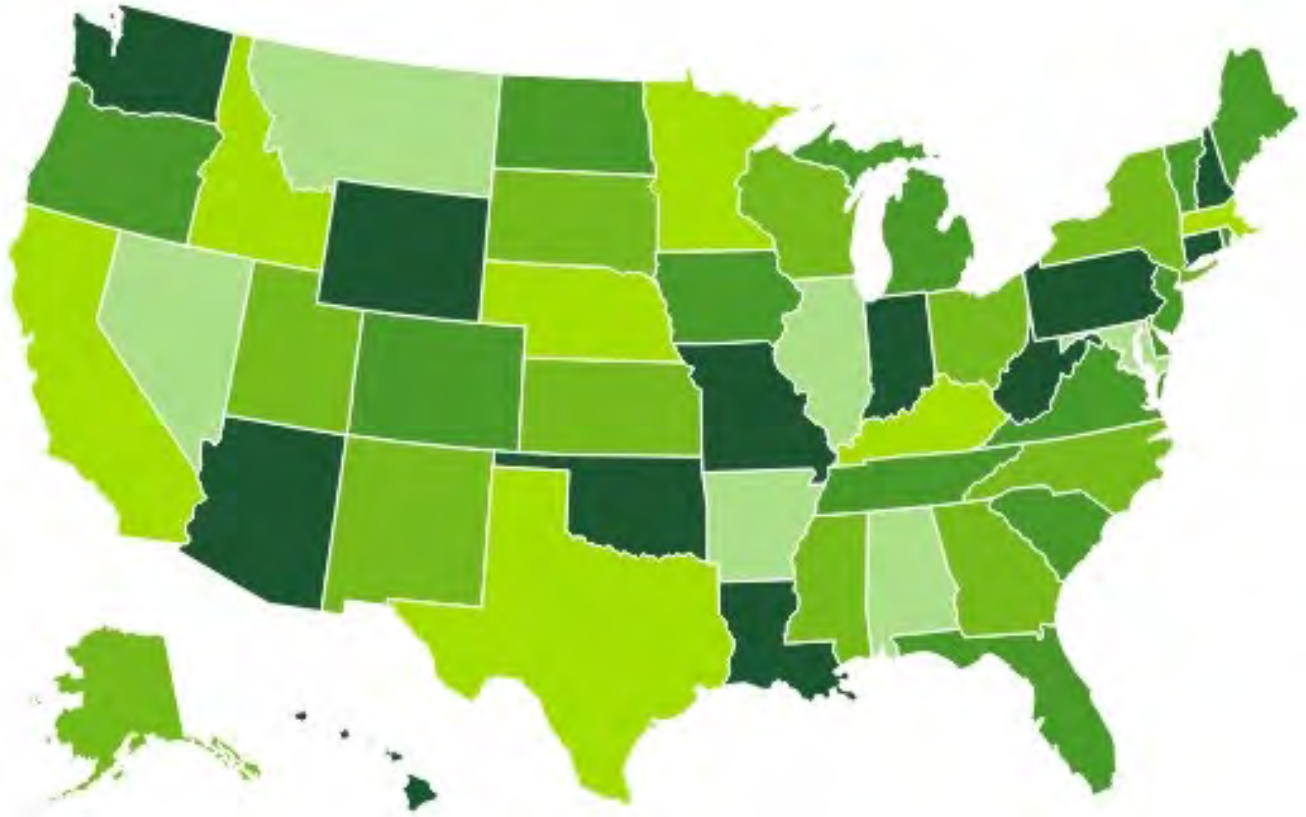
50 Shades of Green



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Gaps and Caps

Gaps in coverage
certain types of insurance plans not subject to the autism insurance law

Caps on coverage
restrictions on age or dollars spent or visits

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GREEN STATE GRID

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Insurance Markets		AL	AK	AR	AZ	CA	CO	CT	DE	DC	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS
Fully Funded	Large Group																										<100
	Small Group														?												MO
	Individual	BCBS													?		MO									MO	
State Health Plan															?												?
QHPs under ACA		COM									NSG	COM		NSG				COM						XO	NSG		COM
EPSDT	Medicaid																										

Insurance Markets			MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Fully Funded	Large Group																										
	Small Group																									<25	
	Individual									MO																	
State Health Plan																								?			
QHPs under ACA				COM		COM						XO	COM		NSG	NSG	NSG	COM	NM		Not SHOP	NSG					NM
EPSDT	Medicaid																										

Row 2 & 3, Small Group & Individual Plans: Includes only grandfathered plans

Row 4, State Health Plans: SHPs are technically self-funded plans, but are subject to regulation by the state

Row 5, QHPs under ACA: Under the Affordable Care Act, Qualified Health Plans must include Essential Health Benefits (EHB), whether the plan is sold on or off a Marketplace.

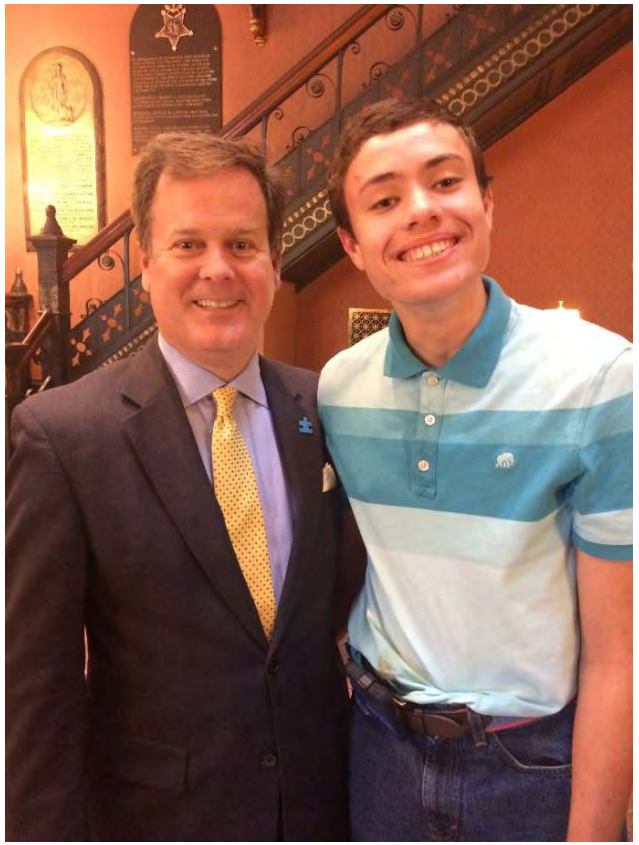
EFFECT OF ACA REPEAL

- ACA repeal could be helpful because the mandate applies to I/SG plans other than ACA plans (QHPs).
- ACA repeal could be helpful because the state could mandate benefits in I/SG without incurring cost.
- ACA repeal will be detrimental because people who currently have ABA benefits in I/SG policies will lose them.

Table of Abbreviations

MO = Mandated Offering (mandate requires only an offer of coverage)
COM = Carved Out of Mandate (QHPs were carved out of the state's autism insurance mandate)
NSG = No Small Group (the state autism insurance mandate does not apply in the small group market, and the state chose or defaulted to a small group plan as its benchmark for QHP benefits)
XO = Executive Order (the executive ordered ABA to be considered a "habilitative service" and thus included in EHB)
NM = No Mandate

Ryan’s Law – still has gaps



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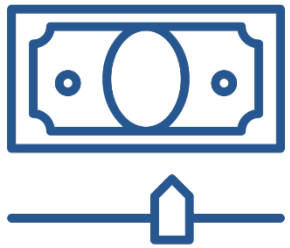
Basics of Mental Health Parity



Mental health parity laws mean that insurers may not limit mental and addiction coverage more than they limit medical and surgical coverage

Because autism spectrum disorder is defined as a mental health condition, parity laws apply

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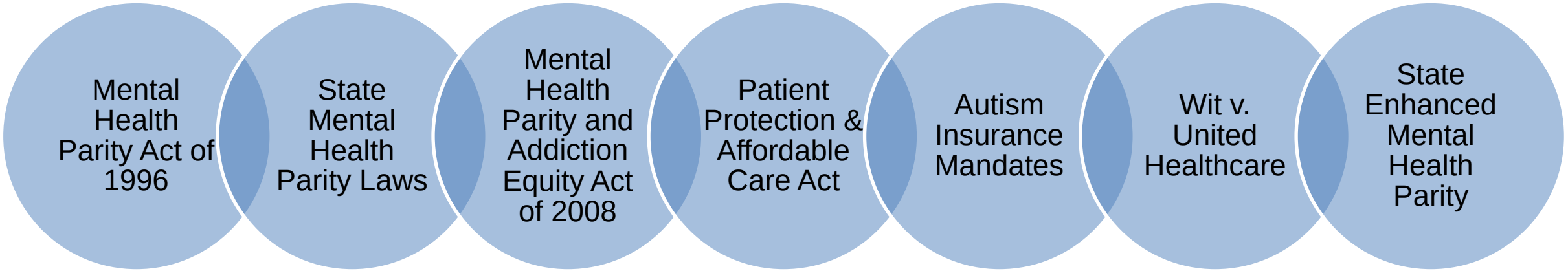

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Mental Health Parity Act of 1996

The federal Mental Health Parity Act, which went into effect on January 1, 1998, prohibited health plans from setting **annual or lifetime dollar limits** on an enrollee's mental health benefits that are lower than any such limits on other medical care.

This federal requirement did not apply to employers with fewer than 50 employees.

Some health plans responded to the prohibition on monetary limits by instituting limits on patient visits, treatment sessions, and hospital lengths of stay.

