No. _____

In The
Supreme Court of the United States

CALIFORNIA PHYSICIANS' SERVICE dba
BLUE SHIELD OF CALIFORNIA,

Petitioner,

v.

JEANENE HARLICK,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

MICHAEL M. BERGER*
**Counsel of Record*
GREGORY N. PIMSTONE
ADAM PINES
JOANNA S. MCCALLUM
MANATT, PHELPS & PHILLIPS, LLP
11355 West Olympic Blvd.
Los Angeles, CA 90064
(310) 312-4000
mmberger@manatt.com

Counsel for Petitioner
California Physicians' Service dba
Blue Shield of California

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

This case presents the most recent example – and the most extreme illustration – of a multiheaded circuit conflict (containing at least four different rules) of direct concern to ERISA plans and plan beneficiaries:

1. Whether the doctrine of waiver applies when an ERISA plan administrator denies a claim for benefits on the ground that the ERISA plan does not provide coverage, and later wants to assert or investigate a ground for denial not stated in the initial denial letter.

2. If the doctrine of waiver can be applied generally in the above context, does it apply in the specific instance where the ERISA plan did not have sufficient facts to have asserted the additional basis for denial when it denied the claim?

PARTIES TO THE PROCEEDING AND RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Petitioner California Physicians' Service dba Blue Shield of California ("Blue Shield") was the defendant and appellee below.

Blue Shield has no parent company. Blue Shield is a California not-for-profit company and has no stock; therefore, no publicly owned company owns 10 percent or more of its stock.

Respondent Jeanene Harlick ("Harlick") was the plaintiff and appellant below.

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF APPENDICES

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

Page

STATUTES

REGULATIONS

TABLE OF AUTHORITIES – Continued

PETITION FOR WRIT OF CERTIORARI

Blue Shield petitions for a Writ of Certiorari to review a final judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The U.S. District Court for the Northern District of California entered summary judgment for Blue Shield on March 4, 2010. (App. 108, App. 135.) Its order was published at 2010 WL 760484 (N.D. Cal. 2010). The Ninth Circuit Court of Appeals reversed on August 26, 2011 in an opinion published at 656 F.3d 832. (App. 66.) Following Blue Shield's timely Petition for Panel Rehearing and Rehearing En Banc, the Ninth Circuit on June 4, 2012 withdrew and superseded its prior opinion on denial of rehearing, and issued a new opinion, again reversing the district court's judgment, in an opinion published at 686 F.3d 699. (App. 1.)

JURISDICTION

The Ninth Circuit entered judgment on June 4, 2012. Blue Shield's timely Petition for Rehearing En Banc and Panel Rehearing of the June 4, 2012 opinion was denied on July 12, 2012. (App. 136.)

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS

The pertinent statutes (29 U.S.C. § 1133 and 42 U.S.C. § 300gg-19) and regulations (29 C.F.R. § 2560.503-1(g) and 45 C.F.R. § 147.136) are in App. F at App. 137.

INTRODUCTION

The district court granted summary judgment in favor of Blue Shield, which had denied coverage for services obtained by Harlick in a residential care facility. The basis for denial was that Harlick's ERISA plan explicitly excluded coverage for residential care services. The Ninth Circuit reversed. The court held, in a ruling of first impression, that while the exclusion was unambiguous on its face, a state statute precluded the exclusion for residential care in these circumstances. The Ninth Circuit concluded that the coverage must be provided if the requested treatment was medically necessary.

The Ninth Circuit then went on to hold that, even though the plan had denied Harlick's claim based on the fact that the requested services were not covered under an unambiguous plan exclusion, the plan was barred from considering on remand whether

the services were medically necessary in Harlick's particular situation.

The court held that the plan had waived the right to conduct an investigation and potentially make that determination because it did not identify lack of medical necessity as an alternative ground for denial when it denied Harlick's claim for the services. Medical necessity investigations are conducted to determine whether services that fall within the plan's general coverage terms should be covered in the specific instance.

