IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT, DIVISION SIX

2nd Civil No. B258505
Civil Case No. 1401650

LOUISE FRADENBURG,

Plaintiff and Appellant,
v.

UNITED HEALTHCARE INS. CO.;
US BEHAVIORAL HEALTH PLAN, CALIFORNIA;
UNITED BEHAVIORAL HEALTH

Defendants and Respondents.

Superior Court of the State of California
County of Santa Barbara

Honorable Donna Geck, Judge Presiding

APPLICATION TO FILE AMICI CURIAE BRIEF; AMICI CURIAE BRIEF IN SUPPORT OF PLAINTIFF AND APPELLANT LOUISE FRADENBURG

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APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF APPELLANT, LOUISE FRADENBURG

TO THE PRESIDING JUSTICE AND ASSOCIATE JUSTICES:

Pursuant to California Rules of Court, Rule 8.200(c), the California Psychiatric Association, Project Return Peer Support Network, Mental Health Advocacy Services, Inc., and Disability Rights California (collectively, "Amici") request permission to file the attached amici curiae brief in support of Petitioners' appeal in the above-captioned matter.

THE AMICI CURIAE

The California Psychiatric Association ("CPA") is a nonprofit corporation responsible for carrying out judicial, legislative, regulatory, educational, advocacy, and public affairs activities on behalf of organized psychiatry and psychiatric patients in California. CPA works to ensure that patients with psychiatric disorders have access to high quality, medically necessary treatment. CPA has over 3,000 members, is the largest professional association of psychiatrists in California, and is affiliated with the American Psychiatric Association.

Project Return Peer Support Network ("PRPSN") is a non-profit peer-run organization of members who have experienced mental illness. Through advocacy and empowerment PRPSN promotes wellness, personal growth and self-determination. PRPSN operates a network of over 150 self-help groups throughout Los Angeles County.

Mental Health Advocacy Services, Inc. ("MHAS") is a non-profit law firm dedicated to serving the legal needs of those with mental health disabilities. MHAS's mission is to protect and advance the legal rights of children and adults with mental health disabilities to maximize autonomy,

promote equality, and secure the resources these people need to thrive in the community.

Disability Rights California ("DRC") is California's federally-mandated protection and advocacy agency whose purpose is to advance the rights of Californians with disabilities. DRC has assisted thousands of individuals with mental disabilities in their struggle to obtain equal rights and opportunities, dignity, choice, and independence.

INTERESTS OF AMICI CURIAE

Each amicus has a strong interest in mental health parity, either as providers, consumers, or advocates for those who need mental health treatment. Amici have all experienced the inequality of health insurance coverage and have advocated in the legislature, in the courts, and in the community to advance mental health parity to ensure high-quality mental health care to support wellness and recovery.

NEED FOR FURTHER BRIEFING

This contract dispute must be understood in the larger context of the fundamental importance of outpatient therapy including, for some, long-term psychotherapy. Counsel for Amici have reviewed the redacted briefs and redacted record filed in this case and believe that they can provide this court with the necessary context in the additional briefing by Amici.

Amici are familiar with the issues before this court, especially the consequences of creating barriers to essential mental health treatment, such as psychotherapy. The attached amici curiae brief addresses the importance and cost-effectiveness of psychotherapy, the need of some patients for extended therapy, and the chilling effect of pre-authorization on seeking mental health treatment. Additionally, the brief analyzes the violation of

parity requirements by singling out intensive psychotherapy for prior authorization.

CONCLUSION

Amici respectfully request the court accept the attached brief in support of Petitioner for filing in this case.