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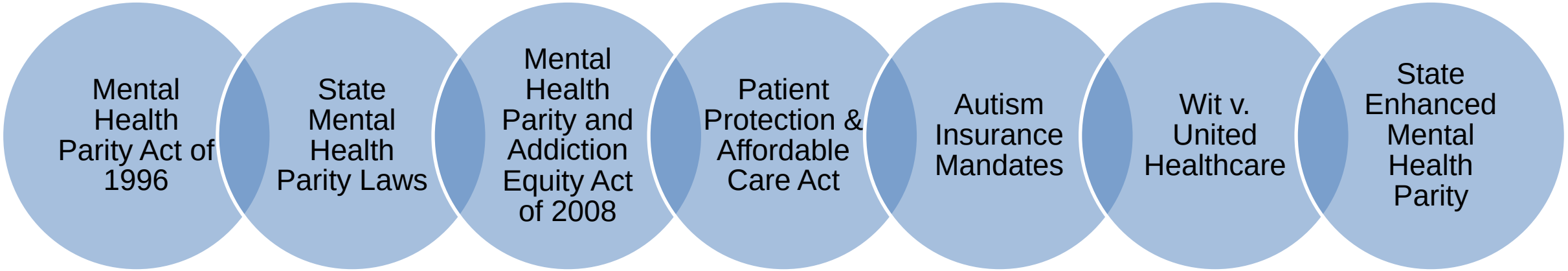

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Requires insurers to provide coverage for the severe mental illnesses of a person of any age, and for the serious emotional disturbances of a child.

Defines "severe mental illnesses" as including:

a) Schizophrenia;

b) Schizoaffective disorder;

c) Bipolar disorder (manic depressiveness);

d) Major depressive disorders;

e) Panic disorder;

f) Obsessive-compulsive disorder;

g) Pervasive developmental disorder or autism;

h) Anorexia nervosa; and

i) Bulimia nervosa.

3)Defines "serious emotional disturbances of a child" as a child who has one or more mental disorders, other than substance abuse or developmental disability, identified in the Diagnostic and Statistical Manual of Mental Disorders.

4)Requires severe mental illness benefits to include outpatient and inpatient services, hospital services, and prescription drugs if a plan contract or insurance policy otherwise covers prescription drugs.

5)Requires terms for maximum lifetime benefits, copayments and deductibles to be applied equally to all benefits under a plan contract or insurance policy.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Prohibits differential financial requirements or treatment limitations on mental healthcare

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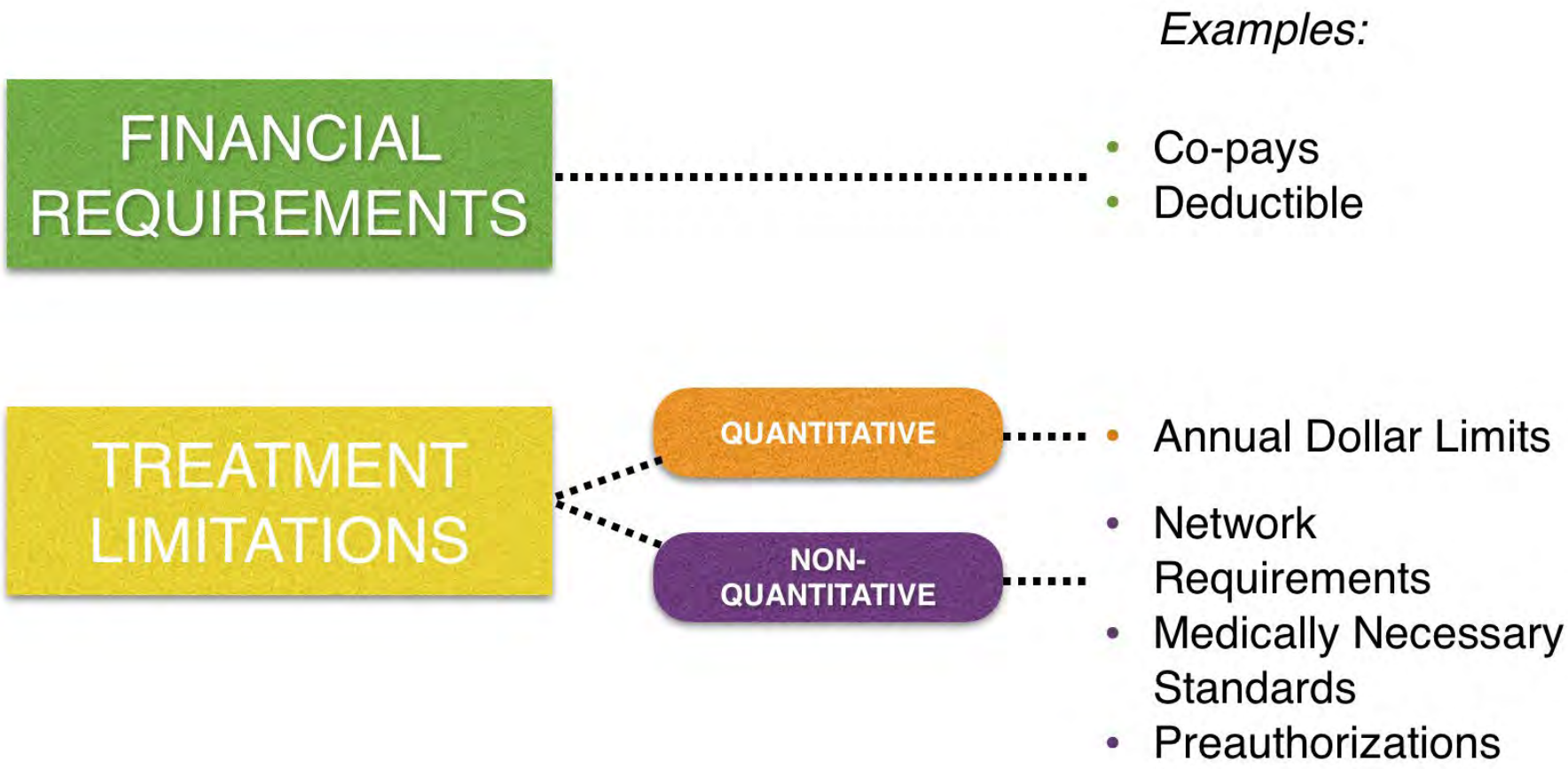
Mental Health Parity Law Prohibits Disparate:



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Mental Health Parity Law Can Help With All Three

Is there coverage?

Is the coverage sufficient?

Are insurance plans providing the coverage in a fair and comprehensive way?

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DEAN CAMERON
Director of the Idaho Department of Insurance

State of Idaho
DEPARTMENT OF INSURANCE

C.L. "BUTCH" OTTER
Governor

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P.O. Box 83720
Boise, Idaho 83720-0043
Phone (208)334-4250
Fax (208)334-4398
Website: https://doi.idaho.gov

DEAN L. CAMERON
Director

BULLETIN NO. 18-02

DATE: April 2, 2018

TO: Disability/Health Insurance Carriers offering Health Benefit Plans, Self-funded Plans

FROM: Dean L. Cameron, Director

SUBJECT: Clarification Regarding Coverage of Treatments for Autism Spectrum Disorder

Due to the currently inconsistent coverage of treatments for autism spectrum disorder by Idaho health plans, the Department of Insurance is clarifying that such treatments cannot be excluded from coverage if rehabilitative or habilitative services are covered. All health benefit plans (as defined in Idaho Code section 41-5203(12))[1] regulated by the Department and subject to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and Section 1557 of the Affordable Care Act, including the individual, small group, and large group insured markets and self-funded health benefit plans subject to Idaho Code, title 41, chapters 40 or 41, must follow the guidance in this bulletin for plan years starting on or after January 1, 2019.

The Department understands that if a group health plan or health insurance coverage includes medical/surgical benefits and mental health/substance use disorder benefits, under the MHPAEA an applicable health plan cannot impose limitations on a numerical basis, e.g. financial, visit limits or day limits (quantitative); or other basis, e.g., medical management, (non-quantitative); unless, under the terms of the plan any such limitation of MH/SUD benefits such as treatments for autism is

1 OF 2

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JON GODFREAD
Commissioner of the North Dakota Department of Insurance

North Dakota
Insurance Department
Jon Godfread, Commissioner

BULLETIN 2018-1

TO: Insurance Carriers offering Health Insurance Policies in North Dakota

FROM: Jon Godfread, Commissioner

DATE: July 10, 2018

SUBJECT: Coverage of Treatments for Autism Spectrum Disorder

Pursuant to the authority granted to the Commissioner by N.D.C.C. § 26.1-02-29, the Insurance Department issues this Bulletin to notify all health insurance carriers choosing to cover Autism Spectrum Disorder that treatments for Autism Spectrum Disorder cannot be excluded from an insurance policy. All grandfathered and transitional health insurance policies regulated by the Department, including the individual, small group, and large group insured markets, must follow the guidance set forth in this Bulletin beginning no later than October 1, 2018. All non-grandfathered health insurance policies regulated by the Department including the individual, small group, and large group insured markets, and all self-funded Multiple Employer Welfare Arrangement health benefit plans regulated by the Department, must follow the guidance in this Bulletin beginning no later than January 1, 2019.

If a health insurance policy includes both medical/surgical benefits and mental health/substance use disorder benefits, under the Mental Health Parity and Addiction Equity

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Doe v. United Behavioral Health

United Health argued that a total ABA exclusion is not a violation of the Mental Health Parity and Addiction Equity Act.

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This action raises the issue of whether the ABA Exclusion violates the Parity Act which provides in pertinent part:

(A) In general. In the case of a group health plan … that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that –

***

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are ***no more restrictive*** than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan ... and there are ***no separate treatment limitations*** that are applicable only with respect to mental health or substance use disorder benefits.

Here, the ABA exclusion only applies to mental health disorders. It reads:

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations* , the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders – Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details.*

***

8. Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.

On its face, the ABA exclusion creates a separate treatment limitation applicable *only* to services for a mental health condition (Autism). By doing so, the exclusion violates the plain terms of the Parity Act.

Not only does the exclusion violate the "separate" treatment limitations in the Act, but it also contravenes the Parity Act by requiring "more restrictive [limitations] than the predominant treatment limitations applied to substantially all medical and surgical benefits[ ]." … The exclusion carves out and rejects from coverage a *core* treatment for Autism: ABA therapy. As Doe correctly highlights, there are no comparable medical/surgical exclusions in the Wipro Plan. Thus, the exclusion, which excludes coverage for the primary treatment modality for a mental health condition, violates the plain language of the statute.