Even before the Ninth Circuit's adoption of the most extreme formulation of the waiver rule, the situation was sufficiently fragmented that, in *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 130-31 (1st Cir. 2004), the First Circuit catalogued what that court viewed as ***seven disparate approaches*** to the issue taken in the various circuits. As laid out in *Glista*, some circuits deem the later-asserted grounds to be waived, but only where the administrator had sufficient information to have raised the additional defenses when the claim was denied. Other circuits take the position that common law doctrines of waiver have no place in review of ERISA claims because coverage cannot be created – and the written terms of an ERISA plan cannot be varied – through the doctrines of waiver and estoppel. Certain circuits permit the new defenses to be asserted in litigation, but subject them to de novo review. Others remand to the plan administrator to consider new plan interpretations and factual evidence presented for the first time

in the district court. In short, the circuits are all over the map.

In this case, the Ninth Circuit adopted yet another, more extreme rule, holding categorically that plan administrators are deemed to have waived defenses to coverage not articulated to the insured when the claim was first denied. This is true, under the Ninth Circuit's formulation, even when the plan did not have sufficient information to assert the additional grounds at the time the claim was denied, and even when it was clear from the face of the plan that the requested service was not covered.

The result of this wide-ranging circuit conflict is that ERISA plans across the country are subject to varying sets of rules that directly impact their obligations when making determinations of benefit claims – decisions made by the thousands on a daily basis. So too, ERISA plan participants are impacted when their plans are forced to conduct potentially needless additional investigations to preserve the plans' rights, which serve only to increase the cost of administering those plans and delay the communication of benefit determinations to plan participants.[1]

---

[1] Moreover, where the alternative basis for denial involves lack of medical necessity, it will prematurely trigger the external review process required by the Patient Protection and Affordable Care Act as well as state law. *See* 42 U.S.C. § 300gg-19; 45 C.F.R. § 147.136. *See infra* pp. 23-25.

ERISA was enacted to create a uniform administrative scheme for employee benefit plans. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Only this Court can bring harmony to the disparate approaches currently adopted by the various circuits on this issue of daily, practical importance to ERISA plans and their participants.

STATEMENT OF THE CASE

Harlick was a member of an ERISA plan that her employer purchased from Blue Shield. Blue Shield was the plan administrator vested with discretionary responsibility to make benefit determinations under the plan.[2] Harlick's plan explicitly stated that services at a residential care facility were not covered.

Harlick suffered from an eating disorder. She sought and obtained services at a residential facility specializing in providing services for eating disorders. Blue Shield denied her claims because treatment in a residential facility (as opposed to a psychiatric hospital or skilled nursing facility) was expressly excluded under her plan. Blue Shield repeatedly informed Harlick of this basis for the denial.

Harlick brought suit, invoking the jurisdiction of the district court under ERISA, 29 U.S.C. § 1132, and

[2] *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

under 28 U.S.C. § 1331 (general federal question jurisdiction). Harlick alleged a violation of ERISA based, in part, on her contention that California's Mental Health Parity Act, Cal. Health & Safety Code § 1374.72, requires plans to provide coverage for residential treatment of eating disorders.[3] She argued that coverage was required under the Parity Act because residential treatment is a useful modality of treatment for eating disorders and/or because the plan provided coverage for treatment of physical illnesses in skilled nursing facilities, which Harlick contended was similar to services in a residential care facility.

The district court granted summary judgment in favor of Blue Shield. The court held that Blue Shield's plan exclusion for residential treatment was unambiguous, and that there was no need to interpret the Parity Act because the residential facility at which Harlick received treatment was not a skilled nursing facility.

Harlick appealed to the Ninth Circuit, asserting the same arguments she had asserted below. She did not contend that the Parity Act should be interpreted to require plans to cover all medically necessary

---

[3] The Parity Act states: "Every health care service plan contract . . . that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of [nine enumerated] severe mental illnesses . . . , under the same terms and conditions applied to other medical conditions. . . ." Cal. Health & Safety Code § 1374.72(a).

treatment for the mental conditions listed in the Act, and the parties did not brief that issue.

At oral argument, the Ninth Circuit raised for the first time the question of whether the Parity Act required coverage for *all* medically necessary treatment for the listed mental conditions. Following oral argument, the court directed the parties to submit supplemental briefing.