DATED: November 10, 2015

Respectfully submitted,

DISABILITY RIGHTS CALIFORNIA;
MENTAL HEALTH
ADVOCACY SERVICES

By: _____
Daniel Brzovic
Counsel for Amici Curiae

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I. Introduction

This case revolves around restricted access to long-term or intensive outpatient mental health treatment. Before the U.S. Congress enacted the federal Mental Health Parity and Addiction Equity Act (MHPAEA), most of UHC's[1] health care contracts imposed a limit of 20 outpatient visits for out-of-network providers but no limit for network providers. (Respondents' Brief, p. 8.) For network providers UHC had an algorithm that triggered an alert when reimbursement reached 20 outpatient mental health visits within a six month period. (Id. 8.) After the MHPAEA became law, the 20-visit cap on visits to out-of-network providers was removed from the contracts but was replaced by the algorithm then being used for network providers. (Id. 8.)

Notwithstanding that plaintiff's health plan contract provided for retrospective review of outpatient mental health treatment using this algorithm, UHC flagged for prospective review reimbursements to plaintiff's psychiatrist for medication management and psychotherapy. UHC ultimately notified the psychiatrist that going forward, payment for medication management would be limited to once per month and payment for psychotherapy visits would not be made at all beginning one month after the date of the letter. This speculation that services would not be needed in the future is based on UHC's assumption that long-term psychotherapy is not necessary and that therapists provide long-term psychotherapy for financial rather than clinical reasons. Not only did this violate plaintiff's contractual right to retrospective review under her health plan contract, but UHC, thus, places a heavy burden on plaintiff and others like her that is not placed on members who need only short-term treatment.

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[11] For clarity defendants and respondents will be collectively referred to as "UBH."

If a claim by plaintiff, or someone in plaintiff's position, is denied, UHC informs them that they can appeal the denial of coverage, request an independent medical review (IMR) from the Department of Managed Health Care, or file an action in Superior Court. This additional burden is particularly hard on people with mental health challenges. It is a system designed to deny benefits to all but the few who have the resources, ability, and stamina to appeal.

In the following sections, amici will discuss the effectiveness of long-term and intensive psychotherapy and the burden that extra-contractual requirements like the ones at issue in this case place on plan members who need these services.[2] Amici also will discuss how federal parity regulations analyze these types of requirements and why the analyses find them to be invalid.

II. Procedural History

In June 2011 Ms. Fradenburg received a letter from the UHC "Alert Department" demanding that she ask her psychiatrist to contact UHC and provide a long list of information within 45 days and that failure to provide the information could lead to denial of outpatient psychotherapy benefits. (First Amended Class Action Complaint, p. 7, ln. 14-15, ln. 21-27 (see 1 Appellant App. 28 ¶ 23).) On or about September 2011, UHC sent a letter to Ms. Fradenburg's psychiatrist stating that going forward they would limit her psychotherapy benefit to one visit per week for one month. (See 1 Appellant App. 28 ¶ 24.) After that, they would limit Ms. Fradenburg's

[2] For clarity both health care insurance and health care service plans will sometimes be referred to collectively as "health plans." Insureds under health insurance policies and enrollees, subscribers, members, and covered persons under health care service plans will sometimes be referred to collectively as "members."

psychotherapy benefit to one visit per month and only for "medication management." (*Id*.) The clear message was that the UHC would not pay for any additional outpatient psychotherapy treatments, effectively reinstating the 20-visit limit that UHC had previously abandoned to comply with parity requirements.

Ms. Fradenburg filed an amended class action complaint on August 20, 2012, alleging violations of the Unfair Competition Law and the Unruh Civil Rights Act. Both counts arose from UHC's uniform practices that breached the Plan's guarantee that "Out-of-Network Outpatient Mental Health and Substance Abuse services are not subject to preauthorization, but must be clinically necessary to be covered and are subject to retrospective review." (Appellants' Opening Brief p. 14, see 1 AA 26, ¶ 18; 1 AA 155, 186-188.) After some discovery, Ms. Fradenburg moved for class certification, stating that UHC's actions were standardized, thereby affecting all persons with the same health plan.

UHC opposed class certification on all grounds. UHC argued that it conducted factually intense, individualized analyses during the utilization reviews and administrative appeals to determine whether ongoing and future mental health treatments were medically necessary.