In sum, the ABA/IBT exclusion violates the Parity Act.

Doe v. United Behavioral Health, 523 F. Supp. 3d 1119, 1127-29 (N.D. Cal. 2021)

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Mental Health Parity Law Can Help With All Three

Is there coverage?

Is the coverage sufficient?

Are insurance plans providing the coverage in a fair and comprehensive way?

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What is Prohibited if Disparate?

Financial Requirements

Financial limits involve the dollar amount of coverage. They include deductibles, co-insurance, or out-of-pocket-maximums. These are regulated separately from non-quantitative limitations.

Ex. A person with mental illness only has $2000 worth of coverage per year but their physical health benefits are not limited.

Quantitative Limitations

Quantitative limits involve the amount of treatment given that are numerically expressed. They include annual, episode, and lifetime visit limits.

Ex. A person with depression can only visit a therapist 20 times per year

Non-Quantitative Treatment Limitations

Non-quantitative treatment limitations involve policies and practices that limit treatment that are not described numerically. Essentially everything that is **not** a QTL.

Ex. A person seeking inpatient therapy is only covered if they had two acute mental health episodes in the last six months

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Is there coverage?

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What are Non-Quantitative Treatment Limits?

Example 1

A person seeking inpatient therapy is only covered if they had two acute mental health episodes in the last six months

Example 2

A self-funded health plan **limits inpatient behavioral healthcare** with medical necessity criteria when it does not restrict similar medical benefits, like inpatient hospice care, with similar criteria.

From *M.S. v. Premera Blue Cross*

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Current Parity Requirements

Private Insurers and Group Health Plans **must generally**:

- Not charge higher co-pays or out of pocket costs for mental health than physical healthcare
- Not limit number of visits or number of days of mental health more than they limit physical healthcare
- Not engage in managed care practices that are more restrictive for mental health than for physical healthcare
- **Disclose their non-quantitative treatment limitations to patients or their authorized representatives upon request**

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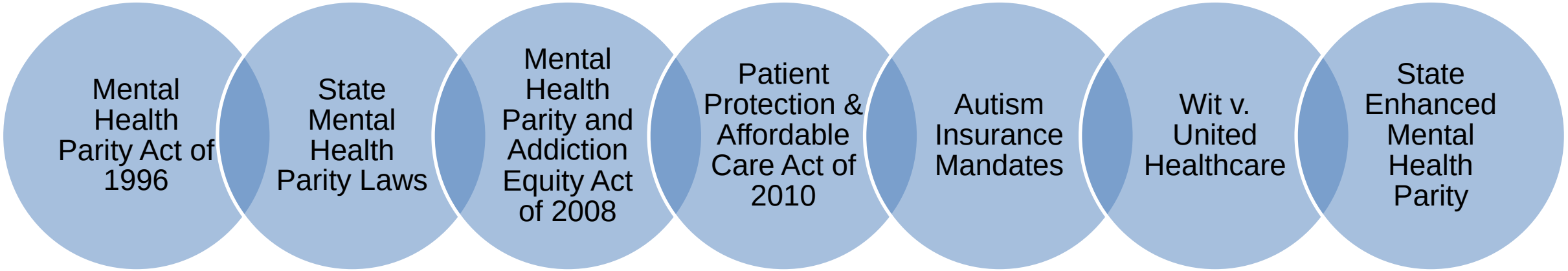

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UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

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

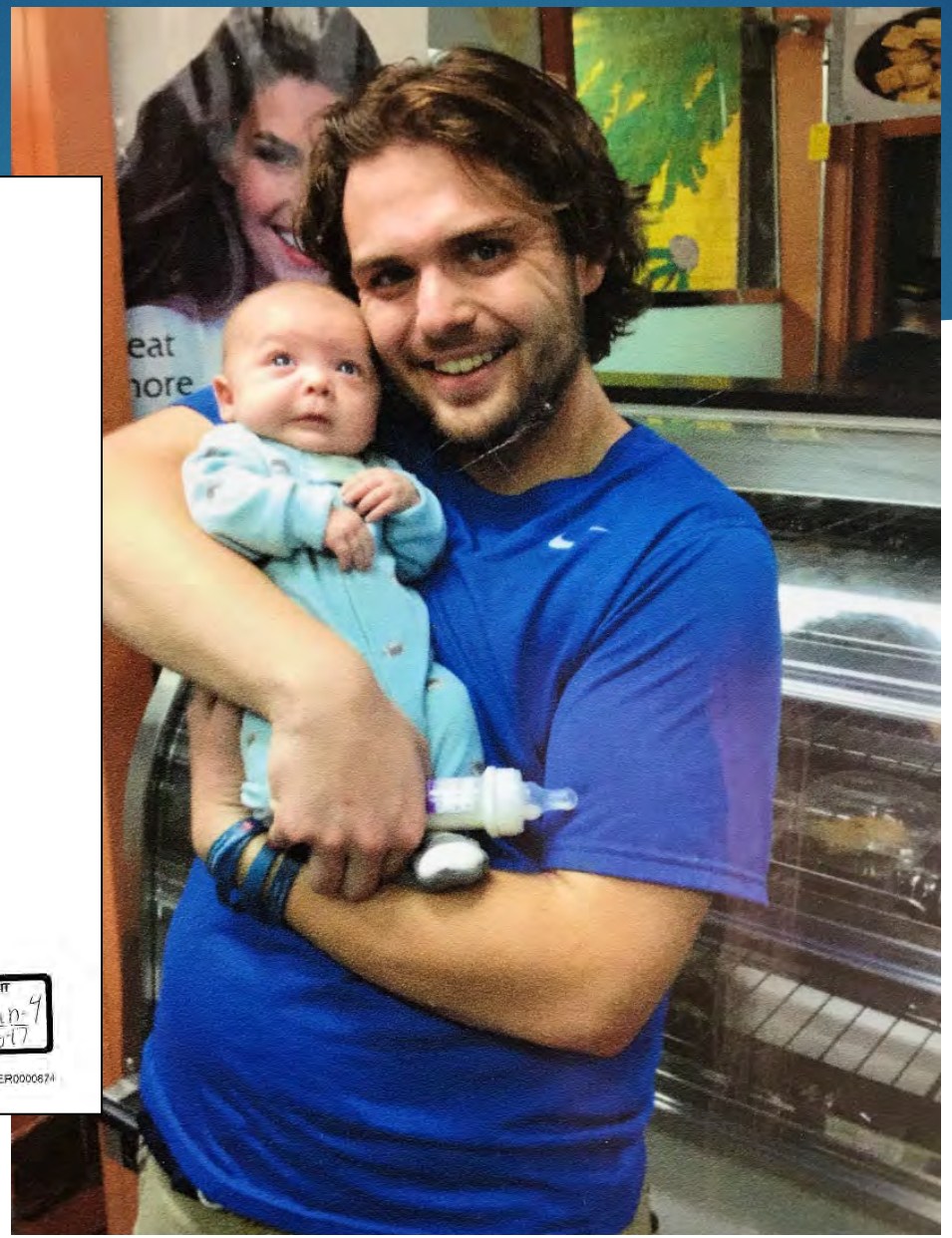
Offered and Underwritten by
UnitedHealthcare Insurance Company

EXHIBIT
Deposition
Alexander

HIGHLY CONFIDENTIAL – ATTORNEYS' EYES ONLY

UBHALEXANDER0000674

TRIAL EX. 225-0002



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Wit v. United Behavioral Health

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

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The Claims

- Zuckerman Spaeder brought suit brought under Employee Retirement and Income Security Act (ERISA)
  - Breach of Fiduciary Duty
  - Wrongful Denial of Claims
- Not under Mental Health Parity and Addiction Equity Act (MHPAEA)

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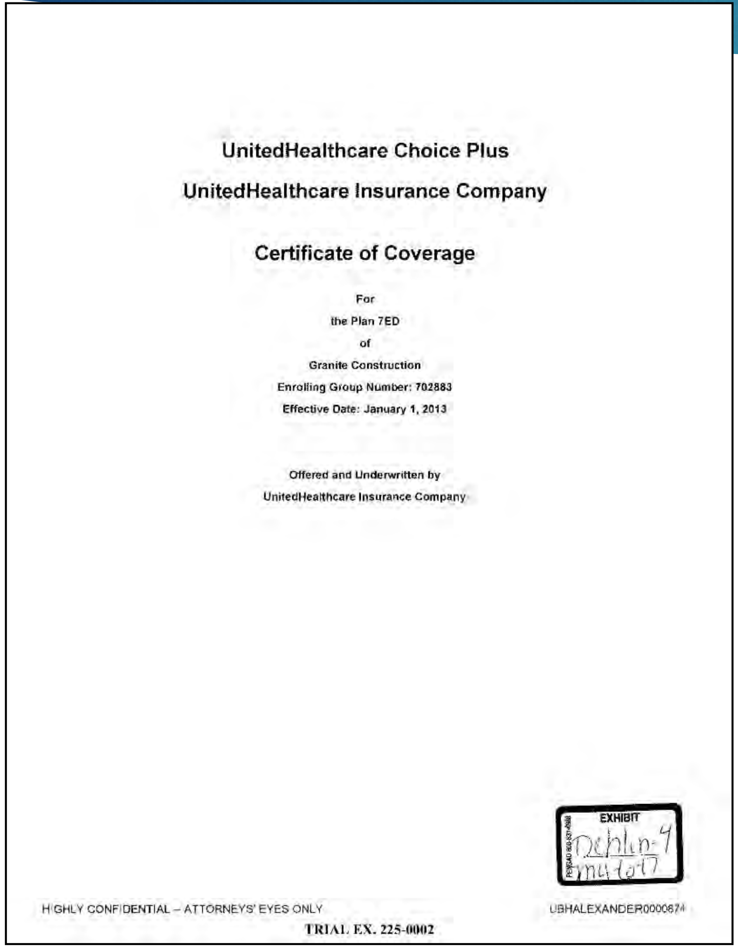
The Claims