On August 26, 2011, the court issued its initial opinion. (App. 66.) After first concluding that the plan's exclusion for residential treatment was clear and unambiguous, the court went on to hold that the exclusion was impermissible under the Parity Act. The Ninth Circuit concluded – as a matter of first appellate impression[4] – that the statute requires plans to provide coverage for *all* medically necessary care for the listed mental conditions, even though *all* medically necessary care need not be covered for physical illnesses under California's statutory scheme governing health plans.

The Ninth Circuit also concluded that the plan had waived the right to consider whether Harlick's particular request for residential care was medically

[4] Each of the district courts that had previously interpreted the Parity Act had reached the opposite conclusion. *See Daniel F. v. Blue Shield of Cal.*, No. C 09-2037 PJH, 2011 WL 830623, at *8 (N.D. Cal. Mar. 3, 2011), *appeal pending*, No. 11-15601 (9th Cir.); *Wayne W. v. Blue Cross of Cal.*, No. 1:07-CV-00035 PGC, 2007 WL 3243610, at *4 (D. Utah Nov. 1, 2007).

necessary. The plan had not asserted lack of medical necessity as an alternative ground for denial at the time it denied the claims, because the claim was denied as non-covered on the face of the plan based on the exclusion for residential care.

Blue Shield timely petitioned for panel rehearing and rehearing en banc. Blue Shield explained why the court's interpretation of the California statute was wrong. Blue Shield also argued that the court's waiver ruling was in conflict with an en banc decision of that court, *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006 (9th Cir. 1997) (en banc), *cert. denied*, 522 U.S. 1098 (1998); was not supported by the other Ninth Circuit authority cited by the court; and conflicted with the rule stated in ERISA decisions in other circuits.

On June 4, 2012, the court withdrew its August 2011 opinion and issued a new opinion. (App. 1.) The holdings, and most of the opinion, were unchanged (although the new opinion included a strong dissent on the issue of the interpretation of the Parity Act). With respect to the waiver holding, the court attempted to distinguish *Vizcaino*, but it did not address the other arguments raised by Blue Shield. On July 12, 2012, the court denied Blue Shield's timely petitions for en banc and panel rehearing of the modified opinion. (App. 136.)

REASONS FOR GRANTING THE WRIT

This case presents a recurring and important issue on which the circuits are split: the applicability of waiver to ERISA plan claim denials and, in particular, whether the plan waives defenses to coverage where it did not have sufficient information to have raised those defenses without further factual investigation when the claim was denied. This issue is of enormous practical importance to ERISA plans throughout the nation.

As this Court has frequently recognized, one important goal of ERISA is to create a uniform national system of laws governing employee benefit plans. *See Ingersoll-Rand*, 498 U.S. at 142. On the issue of whether a plan administrator has waived a defense not identified in its initial denial, the circuits are sharply split – some cases applying hard-and-fast rules on one side or the other; some applying case-by-case, fact-specific analyses; some varying the applicable analysis in opinions even within the same circuit. *See Glista*, 378 F.3d at 130-31 (discussing various approaches).

In addition to the absence of uniformity in rules applicable to ERISA plans (many of which operate across multiple federal jurisdictions), the question has a direct impact on the nature, cost and timing of a plan's review and determination of benefits claims – decisions made by the thousands every day. If ERISA plans are faced with the threat of waiver, they will have no choice but to engage in extensive fact-finding

even when an absence of coverage is easily seen from the face of the claims and the plan, in order to make sure that they inform the participant of *every possible other ground for denial*.

This case creates further fragmentation where there ought to be a rule of uniform national application, regardless of the circuit in which a matter is litigated. The disparity in the applicable analysis has significant operational impact on ERISA plans and, by extension, employers and plan participants who will bear the cost of the further fact-finding required.

The Ninth Circuit rule also harms plan participants by needlessly delaying action on claims. It effectively requires plans to defer decisions until the facts relating to all potential grounds can be gathered and evaluated, even when, as here, coverage can be determined expeditiously based on the plain terms of the plan.

The numerous different approaches developed in the circuits will only be harmonized if this Court grants certiorari and provides clarity to the process.