The trial court denied certification and gave two reasons for the denial. First, for the unfair competition claim, the court held that commonality was not present as individual factual issues of "medical necessity" regarding each member's right to benefits for out-of-network, outpatient mental health treatments predominated over common issues. Second, for the Unruh Act claim, subclass certification was denied because the court held that Ms. Fradenburg did not introduce evidence comparing UHC's processing of claims for mental health treatments with claims for other illness.

III. The Legality of The Procedure for Authorizing Outpatient Psychotherapy is the Central Issue in this Case, Not Whether Services are Medically Necessary.

The trial court's decision denying class certification improperly focused on medical necessity determinations rather than on whether UHC's procedures for authorizing outpatient mental health care violated the health plan contract and thereby placed an unlawful burden on individuals seeking outpatient psychotherapy. Medical necessity is not the issue in this case. The issue is UHC's use of prospective procedures that are not authorized under the health plan contract and that thereby violate the Mental Health Parity Act by denying outpatient mental health treatment to those members who need more than 20 visits per six months.

IV. Extended or Intensive Outpatient Treatment Is Both Necessary and Cost Effective for Some People.

This health plan contract dispute must be understood in the larger context of the fundamental importance of outpatient therapy including, for some, long-term psychotherapy. Psychotherapy is an effective treatment for a wide variety of mental disorders, including depression. Treatments for some, however, might need to be long term. (Levy, Ehrenthal, Yeomans, and Caligor, (2014)*The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example, 42 Psychodynamic Psychiatry 377.)*

Ms. Fradenburg has been diagnosed as having major depressive disorder. The efficacy of psychotherapy in treating depression is one of the most studied of any psychological condition. As referenced in Levy *et al*., above, there have been 40 meta-analytic reviews of the outcomes for patients with depression alone. Based on an analysis of these reviews, the authors conclude that psychotherapy is effective and that "there is an

established literature showing that short-term treatments tend to ameliorate symptoms but do not lead to more established rehabilitative changes in personality and functioning." (Levy *et al.*, *supra*, at 402.)

In addition to being an effective clinical treatment, psychotherapy is a cost-effective treatment as it provides immense benefits to individuals and can prevent more costly treatments or interventions. This conclusion is supported by numerous studies through several decades. In her review of the literature examining the cost-effectiveness of psychotherapy, Susan Lazar concluded that "[P]sychotherapy has been shown to be both effective and cost-effective for depression by decreasing disability (Kamlet, Wade, Kupfer, & Frank, 1992; Mynors-Wallis, 1996; Rose, Smith & Dickinson, 2004; Schoenbaum, Sherbourne & Wells, 2005; Smit et al., 2006), decreasing days in the hospital (Huxley, Parikh & Baldessarini, 2000; Retzer, Simon, Weber, Stierlin, & Schmidt, 1991; Rosset & Andreoli, 1995; Verbosky, Franco, & Zrull, 1993), and in some studies leading to reductions in total health care costs (Browne et al., 2002; Dunn et al., 2007; Edgell, Hylan, Draugalis, & Coons, 2000; Hengeveld, Ancion, & Rooijmans, 1988)." (Lazar, *The Cost-Effectiveness of Psychotherapy for the Major Psychiatric Diagnoses*, (2012) 42 Psychodynamic Psychiatry, at 433.) Of great concern is the plight of those, like Ms. Fradenburg, who need more than a short-term intervention to recover. As Dr. Lazar points out, "a policy that arbitrarily limits psychotherapeutic services results in increased costs in medical services, disability, morbidity, and mortality." (Lazar at 440.)