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

HIGHLY CONFIDENTIAL – ATTORNEYS' EYES ONLY UBHALEXANDER0000674

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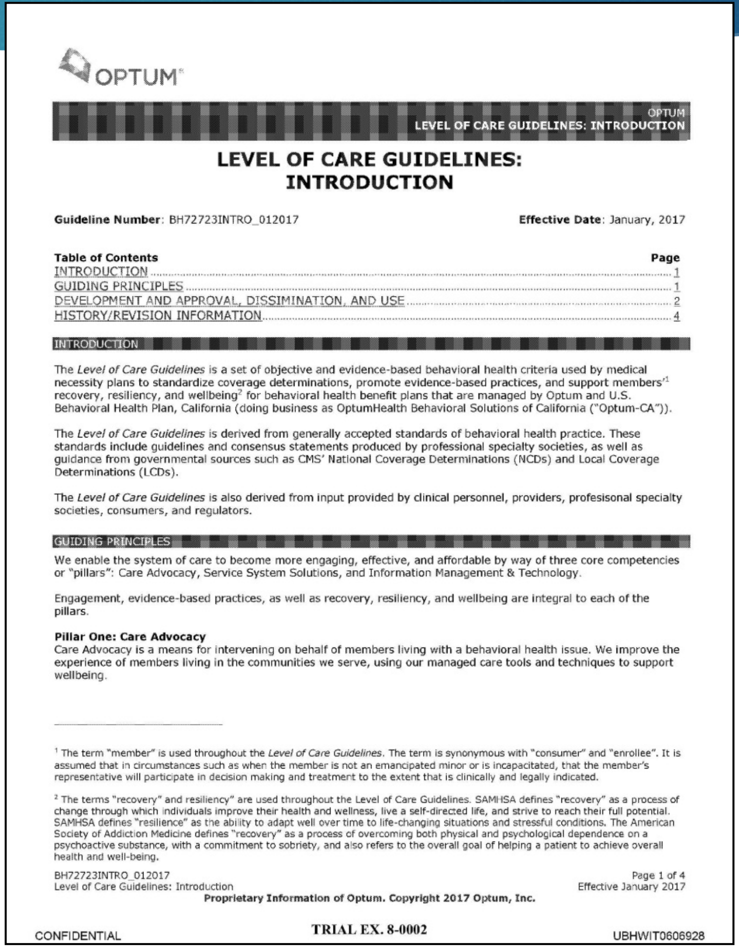

OPTUM

OPTUM
LEVEL OF CARE GUIDELINES: INTRODUCTION

LEVEL OF CARE GUIDELINES:
INTRODUCTION

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

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INTRODUCTION

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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.

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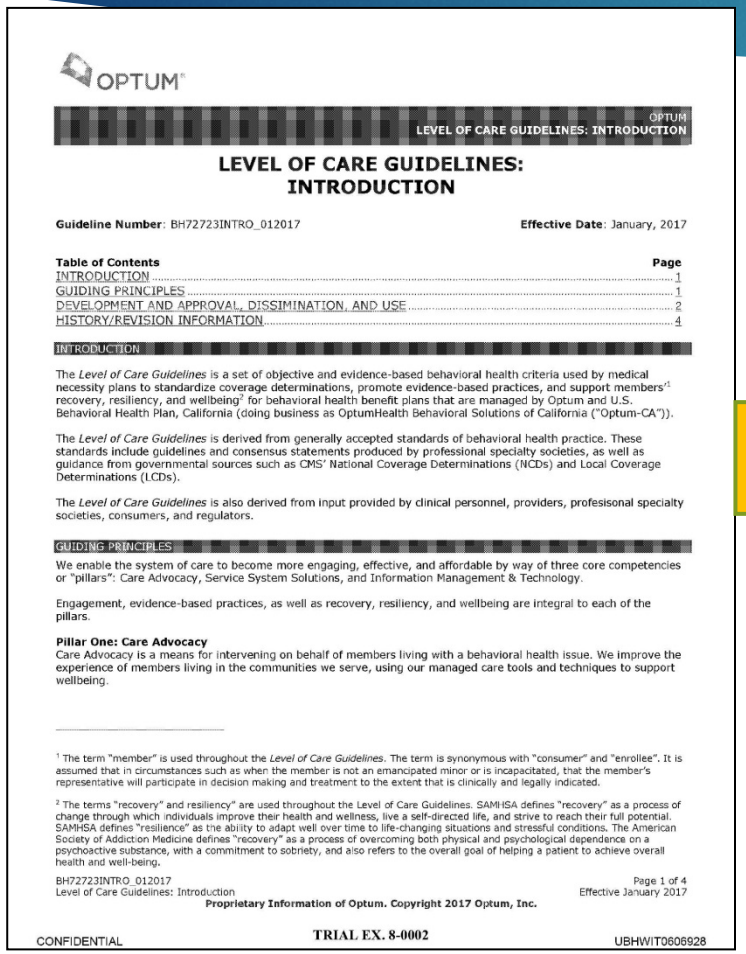
The Claims



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Coverage for Residential Care, Intensive Outpatient Care, Outpatient Care under Plan terms

- Claim was that UBH violated its fiduciary duty and wrongfully denied claims by using its own guidelines instead of generally accepted standards of care.

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Two Key Questions

- What are “generally accepted standards of care”?
- Do generally accepted standards of care exist in the substance use disorder community?

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Question #1

- What are “generally accepted standards of care”?
- Generally accepted standards of care are the standards that have achieved widespread acceptance among behavioral health professionals.

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Question #2

- Do “generally accepted standards of care” exist in the substance use disorder community?
- Lawyers for the plaintiff class argued that there are generally accepted standards of care in the substance use disorder community and offered the following as evidence.

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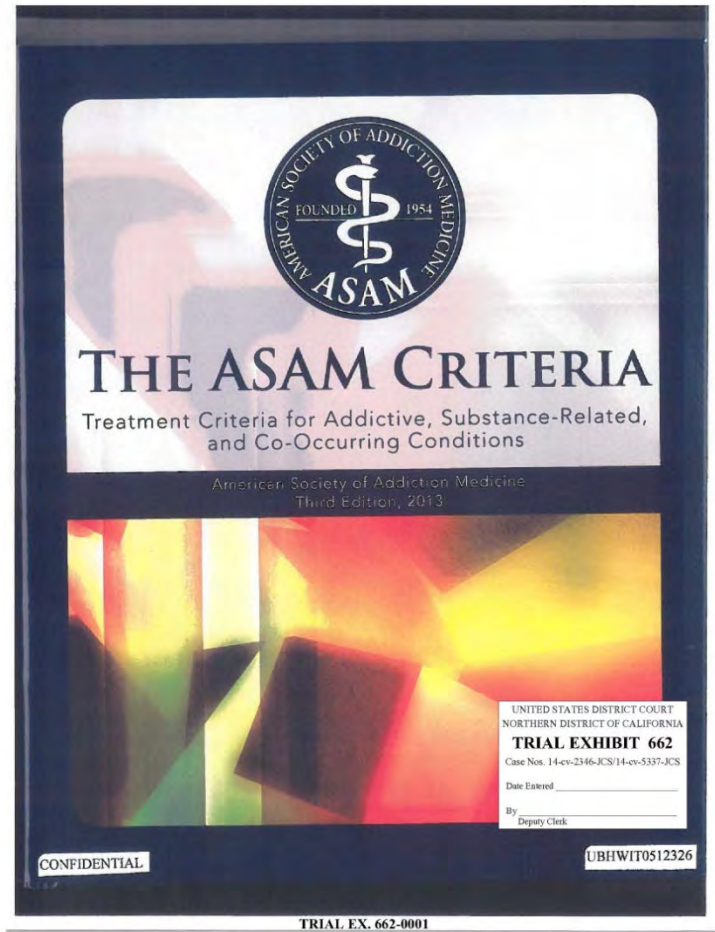
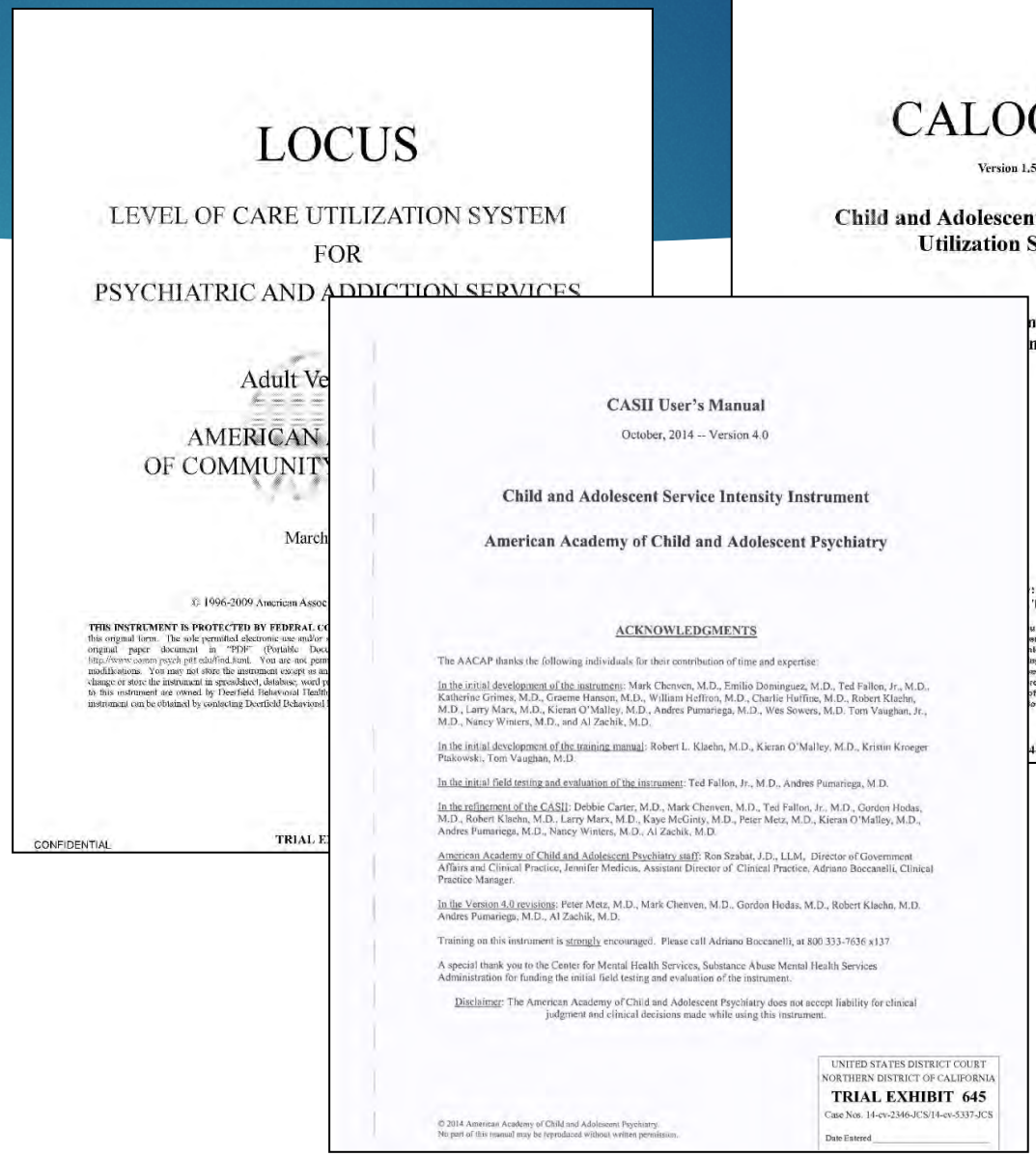
The Evidence





