diversion request. The *Braden* decision highlights the intricacies of interpreting CPC § 1001.36 and sets important implications for upcoming cases involving mental health diversion. It is important for forensic psychiatrists to be aware of ongoing interpretations of this statute to help advocate for patients with severe mental illnesses, both in individual cases, as well on a systemic level.

Legal Rights and Responsibilities of Healthcare Administrators and Insurers

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Court Considers Regulation of Health Care Plan Administrator's Denial of Coverage despite Treatment Being within Generally Accepted Standards of Care

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Key words: insurance; ERISA; standard of care; treatment coverage; benefits

In *Wit v. United Behavioral Health,* 58 F.4th 1080 (9th Cir. 2023), the Ninth Circuit Court of Appeals considered an appeal by United Behavioral Health (UBH) after the district court found that it failed to comply with terms of its health care plans and that it was liable to a class of plaintiffs for breaching fiduciary duty and wrongful denial of benefits. On appeal, the Ninth Circuit affirmed in part and reversed in part the district's court's class certification order. The appeals court reversed the plaintiffs' judgment on their denial of benefits claim and the breach of fiduciary duty claim to the extent that it was based on erroneous interpretation of the health care plans.

Facts of the Case

The plaintiffs are beneficiaries of health benefit plans administered by UBH. The plaintiffs sought a class action lawsuit against UBH for breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(1)(B) (1997) and improper denial of benefits under 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3)(B) (1997).

These two claims were based on the allegation that UBH improperly developed and applied internal guidelines that were inconsistent with individuals' benefit plans or with state-mandated criteria for determining coverage. There were eleven individually named plaintiffs in the case who sought action on behalf of three classes who had been denied coverage for services ranging from residential, inpatient, or outpatient care for mental illness or substance use disorders (SUD) after UBH applied their internally developed guidelines to determine eligibility for coverage. The classes were generally divided into the types of services denied and whether their plans were governed by the Employment Retirement Income Security Act of 1974 (ERISA) or both ERISA and state-mandated level-of-care criteria. The plaintiffs asserted that the suit was brought not to determine whether they were actually entitled to the benefits denied, but rather that the guidelines used by UBH were inconsistent with the class members' plans and with state-mandated criteria.

ERISA was established to regulate most retirement and health plans and protect contractually defined benefits. It does not mandate that employers offer employee benefits, nor does it mandate what benefits must be provided. ERISA was written to protect beneficiaries of employer-sponsored health care plans while not being so restrictive as to discourage employers from providing health care benefits. ERISA focuses on the written terms of the plans; its primary function is to protect contractually defined benefits.

UBH is one of the largest managed behavioral health care organizations in the nation and is responsible for managing the claims and coverage for behavioral health and substance use disorders for numerous commercial health care insurance plans. UBH was the administrator for all of the plaintiffs' benefits plans and, in some cases, UBH served as both the administrator and insurer.

The plaintiffs claimed that UBH acted in its own financial interests by creating guidelines that narrowed the scope of coverage and were inconsistent with generally accepted standards of care (GASC), state mandate, and the plans themselves, thereby breaching its fiduciary duty to plan members. The plaintiffs also claimed that UBH violated ERISA

when it inappropriately denied coverage claims using these guidelines.

The U.S. magistrate judge in the U.S. District Court for the Northern District of California granted a motion to certify the three putative classes in September 2016. In October 2017, the district court held a 10-day bench trial and ruled in the plaintiff's favor that UBH breached its fiduciary duty to the plaintiffs. Additionally, the district court found that UBH improperly denied benefits by applying its internally developed guidelines, which were more restrictive than and inconsistent with GASC and, in some instances, inconsistent with state law.

It was not disputed that UBH had the authority to create their own guidelines for determining coverage, but the district court found that the dual role UBH had as administrator and insurer for some plans created both a structural and financial conflict of interest. The district court held that UBH's interpretation of the internally created guidelines was unreasonable and an abuse of discretion because the guidelines were inconsistent with GASC; it issued declarative and injunctive relief. The district court further directed new guidelines to be used for reprocessing of the plaintiffs' claims and mandated a 10-year period in which a special master would oversee UBH's adherence to these new guidelines.

UBH appealed, claiming that the plaintiffs lacked Article III standing and the district court's class certification decision was an abuse of discretion. UBH also argued that the district court "erred in concluding that the UBH Guidelines improperly deviated from GASC, and the district court did not apply an appropriate level of deference to UBH's interpretation of the Plans" (*Wit*, p 1095–1096). UBH did not challenge the judgment that their guidelines deviated from state-mandated criteria.

Ruling and Reasoning

The Ninth Circuit Court of Appeals affirmed in part, reversed in part, and remanded the case. It found that the plaintiffs did, in fact, have Article III standing for their claims of improper denial of benefits and breach of fiduciary duty. The Ninth Circuit found that the district court did not err in certifying the three classes, but it did violate the Rules Enabling Act, which prohibits using a class action to expand substantive rights and, thereby, disagreed with the lower court's decision to have plaintiffs' claims reprocessed. The Ninth Circuit noted that reprocessing was a means to the ultimate remedy under ERISA and not a remedy itself; thus, viewing reprocessing as an appropriate class-wide remedy was deemed an abuse of discretion.