A CIRCUIT CONFLICT EXISTS AS TO WHETHER WAIVER APPLIES AND REQUIRES AN ERISA PLAN TO CONDUCT ADDITIONAL FACT-FINDING TO DEVELOP ALTERNATIVE BASES FOR DENYING A CLAIM

A. The Statutory and Regulatory Framework.

In enacting ERISA, Congress intended to ensure a *uniform* body of laws governing ERISA plans. *See Ingersoll-Rand*, 498 U.S. at 142 (Congress intended ERISA's preemption provision to ensure that "plans . . . would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries."). This Court has held that where ERISA itself is silent, federal courts should create a body of common law to fill the gaps, with an eye toward ensuring uniformity. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); *see also Phoenix Mut. Life Ins. Co. v. Adams*, 30 F.3d 554, 564 (4th Cir. 1994) ("federal common law should be consistent across the circuits") (citation omitted); *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990) ("interpretation of ERISA insurance policies is governed by a uniform federal common law").

Yet the circuits have developed very different, and inconsistent, approaches to deciding whether waiver applies in the context of ERISA's notice requirement for claim denials.

ERISA states that a plan must:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 U.S.C. § 1133.

The specific information that must be provided to a plan member upon a denial of benefits is set forth by regulation, 29 C.F.R. § 2560.503-1(g), and includes "[t]he specific reason or reasons for the denial" and the "[s]pecific reference to pertinent plan provisions on which the denial is based." *See also* 45 C.F.R. § 147.136(b) (additional notice requirements imposed by the Patient Protection and Affordable Care Act). But these requirements must be applied sensibly, so as to impart meaningful information to the participant:

> If [ERISA] plan administrators lost the ability to assert in court reasons for declining coverage that were not asserted at the time reimbursement was declined, the notices would threaten to become meaningless catalogs of every conceivable reason that the cost in question might not be reimbursable, instead of candid statements as to why the administrator framing the notice thinks

> reimbursement is unwarranted. The result, we fear, would be the loss of some of the usefulness of these exchanges.

Juliano v. Health Maint. Org. of N.J., Inc., 221 F.3d 279, 288 (2d Cir. 2000).

As shown below, the circuits are all over the map with respect to what an ERISA plan is required to do prior to notifying a participant that a claim has been denied.

B. Inconsistent and Irreconcilable Approaches Have Developed in the Circuit Courts.

Courts confronted with the issue presented here have taken a variety of approaches, summarized below. *See Glista*, 378 F.3d at 130-31 (discussing different approaches to the question in various federal courts).

The "No Waiver" Rule

Courts in the Second, Fifth, Seventh, and Eighth Circuits have held that a plan does not waive the right to later assert an alternative basis for denial of a claim not stated in the plan's initial communication with the participant.

In *Juliano*, 221 F.3d 279, the plan initially denied a claim because the service was not covered under the terms of the policy. The Second Circuit held that in so doing, the plan did not waive the argument that the service also was not covered because it was not

medically necessary, noting that waiver cannot be used to create coverage under a policy where coverage does not exist. The court further stated: "We do not think USH's failure to mention medical necessity . . . in its communications to the Julianos [ ] constituted a waiver or estoppel with respect to its use of lack of 'medical necessity' as a defense in this lawsuit." *Id.* at 287-88. *But see Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375 (2d Cir. 2002) (holding that the plan waived the right to assert that the plaintiff was not disabled within the meaning of a disability insurance policy because it had all the facts to show her disability at the time it initially denied the claim on another ground).

In *Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653 (8th Cir. 1992), the plan initially denied a claim on the ground that the treatment was experimental, and thus not covered under the terms of the plan. The Eighth Circuit rejected the plaintiff's contention that the plan could not later claim lack of medical necessity as an alternative ground because it had never mentioned it in the denial letters. The court explained:

> Mr. Farley has cited no authority, and we have found none, for the proposition that a court reviewing a denial of coverage may consider only those policy provisions specified by an insurer as the basis of denial of coverage when other policy provisions clearly may also be a basis for such a denial. The practical effect of such a rule would be to

> permit the oral modification of employee welfare plans governed by ERISA, a result manifestly in conflict with the intent of the statute and with the case law governing it.

Id. at 659-60.