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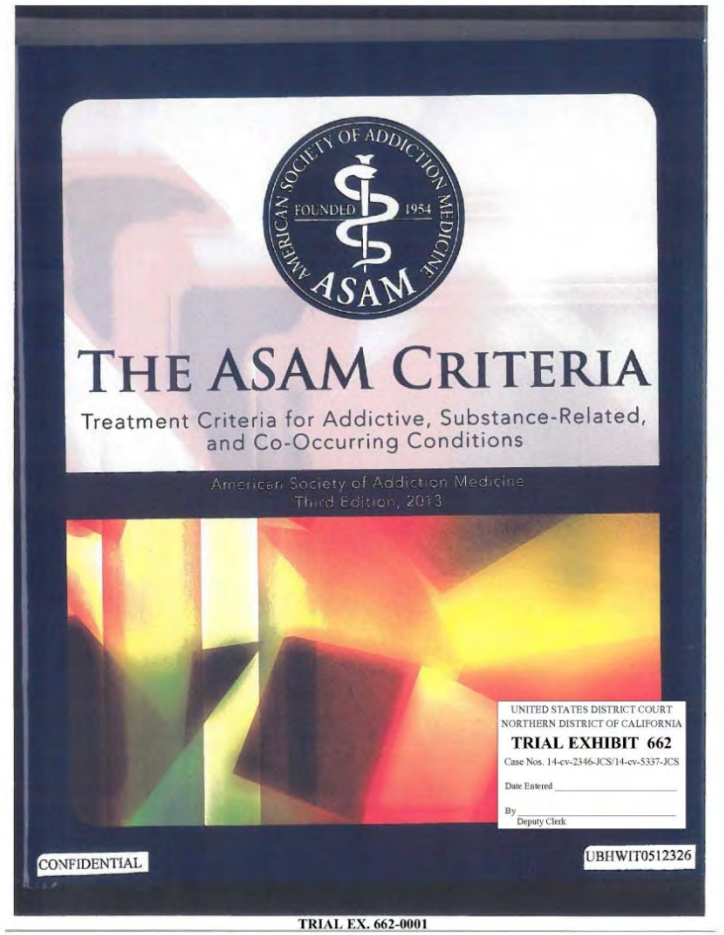
Court's Liability Ruling

Generally Accepted Standards

The Council of Autism Service Providers

Court's Liability Ruling



"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."

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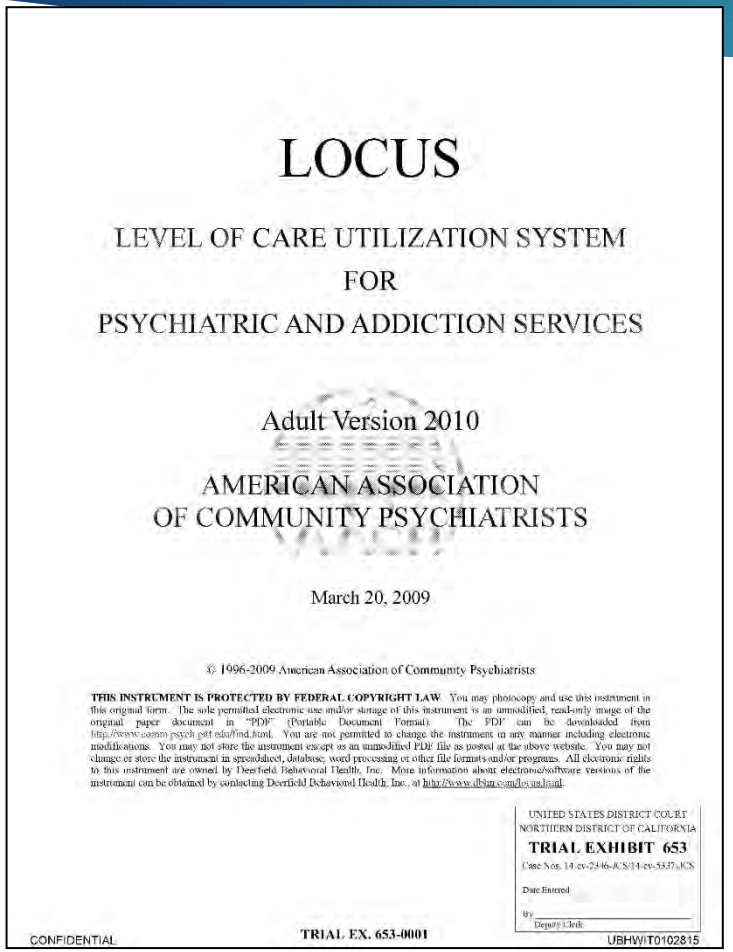
Court's Liability Ruling



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-5537-JCS
Date Entered
By
Deputy Clerk

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

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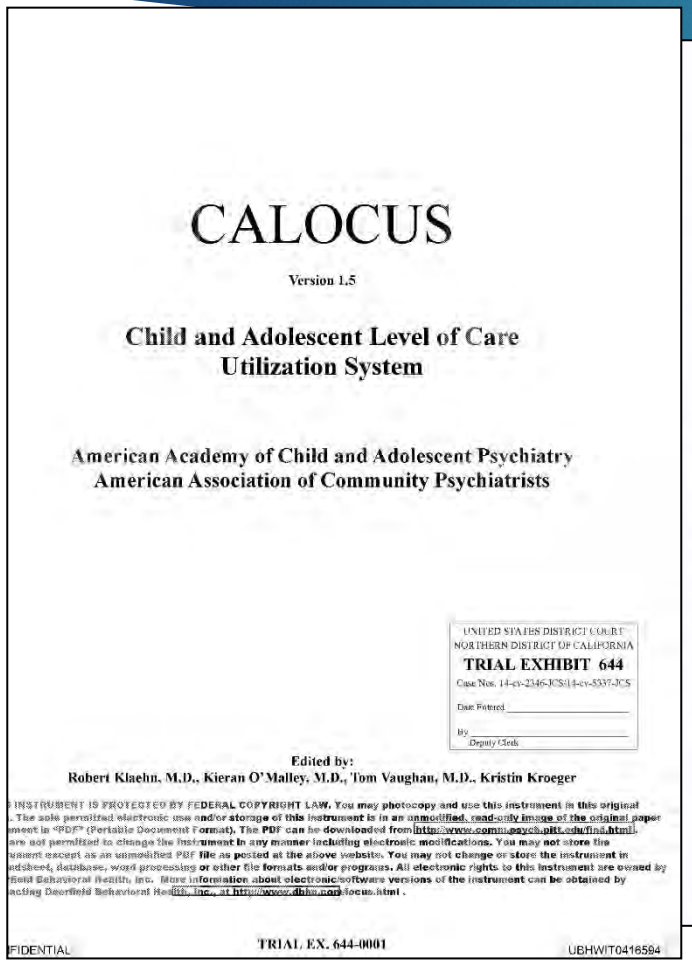
Court's Liability Ruling



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

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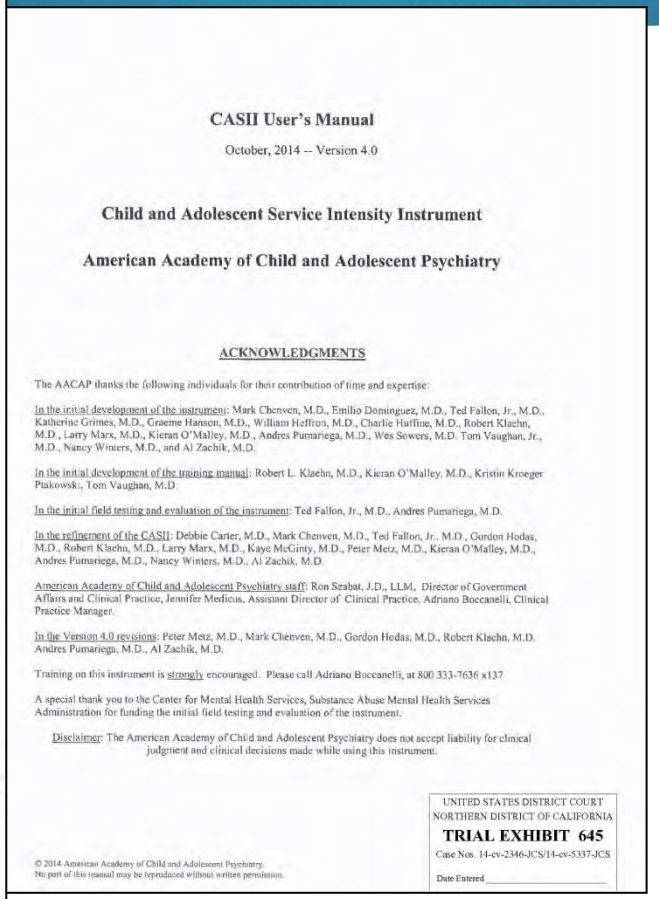

CASII User's Manual

October, 2014 -- Version 4.0

Child and Adolescent Service Intensity Instrument

American Academy of Child and Adolescent Psychiatry

ACKNOWLEDGMENTS

The AACAP thanks the following individuals for their contribution of time and expertise:

In the initial development of the instrument: Mark Chenven, M.D., Emilio Dominguez, M.D., Ted Fallon, Jr., M.D., Katherine Grimes, M.D., Graeme Hansen, M.D., William Heffron, M.D., Charlie Huffine, M.D., Robert Klaehn, M.D., Larry Marx, M.D., Kieran O'Malley, M.D., Andres Pumariega, M.D., Wes Sowers, M.D. Tom Vaughan, Jr., M.D., Nancy Winters, M.D., and Al Zachik, M.D.