As noted in the preamble to the interim final regulations implementing the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, the largest benefit expected from the implementation of the Act was the elimination of arbitrary limits on visits, thereby enabling a relatively small number of people to receive the long-term therapy they

need and thereby provide better outcomes and reduce costs for inpatient hospitalization:

> The Departments expect that the largest benefit associated with MHPAEA and these regulations will be derived from applying parity to cumulative quantitative treatment limitations such as annual or lifetime day or visit limits (visit limitations)…. Applying parity to visit limitations will help ensure that vulnerable populations—those accessing substantial amounts of mental health and substance use disorder services—have better access to appropriate care.… Though difficult to estimate, the number of beneficiaries who have a medical necessity for substantial amount of care are likely to be relatively small. Severe mental health disorders account for 2–3 percent of people in private health insurance plans and a substantially larger share of mental health spending. Evidenced-based treatments for severe and persistent mental illnesses like schizophrenia, bipolar disorder and chronic major depression requires prolonged (possibly lifetime) maintenance treatment that consists of pharmacotherapy, supportive counseling and often rehabilitation services. [Citing, Lehman AF ‘‘Quality of care in mental health: the case of schizophrenia’’ 18 Health Affairs (1999) No. 5, p. 52.] The most common visit limits under current insurance arrangements are those for 20 visits per year. That means assuming a minimal approach to treatment of one visit per week, people with severe and persistent mental disorders will exhaust their coverage in about five months. This often results in people foregoing outpatient treatment and a higher likelihood of non-adherence to treatment regimes [sic.] that produce poor outcomes and the potential for increased hospitalization costs.

(Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; (Feb. 2, 2010) Interim Final Rule, 75 Fed.Reg. 5410, 5422.)

Despite this large body of research demonstrating the clinical effectiveness and cost effectiveness of long-term treatment for major psychiatric disorders, including Ms. Fradenburg's depression, UHC continues to rely on an algorithm—for which there is no basis in the record other than the illegal historical cap of 20 outpatient visits—to arbitrarily reduce utilization of psychotherapy by increasing the burden on the patient to establish medical necessity through the preauthorization process. Not only is there no scientific evidence to support this prospective authorization process, but it also violates the terms of the applicable health plan which provides for retrospective, not prospective, review.

V. Using Algorithms and Treatment Protocols to Deny Long-Term or Intensive Outpatient Treatment Ignores the Cyclical Nature of Serious Mental Disorders.

Treatment protocols that deny the efficacy of long-term treatment fail to recognize that what is needed to address a mental health condition cannot be easily quantified. The available signs, symptoms, test results, and laboratory findings may not be as precise or as helpful in predicting the course of treatment for mental health conditions as compared to this type of information available for treating physical health conditions. (See Marczyk and Wertheimer, (2001) *The Bitter Pill of Empiricism: Health Maintenance Organizations, Informed Consent and the Reasonable Psychotherapist Standard of Care*, 46 Vill. L. Rev. 33.) For example, when looking at high blood pressure, cancer, diabetes, and other medical conditions, objective information is available to the provider to assess the condition. But when evaluating the severity of depression, the aftereffects of trauma, or the lack

of self-awareness that can accompany psychosis, there is rarely a mental health symptom or set value that can be assessed and empirically tested. If a particular intervention does not have the desired outcome, the provider and the patient often choose other treatment options. It can take much time and many treatment changes to find the most effective treatment for a particular individual. Even effective treatments may become less effective over time. In addition, some patients simply cannot tolerate the particular treatment the managed-care plan wants the provider to use. Peoples' conditions vary in unpredictable ways. It is hardly ever possible to predict when someone will begin to feel worse or begin to feel better.

UHC's algorithms single out and place additional burdens on people who need long-term or intensive treatment. The prospective (forward-looking) denials of coverage that these algorithms are designed to justify usually result in the cessation of treatment for people who need it but cannot afford to pay for it out of pocket. (See *A Long Road Ahead, Achieving True Parity in Mental Health and Substance Use Care* (April 2015) <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf> [as of November 9, 2015]). As a result, treatment that the therapist, working with the patient, determined is medically necessary is abandoned.