It was not disputed that the guidelines developed by UBH were inconsistent with state-mandated criteria nor that UBH had both a structural and financial conflict of interest. But, the Ninth Circuit disagreed with the district court's finding that UBH abused its discretion when interpreting its guidelines because UBH's interpretation was consistent with the language in the plans.

The plans state that treatment received must be consistent with GASC to qualify for coverage and that treatment inconsistent with GASC did not qualify for coverage. The appeals court noted that ERISA does not mandate what benefits employers must provide and that the focus must remain on the written terms of the plans. They noted that ERISA does not mandate consistency with GASC. The court said that the district court should have applied an "abuse of discretion" standard, noting that this is the relevant standard even if the administrator has a conflict of interest. It found that a conflict of interest should be weighted as a factor in determining whether the administrator abused its discretion, but "cannot agree that UBH abused its discretion on the facts of this case" (*Wit*, p 1097) where plaintiffs waived review of the grounds for denial of their claims.

In addition, the Ninth Circuit found that the district court erred when it excused unnamed class members from demonstrating that they complied with the plan's administrative exhaustion requirement. It noted that futility, inadequate remedy, and unreasonable claims procedures are three exceptions to the prudential exhaustion requirement, but that the plaintiffs had not shown that the Ninth Circuit extended these exceptions to a contractual exhaustion requirement. It also noted that it was uncontested that some beneficiaries successfully appealed the denial of their benefit claims, so these exceptions were not satisfied.

Because the district court erred in concluding that the guidelines impermissibly deviated from GASC and applied that erroneous conclusion to judge that UBH improperly denied benefits and breached its fiduciary duty to the plaintiffs, the court of appeals reversed those portions of the district court's judgment. UBH did not appeal the portions of the district court's judgment finding the guidelines were impermissibly inconsistent with state-mandated

criteria and that portion of the district court's decision remained intact.

Discussion

The *Wit* case has taken a long and circuitous path through the judicial system. Interestingly, the case opinion summarized here in *Wit* was recently vacated by the court, and the court issued a new concurrent opinion in *Wit v. United Behavioral Health*, 79 F.4th 1068 (N.D. Cal. 2023). With this, the court remanded the case to the district court to answer a threshold question of whether the plaintiffs' fiduciary duty claim is subject to an exhaustion requirement. The American Psychiatric Association has submitted amicus briefs in this line of cases.

A key point in this line of cases is that excluding coverage for treatment that falls within GASC may result in beneficiaries receiving inadequate treatment or being financially responsible for treatment that is excluded in their plans. The Ninth Circuit acknowledged that plan beneficiaries have a valid interest in knowing the scope of their plan coverage to make informed decisions about coverage purchases. It is unclear based on this holding, however, how or whether plan members could obtain information about the internal guidelines that are used to determine what care is covered.

The case has implications for psychiatrists' reimbursements for treatment if administering treatment is within the standard of care but is not a covered benefit under the plan administrators' interpretation of the plan. Psychiatrists could be left with the decision to provide inadequate, but reimbursable, care or provide adequate treatment that potentially leaves a financial burden on their patients. This may further introduce concerns about administrative burdens of attempting to obtain reimbursement for care that is consistent with generally accepted standards of care. Confirming an avenue by which health care administrators and insurers may exclude coverage may also have implications regarding mental health parity and access.

Worker's Compensation for PTSD

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A Previous Diagnosis of PTSD is Not Sufficient for Ongoing Worker's Compensation Benefits

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In *Chrz v. Mower County,* 986 N.W.2d 481 (Minn. 2023), the plaintiff sought worker's compensation benefits based on a prior diagnosis of PTSD from work-related trauma. The Supreme Court of Minnesota held that a formal, current diagnosis of posttraumatic stress disorder (PTSD) is required for worker's compensation, and that the plaintiff's diagnosis of unspecific trauma and stressor related disorder was not sufficient or compensable under state law.

Facts of the Case

Relator Ryan Chrz began serving as a Mower County Deputy Sheriff in November 2007, and he experienced traumatic events involving violence and death during his 12.5 years of employment with Mower County. In February 2019, Mr. Chrz was placed on administrative leave after using physical force to subdue a juvenile. While on leave, Mr. Chrz experienced suicidal ideation and he was evaluated by a psychologist, Dr. Nicole Slavik, who diagnosed Mr. Chrz with "PTSD, mild depressive disorder in partial remission, and mild alcohol use disorder in early remission" (*Chrz*, p 483). Dr. Slavik attributed Mr. Chrz's PTSD diagnosis to traumatic events in his role as deputy sheriff. On November 13, 2019, Dr. Slavik submitted a Report of Work Ability, indicating that Mr. Chrz was unable to work, ongoing, from September 2019.

On March 31, 2020, Mr. Chrz retired from the Mower County Sheriff's Office. On May 18, 2020, Mr. Chrz filed a claim petition, alleging entitlement