In the initial development of the training manual: Robert L. Klaehn, M.D., Kieran O'Malley, M.D., Kristin Kroeger Ptakowski, Tom Vaughan, M.D.

In the initial field testing and evaluation of the instrument: Ted Fallon, Jr., M.D., Andres Pumariega, M.D.

In the refinement of the CASII: Debbie Carter, M.D., Mark Chenven, M.D., Ted Fallon, Jr., M.D., Gordon Hodas, M.D., Robert Klaehn, M.D., Larry Marx, M.D., Kaye McGinty, M.D., Peter Metz, M.D., Kieran O'Malley, M.D., Andres Pumariega, M.D., Nancy Winters, M.D., Al Zachik, M.D.

American Academy of Child and Adolescent Psychiatry staff: Ron Szabat, J.D., LLM, Director of Government Affairs and Clinical Practice, Jennifer Medicus, Assistant Director of Clinical Practice, Adriano Boccanelli, Clinical Practice Manager.

In the Version 4.0 revisions: Peter Metz, M.D., Mark Chenven, M.D., Gordon Hodas, M.D., Robert Klaehn, M.D. Andres Pumariega, M.D., Al Zachik, M.D.

Training on this instrument is strongly encouraged. Please call Adriano Boccanelli, at 800 333-7636 x137

A special thank you to the Center 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.

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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."

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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**

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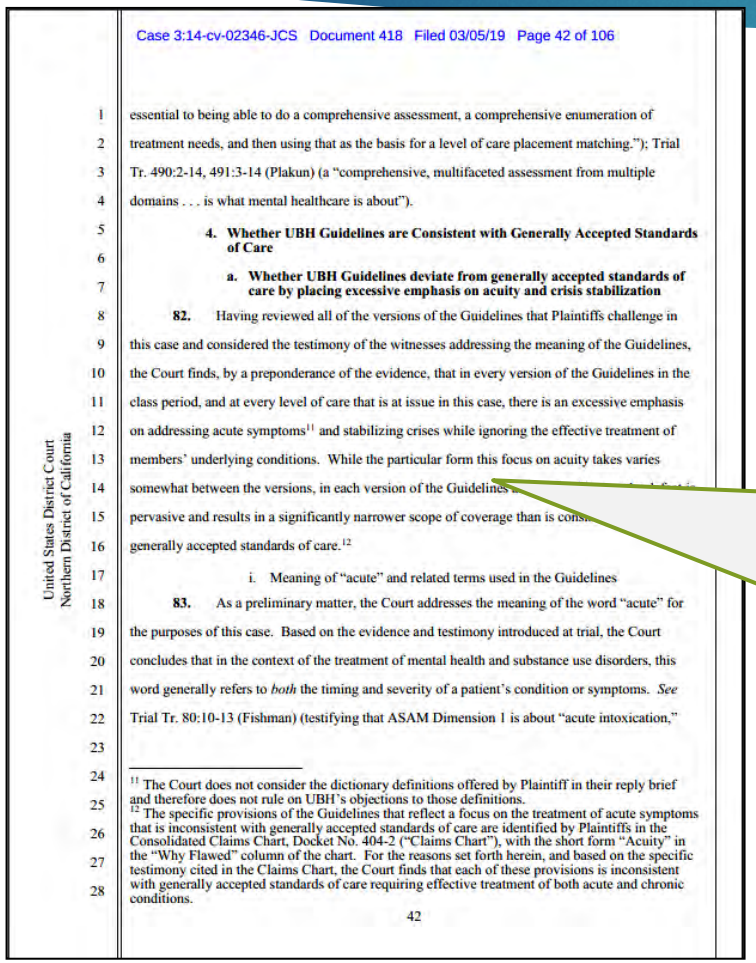
Court Ruling



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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 of members' underlying conditions. While the particular form this focus on acuity takes varies somewhat between the versions, in each version of the Guidelines [illegible] pervasive and results in a significantly narrower scope of coverage than is consis[illegible] generally accepted standards of care.[12]

i. Meaning of "acute" and related terms used in the Guidelines

83. As a preliminary matter, the Court addresses the meaning of the word "acute" for the purposes of this case. Based on the evidence and testimony 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."

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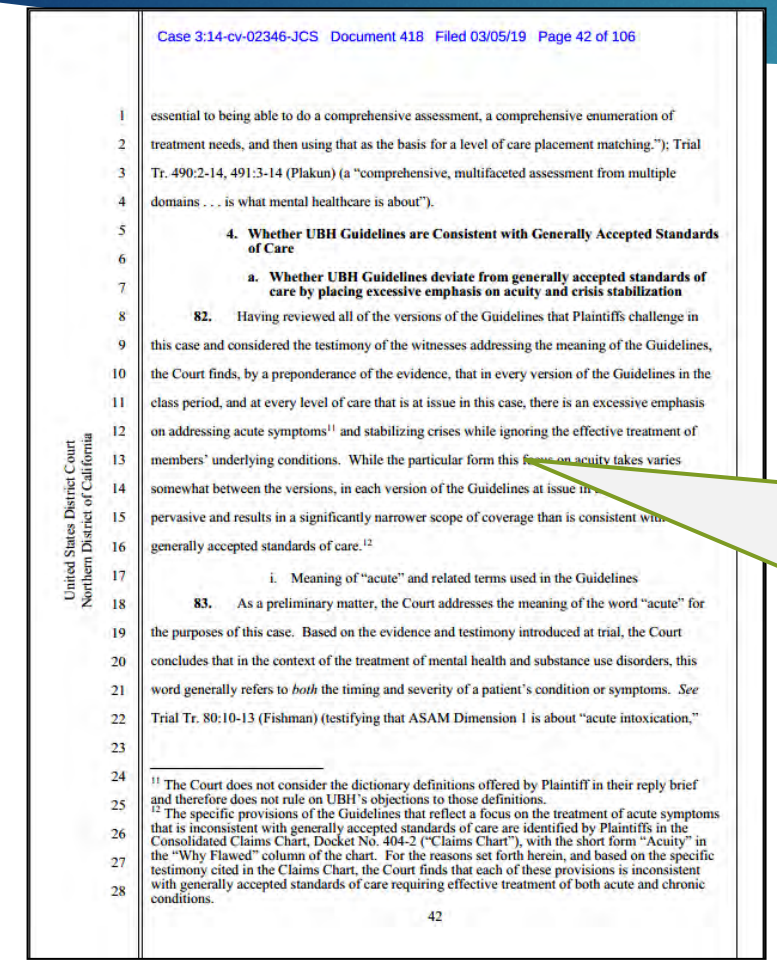
Court Ruling



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United States District Court
Northern District of California

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"[T]he **defect is pervasive** and results in a significantly narrower scope of coverage than is consistent with generally accepted standards of care."

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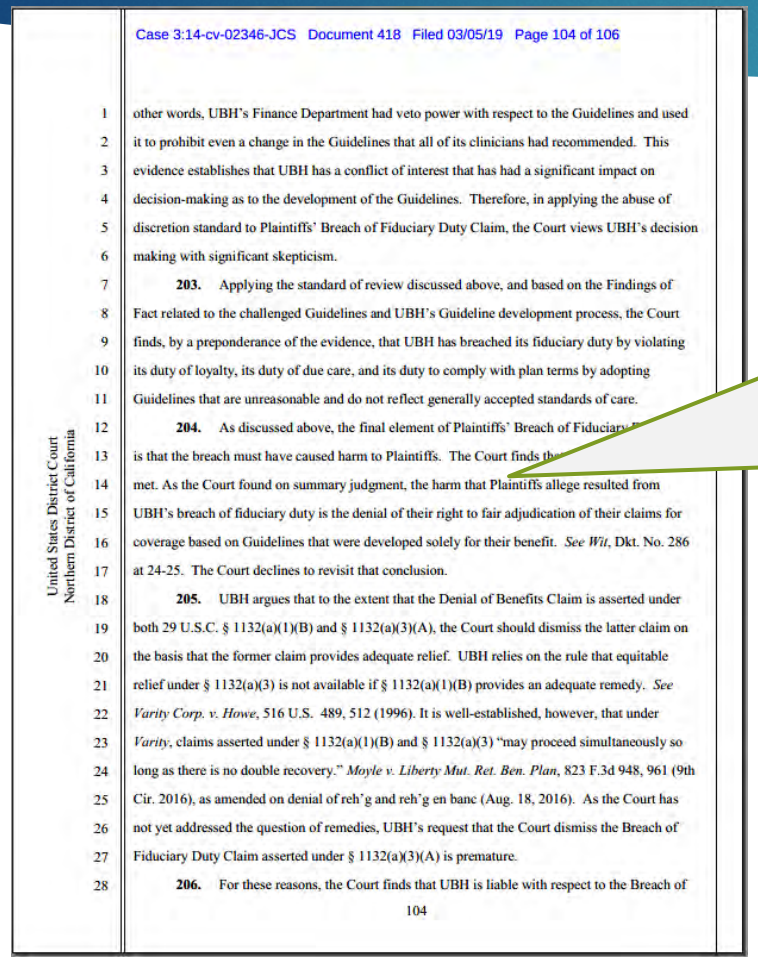
Court Ruling



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United States District Court
Northern District of California

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 [illegible] is that the breach must have caused harm to Plaintiffs. The Court finds that [illegible] met. As the Court found on summary judgment, the harm that Plaintiffs allege resulted from UBH's breach of fiduciary duty is the denial of their right to fair adjudication of their claims for coverage based on Guidelines that were developed solely for their benefit. *See Wit*, Dkt. No. 286 at 24-25. The Court declines to revisit that conclusion.