The quantitative treatment approach for mental illness also defies value-based assessment. The effectiveness of a given treatment approach is going to vary based upon the values and philosophies of not only the provider but also the patient. (Goold and Lipkin, Jr., *The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies, J Gen Intern Me.* (Jan. 14, 1999, Suppl 1), S26-S33).) Some people may respond well to a particular type of treatment while others respond well to a different type of treatment. Some therapists are more skilled at providing certain types of treatment as compared to other types of treatment. No one responds

equally well to everything, and no one approach to providing therapy works for everyone. The therapist and the patient must work together and perhaps try different things in order to find what works. Because of this intense and personal relationship between the provider and the patient, the decisions of the therapist and the patient about the effectiveness and need for continued treatment must be respected and given primary consideration. This is best accomplished by the retrospective review of medical necessity included in the plan contract, rather than by the prospective approach challenged in this litigation.

VI. Prospective Review Needlessly Interferes with the Therapist-Patient Relationship

Prospective denial of mental health treatment based on an algorithm replaces the judgment of the therapist with arbitrary limits and interferes with the patient-therapist relationship. (Leigh, Biopsychosocial Approaches in Primary Care, State of the Art and Challenges for the 21st Century (1997) p. 226.) As a result, needed care is denied, negatively impacting a patient's mental health and ability to seek services.

A patient's therapist must advocate for the needs of the patient for the patient to trust the therapist. If a third-party insurer or health plan imposes restrictions on types and length of mental health treatment as part of utilization review, patients are rightly concerned about who is actually making health care decisions for them as their individual provider may be overruled. As a result, patients may wonder if doctors care primarily about them, the insurance plan, or the treater's own jobs or incomes. (See Goold) This provider-patient relationship is so sensitive to outside influences that any concern about the loyalties of the provider can have a deleterious effect on the quality of the treatment provided. The Respondents own health plan documents provide for retrospective review and reflect this desire to limit

their effect on the relationship. The documentation for the behavioral health benefits specifies that "UHC performs a Utilization Review to determine whether the service or supply is a Covered Service. The Covered Person and his/her provider decides which Behavioral Health Services are given, but the Plan only pays for Covered Services." (First Amended Class Action Complaint, Exhibit 2, p 11.) This retrospective two-step process, provision of the service and then review, gives the therapist-patient relationship time to develop while still allowing the plan to decide whether it will pay for the service. The therapist and patient work together to build a treatment plan and the patient can be assured that the treatment plan will proceed as designed. The therapist can follow up with the patient should the health plan deny payment of any treatment. Because of this two-step process, there is less of a concern about loyalties. The treatment has been provided without the intervention of a third party.

The ambiguity inherent in wondering if the therapist is caring for the patient, the health plan, or the therapist's own job and income erodes a patient's trust, promotes adversarial relationships, and inhibits patient-centered care. (Goold at S27.) Professional ethics require that therapists ensure that their interests and those of the patients are congruent in clinical practice. "Plan interests, however, can pull physicians away from this goal, as the organizations' values and their implementation inevitably influence attitudes, behavior and experiences." (Id. at S28.) Sadly, many patients may go without necessary mental health treatment as they are not able to self-pay. In the Mental Health America report "Parity or Disparity: The State of Mental Health in America 2015," an estimated 1, 250,169 people in California were unable to receive appropriate mental health care due to the cost of treatment. *(Parity or Disparity: The State of Mental Health in America 2015,* available at

http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%20Report%20FINAL.pdf)

Health plans and health insurers should not add additional burdens and layers of appeals on people—especially vulnerable people—just because they need long-term or intensive services. Prospective review and prior authorization are unnecessary. UHC can determine medical necessity with a retrospective review.

VII. The Retrospective Review Provisions in the Health Plan Contract Are Required under the Mental Health Parity Laws to Protect the Patient.

a. Prospective Review Discourages Providers from Providing Treatment.

The problem with UHC's procedures is not only that they prescribe a rigid model of mental health treatment for people who need more treatment than that model allows but also that they discourage providers from billing UHC for services. A therapist will not want to bill a health plan or health insurer for services if that entity categorically states that it will not pay for any future services of the type being provided.