In *Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 901-03 (7th Cir. 1993), the Seventh Circuit held that the insurer did not waive a condition precedent to coverage by failing to assert it as a ground for denial in the denial letter. "The mere omission of a defense in a letter to a plan beneficiary does not constitute a waiver of the defense. Nothing in Humana's letters expresses an intention to surrender its right to enforce other applicable provisions of the policy." *Id.* at 901 (citation omitted); *see also Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1996) ("When challenged in court, the plan administrator can defend his interpretation with any arguments that bear upon its rationality. He cannot augment the administrative record with new facts bearing upon the application for benefits [ ], but he is not limited to repeating what he told the applicant.") (citations omitted), *cert. denied*, 521 U.S. 1129 (1997).

In *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998), the plan denied a claim on the ground that the insured had never obtained coverage under the policy. In litigation, the plan also claimed that the benefit was excluded under the policy. Because "the administrator advanced a non-frivolous argument that the VAD&D Policy had never been in effect as to

Mr. Schadler[, t]he administrator therefore was not called upon to make any further benefits determinations or even to interpret the terms of the Plan . . . ." *Id.* at 396-97. The court reasoned that it "would stand ERISA on its head if [the court] countenanced bypassing the procedures provided by the statute for making benefits decisions in favor of making the initial benefits decision [itself]." *Id.* The Fifth Circuit concluded by saying that when it became clear to the district court that the defendants were no longer asserting that the participant had not effectively enrolled in the policy, the district court should have "remanded [the case] to the administrator for the development of a full factual record and for the making of the decision on whether to grant or deny benefits [under the policy] in the first instance." *Id.*

The "Limited Waiver" Rule

Another approach permits waiver but declines to adopt any bright-line rule, opting for fact-specific examination to determine whether specific facts justify application of the waiver doctrine. Decisions applying this mode of analysis state that waiver may be found where the plan administrator had before it the information necessary to assert an alternative basis for denying a claim, but chose not to do so.

The First Circuit holds that the particular facts of each situation must be examined, and may or may not support a finding of waiver. *Glista*, 378 F.3d 113. The *Glista* court – after a comprehensive analysis of

the varying approaches taken by other circuits – specifically declined to adopt a hard-and-fast rule: "We [ ] conclude that where a plan administrator articulates in litigation an additional reason for denial of benefits that differs from the reasons articulated to the plaintiff, *reviewing courts have a range of options available*." *Id.* at 116 (emphasis added). Still, the court decided not to consider the insurer's later-raised basis for denial. *Id.* at 128-32. The court reasoned that:

> [ERISA's] goals are undermined where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary. Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits.

Id. (citations omitted). *See also Lauder*, 284 F.3d at 381-82 (Second Circuit case distinguishing *Juliano* and applying a case-by-case analysis).

The "De Novo Review" Rule

Decisions in the Seventh and Third Circuits have not viewed unasserted claims as waived, but instead permit newly asserted grounds to be litigated under a de novo standard of review. *See Matuszak v. The Torrington Co.*, 927 F.2d 320, 322-23 (7th Cir. 1991) ("This Court would emasculate ERISA's disclosure requirement if it were to defer to reasons that the Board first identified on appeal in the District Court,

years after the decision at issue," and "de novo review of the Board's decision [is required] because *no* plan can provide discretion to deny benefits for reasons identified only years after the fact") (emphasis in original).

In *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002), the Third Circuit did not address whether a plan had waived a basis for denial when it had simply let the claim be "deemed denied" by passage of time and then raised the argument in litigation. Instead, the court held that de novo review of the argument was appropriate, rather than the abuse of discretion review that would have applied had the plan actually exercised its discretion.

The Ninth Circuit's "Automatic Waiver" Rule

Here, the Ninth Circuit staked out a position far beyond that articulated by any other circuit: automatic waiver of any basis not expressly stated in the denial letter. The court held that Blue Shield was not entitled to consider the issue of medical necessity for the simple reason that it had not asserted lack of medical necessity as a reason for the initial denial of benefits. The court said:

> The general rule . . . in this circuit and in others, is that a court will not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process.

(App. 43.)

Relying on the notice requirements in the ERISA statute and its regulations, the Ninth Circuit categorically concluded that:

> A plan administrator may not fail to give a reason for a benefits denial during the administrative process and then raise that reason for the first time when the denial is challenged in federal court, unless the plan beneficiary has waived any objection to the reason being advanced for the first time during the judicial proceeding.