205. UBH argues that to the extent that the Denial 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."

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Court Ruling

- UBH owed duty to administer plans solely in the interest of the participants. Promised to cover all care in accordance with generally accepted standards.
- Violated obligations by using guidelines more restrictive than generally accepted standards and prioritizing cost savings over members interests.
- Financial incentives “infected” the guidelines development process
- Court noted multiple sources for determining generally accepted standards of care, including:
  - peer-reviewed studies;
  - consensus guidelines from professional organizations (ex., American Association of Community Psychiatrists, American Academy of Child and Adolescent Psychiatry, APA)
  - guidelines and materials distributed by government agencies (ex., CMS).

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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
Deposition
Alexander

HIGHLY CONFIDENTIAL – ATTORNEYS' EYES ONLY

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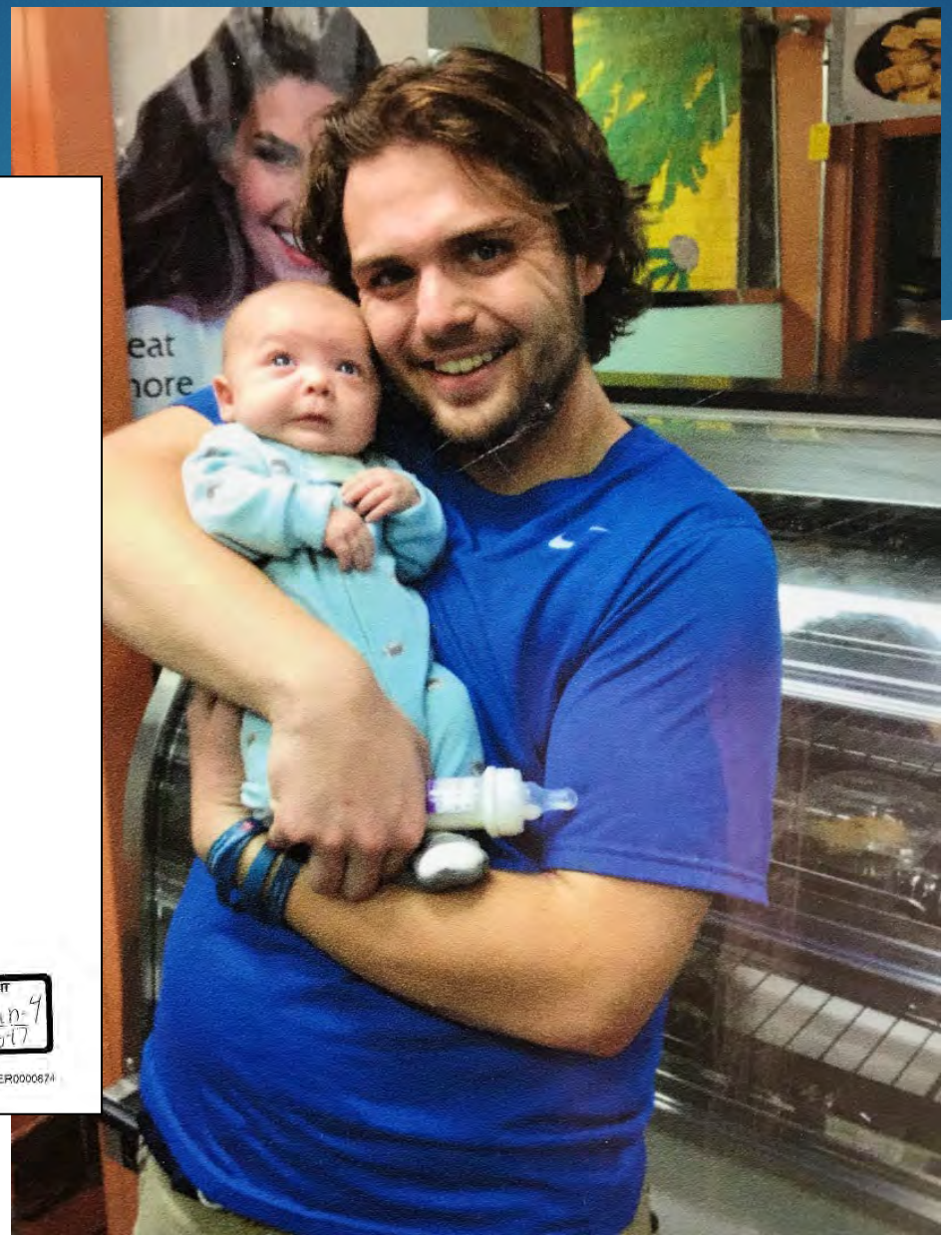
TRIAL EX. 225-0002



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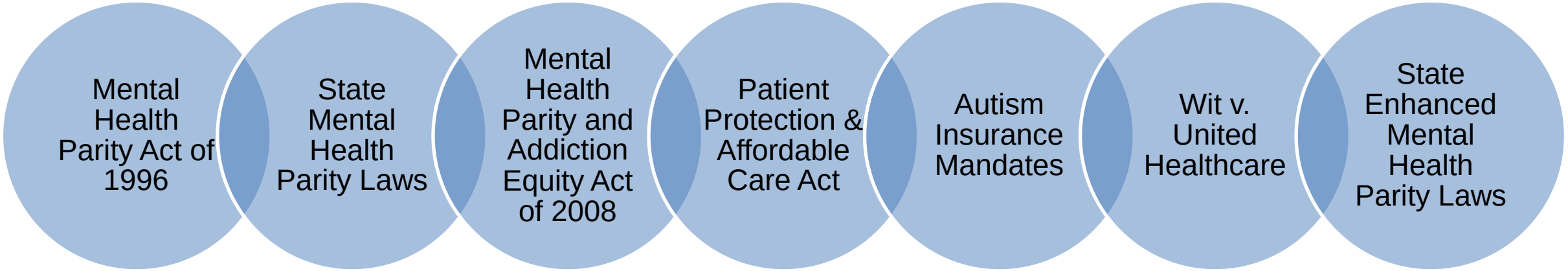

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Enhanced Mental Health Parity Laws
Example: California SB 855

(a) A health care service plan . . .shall base any medical necessity determination or the utilization review criteria . . .on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review . . . shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the **nonprofit professional association** for the relevant clinical specialty.

(c) In conducting utilization review . . . shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources.

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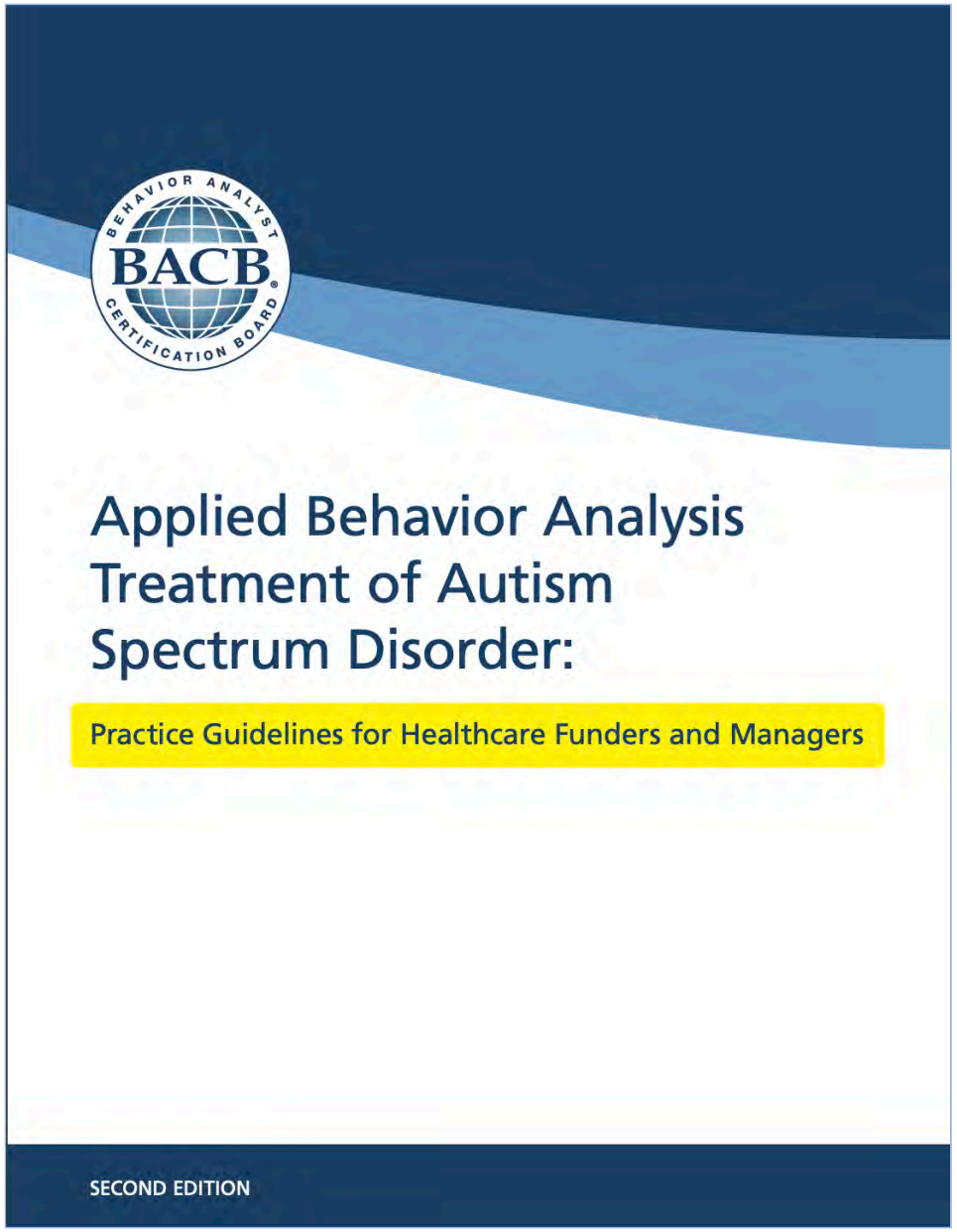

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Applied Behavior Analysis Treatment of Autism: Spectrum Disorder

Practice Guidelines for Healthcare Funders and Managers

SECOND EDITION

The BACB was the original publisher of this document. This and future editions will now be published by CASP.