In this case, UHC sent a letter to the therapist stating that payment for medication management would be limited to once per month, and that after a one-month transition period payment for therapy would not be available at all. (First Amended Complaint, p.7, ¶24.) A therapist is not going to see this kind of a categorical statement about future payment as a medical-necessity decision that can be discussed with the health plan or easily appealed. It looks more like a statement about scope of coverage. Any therapist who receives a letter like this is likely to tell the patient that there is nothing they can do and leave it to the patient to fight with the health plan. The therapist has an incentive to refuse to provide any

additional treatment unless the patient pays for it. Regrettably, many patients cannot afford to do so without the benefits that their health insurance provides.

With retrospective review the therapist has more of a stake in the outcome and is therefore likely to provide more assistance to the patient. This is because the service has already been provided, but the therapist has not yet been paid. Payment may depend on the therapist getting it from the insurance company.

No one should be surprised that UHC has devised procedures that will discourage clinicians from providing long-term or intensive psychotherapy unless their patients pay out-of-pocket for the treatment. It is the most vulnerable patients, those in need of intensive or long-term therapy, who are most harmed by the respondents' policy. It is this harm that the mental health parity laws, and the provisions of the health plans enacted in compliance with these laws, are designed to prevent.

b. The Federal Mental Health Parity and Addiction Equity Act Provides Guidance for Determining Parity under the California Mental Health Parity Act

Although not specific to the California parity statute, the federal regulations that govern how health plans must develop mental health parity procedures provide guidance in applying California's requirements. The regulations give examples that are highly instructive and can be used as a guide in evaluating UHC's pre-authorization and concurrent review practices.

The federal law and its implementing regulations are relevant because the federal law and regulations, like California law, require equal application of the terms and conditions of the health plan. California law requires that mental health benefits be provided "under the same terms and

conditions applied to other medical conditions" (Health & Saf. Code, § 1374.72(a)) and that the terms and conditions of the contract "be applied equally to all benefits under the plan." (Health & Saf. Code § 1374.72(c).) The federal law is similar to the California law but not identical. Under federal law the equal application requirement is a minimum requirement. Federal law requires that the treatment limitations applicable to covered mental health benefits be "no more restrictive than the predominant treatment limitations applied to substantially all [covered] medical and surgical benefits… and there are no separate treatment limitations that are applicable only with respect to mental health… benefits."[3] (26 U.S.C. 9812, 29 U.S.C. 1185a(a)(3)(a)(ii), 42 U.S.C. 300gg-26.)[4] Therefore, while the language of the California and federal statutes are not identical, both require at a minimum that terms and conditions be applied equally under the plan and so federal regulations that speak to this issue should be considered.

Prior authorization is a particular focus of the federal regulations because it is such a powerful tool for evading mental health parity requirements. The regulations, in fact, have a number of examples

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[3] While the California Mental Health Parity Act, itself, does not incorporate the federal laws, a separate section of the California Knox-Keene Act requires plans to follow them. (Health & Saf. Code § 1374.76.) Therefore, UBH must follow both the state and federal requirements as a matter of California law.

[4] Virtually identical provisions of the federal Mental Health Parity Act of 1996 (MHPA) and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amend three different federal statutes, the Internal Revenue Code, ERISA, and the Public Health Service Act, and appear in three different titles of the United States Code. (See, 78 Fed.Reg. 68240-41 (November 13, 2013).) Because the three sets of laws, and the three sets of regulations implementing those laws, are virtually identical, further citations will be to 26 U.S.C. § 9812, and 26 C.F.R. § 54.9812-1, et seq. (the statute and regulations administered by the IRS).

addressing prior authorization. California law and regulations are not as specific as the federal regulations but the federal examples can be applied in this case because they are examples of how to apply prior authorization standards equally—a requirement of both federal and California law.