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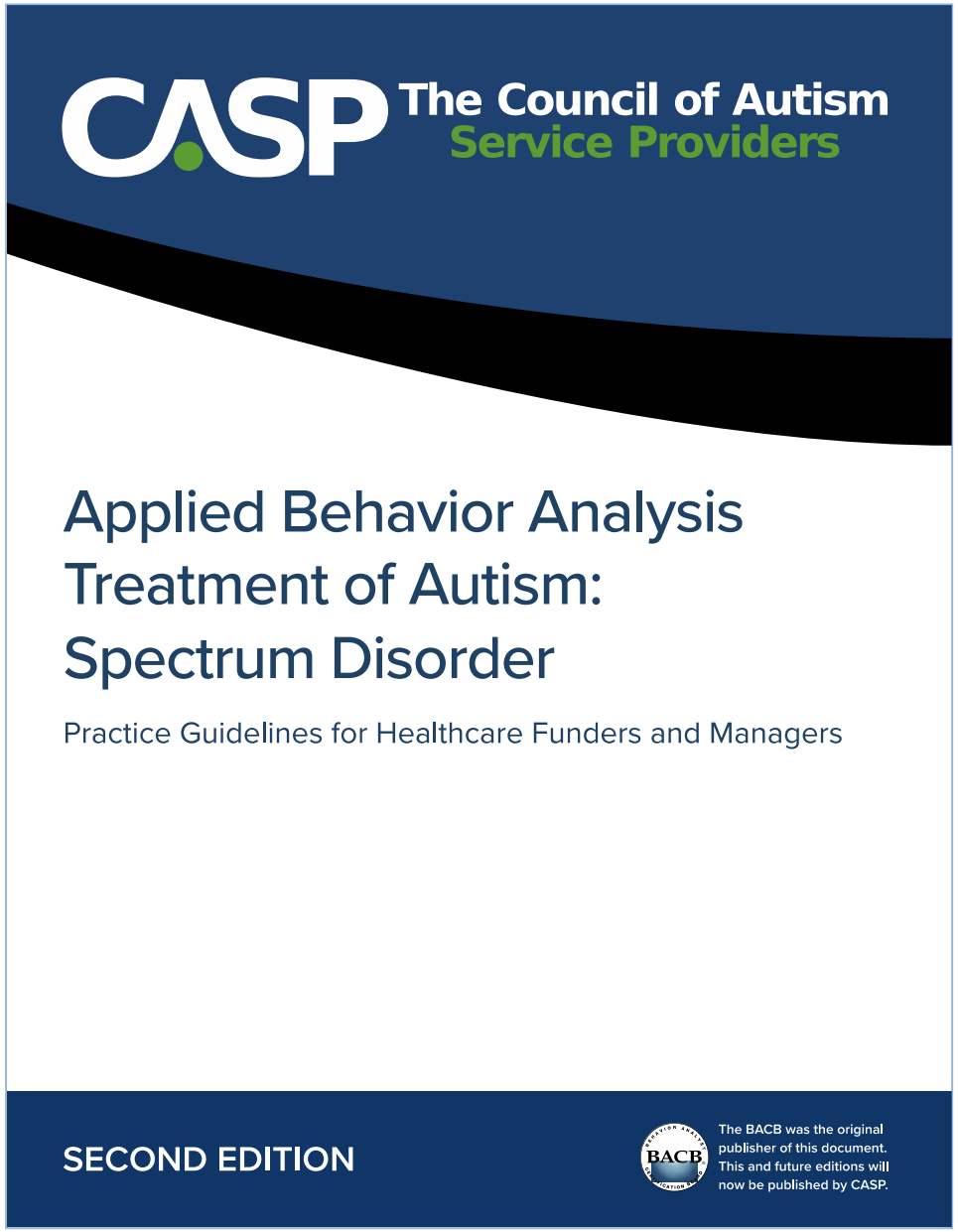

"The document is based on the best available scientific evidence and expert clinical opinion regarding the use of ABA as a behavioral health treatment for individuals diagnosed with ASD. The guidelines are intended to be a brief and user-friendly introduction to the delivery of ABA services for ASD. These guidelines are written for healthcare funders and managers, such as insurance companies, government health programs, employers, among others. The guidelines may also be useful for consumers, service providers, and regulatory bodies."

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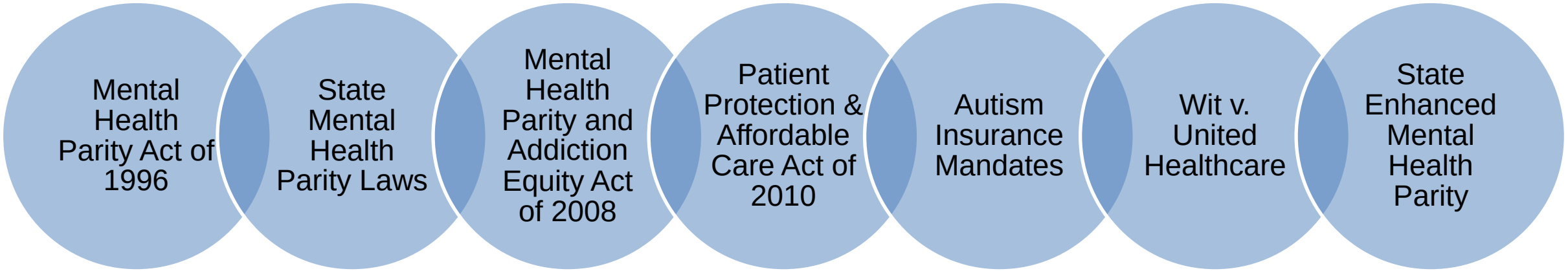
The Council of Autism
Service Providers



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Source: The Kennedy Forum

MHPAEA interim regulations were published on February 2, 2010 and the final regulations went into effect on January 13, 2014 for most of the covered plans highlighted in the table below. Over the years, the federal government has published additional regulations and sub-regulatory guidance. Even with this guidance, the Federal Parity Law continues to see challenges in optimizing health plan compliance and regulatory enforcement.

MH/SUD Federal Parity Coverage Requirements

Insurance Coverage Type?	*Applies?*	*Notes*
Commercial Insurance (State Regulated)		
Commercial Large Group Plans: (e.g., plans with more than 50 employees—full-time and part-time employees each count as one employee)	Yes	Pursuant to The Mental Health Parity and Addiction Equity Act (MHPAEA), the Affordable Care Act (ACA), and applicable state law.
Commercial Small Group Plans: Non-Grandfathered (e.g., fewer than 51 employees)	Yes	Technically MHPAEA does not apply directly to small group health plans sold through a commercial market, although its requirements are applied indirectly to non-grandfathered small group plans for plan years beginning on or after January 1, 2014 through the ACA's essential health benefits (EHBs) requirement. Non-grandfathered plans are plans that became effective after the March 23, 2010 passage of the ACA or plans that lost their grandfathered status at renewal by making certain changes in benefit coverage, cost-sharing, or premiums.

Insurance Coverage Type?	*Applies?*	*Notes*
Commercial Insurance (State Regulated)		
Commercial Small Group Plans: Grandfathered (e.g., fewer than 51 employees)	No	MHPAEA does not apply directly to grandfathered small group health plans sold through a commercial market.
Commercial Individual/ Nongroup Plans: Non-Grandfathered	Yes	Technically MHPAEA does not apply directly to individual health policies, although its requirements are applied indirectly to non-grandfathered individual policies for plan years beginning on or after January 1, 2014 through the ACA's EHB requirement. This applies to policies offered both through and outside of the health insurance market places.
Commercial Individual/ Nongroup Plans: Grandfathered	No	Grandfathered individual health insurance policies are not subject to the EHB requirements. However, to the extent that MH/SUD benefits are covered under the policy, coverage must comply with MHPAEA for policy years beginning on or after July 1, 2014 (which, for calendar year policies, is January 1, 2015).
Self-Funded Health Plans (U.S. DOL Regulated)		
Large Employer Self-Funded	Yes	Group health plans for employers with more than 50 employees in which the employer pays for health benefits with its own funds, rather than purchasing health insurance from an issuer, are called self-funded group health plans and are directly covered by MHPAEA, which amended the ERISA.
Small Employer Self-Funded: Non-Grandfathered	Yes	Technically MHPAEA does not apply directly to small group health plans that are self-funded, although its requirements are applied indirectly to non-grandfathered small group plans for plan years beginning on or after January 1, 2014 through the ACA's essential health benefits (EHBs) requirement. Non-grandfathered plans are plans that became effective after the March 23, 2010 passage of the ACA or plans that lost their grandfathered status at renewal by making certain changes in benefit coverage, cost-sharing, or premiums.
Small Employer Self-Funded: Grandfathered	No	MHPAEA does not apply directly to grandfathered small group health plans that are self-funded.
Union/Taft Hartley Plans	Yes	Union-negotiated plans are typically multiemployer defined benefit plans that are governed by a joint board of trustees (Trustees) with equal representation from employees and management. MHPAEA applies directly to Union plans.

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