The regulations illustrate application of a prior authorization procedure that provides parity on its face but, in practice, has more stringent requirements for mental health benefits than for medical/surgical benefits. This is similar to UHC's de-facto pre-authorization procedures in this case because UHC places an additional burden on those who need more than 20 outpatient mental health visits as compared to members who need less than 20 outpatient mental health visits. In the example:

> A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

(26 C.F.R. § 54.9812-1(c)(4)(iii) Example 1 (i) Facts.)

According to the regulations, this practice violates parity requirements:

> …the plan violates the [nonquantitative treatment limitation rules] because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

(26 C.F.R. § 54.9812-1(c)(4)(iii) Example 1 (ii) Conclusion.)

The regulations also give an example of application of a prior authorization procedure that places different caps on the number of outpatient treatment visits permitted before prior authorization is required, and after prior authorization is obtained. That is similar to what happened in this case when the plan determined that it would pay for only a limited number of future outpatient psychotherapy visits after a certain number of visits had already been paid for. Under the UHC procedure, members who need less than 20 visits routinely receive these visits with no pre-authorization requirement while those who need more therapy are routinely denied the visits by means of UHC's refusal to pay for future visits. In the example:

> A plan requires prior authorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.

(26 C.F.R. § 54.9812-1(c)(4)(iii) Example 11 (i) Facts.)

According to the regulations this practice violates parity requirements because the prior authorization requirement is not applied in a comparable way:

> While the plan is more generous with respect to the number of visits initially provided without preauthorization for mental health benefits, treating all mental health conditions and substance use disorders in the same manner, while providing for individualized

treatment of medical conditions, is not a comparable application of this non-quantitative treatment limitation.

(26 C.F.R. § 54.9812-1(c)(4)(iii) Example 11 (i) Conclusion.)

The above examples when applied to this case clearly indicate a parity violation where the 20-visit algorithm applied to mental health outpatient treatment by UHC provides more stringent limitations than for similar medical outpatient treatments.

VIII. Conclusion

Amici respectfully request the Court of Appeal reverse the trial court's decision to deny Ms. Fradenburg's motion for class certification. The trial court did not apply California parity law correctly in its denial of class certification. UHC has limits in place for mental health treatment that do not exist for physical health treatment. UHC discriminates against those with the most severe mental health conditions by placing a heavy and unnecessary burden on them that does not apply to others. UHC applies an overreaching, expansive prospective limitation to mental health benefits that violates the health plan contract and interferes with the patient-therapist relationship. This violates the California mental health parity laws.

The Court should reject the trial court's reasoning, reverse its decision, and remand for further proceedings.

Dated: November 10, 2015

Respectfully submitted,

DISABILITY RIGHTS CALIFORNIA;
MENTAL HEALTH
ADVOCACY SERVICES

CERTIFICATE OF WORD COUNT

Amici for Appellant Fradenburg hereby certifies that this brief consists of 4985 words (excluding tables, proof of service, and this certificate), according to the word count of the computer word-processing program. (Cal. Rules of Court, Rule 14(c)(1).)

I declare under the penalty of perjury under the laws of the state of California that the foregoing is true and correct and that this declaration was signed on November 10, 2015, at Sacramento, California.

By: _____
Daniel Brzovic

Attorney for Amici Curiae

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF SACRAMENTO

Case Caption: Fradenburg v. United Healthcare Ins., et al.
2nd Civil No.: B25805 / Civil Case No.: 1401650

I am employed in the County of Sacramento, California. I am over the age of eighteen years and not a party to the within action. My business address is 1831 K Street, Sacramento, California 95811.

On November 10, 2015, I served the foregoing document(s) entitled as:

1. **APPLICATION TO FILE AMICUS CURIAE BRIEF; AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF AND APPELLANT LOUISE FRADENBURG**

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Santa Barbara, CA 93121
[Case No. 1401650]

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[*Electronic Service Per Cal. Rules of Court, Rule 8.212(c)(2)]*

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Executed on November 10, 2015, at Sacramento, California.

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LYNNE GRIFFITHS