(App. 42-43.)[5]

* * *

As discussed above, the various circuits have adopted divergent approaches when considering whether waiver applies at all and, if otherwise applicable, whether it applies where the plan would have been required to undertake additional investigatory efforts to confirm the alternative ground when the claim appeared to be excluded on the face of the policy itself. The lack of uniformity among the circuits manifests itself most starkly when comparing the Ninth Circuit's and Second Circuit's very different responses to the identical question – the plan's ability

[5] The Tenth Circuit veered toward – but did not reach all the way to – the Ninth Circuit's end of the spectrum. *See Spradley v. The Owens-Illinois Hourly Employees Welfare Benefit Plan*, 686 F.3d 1135, 1143 (10th Cir. 2012) (refusing to consider the plan's new argument that the claim was not covered under one policy provision rather than the provision on which it initially relied).

to conduct a review of medical necessity after its initial coverage denial was overturned. The Ninth Circuit concluded:

> A plan administrator may not fail to give a reason for benefits denial during the administrative process and then raise that reason for the first time when the denial is challenged in federal court . . . (App. 42.)

The Second Circuit reached exactly the opposite result:

> We do not think [the plan's] failure to mention medical necessity . . . in its communications to the Julianos [ ] constituted a waiver or estoppel with respect to its use of lack of "medical necessity" as a defense in this lawsuit.

Juliano, 221 F.3d at 287.

An ERISA plan's rights and obligations should not depend on the coast on which the dispute arose. The current circuit conflict can only be resolved by this Court.

C. The Ninth Circuit's Rule Is Erroneous, Making This the Appropriate Case in Which to Resolve the Circuit Conflict.

As can be seen from the discussion above, there is no consistent "general rule" in the circuits. Nor is there even a consistent rule in the Ninth Circuit.

In particular, a recent en banc decision of that very same court affirmed that where a new issue is raised regarding whether a plan provides benefits, the issue must be considered by the plan administrator on remand – not decided by the courts. *See Vizcaino*, 120 F.3d at 1013 (reversing prior panel decision not to remand for consideration of a new ground for denial, holding "we should not allow ourselves to be seduced into making a decision which belongs to the plan administrator in the first instance"); *see also id.* ("we cannot, and will not, predict how the plan administrator, who has the primary duty of construction, will construe the terms of the [plan]"); *id.* at 1013-14 ("We would set a poor precedent were we to intrude upon [the plan administrator's] exercise of discretion before he has even considered and ruled upon the issue"); *id.* at 1014 (the plan administrator "has both the right and the duty to decide [the issue]").

The Ninth Circuit's rule, as set forth in this case, makes little sense. Inquiries into medical necessity require the plan to obtain and review the participant's medical records in order to evaluate the medical necessity of the services in the particular instance. There is no reason for a plan to engage in this fact-finding and hypothetical analysis when comparison of the claim with the terms of the plan facially reveals that the requested service is not covered, even if medically necessary. Any such requirement would add to the cost of administering ERISA plans – a cost that

is unnecessary if the coverage ground for the denial is found to be proper.

There are at least four further reasons why traditional waiver principles should be inapplicable in the context of an ERISA plan's denial of benefits on only one of several potential grounds.

First, state and federal common law doctrines of waiver and estoppel are irrelevant in the context of ERISA. State laws are preempted by ERISA, and federal common law cannot incorporate concepts of waiver and estoppel that would modify the terms of a written ERISA plan, contrary to ERISA's requirements. *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir.), *cert. denied*, 522 U.S. 950 (1997) (citing 29 U.S.C. §§ 1102(a)(1), 1102(b)(3)).[6]

Second, waiver requires evidence of the voluntary and intentional relinquishment of a known right – evidence that likely will be absent in the case of a plan denying benefits because no coverage exists. *See Farley*, 979 F.2d at 659.

Third, in the insurance context, where the dispute goes to whether coverage exists under the policy in the first place, waiver is inapplicable to create coverage where none exists. *See Juliano*, 221 F.3d at

---

[6] *But see Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 647-49 (7th Cir. 1993), and *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1348 (11th Cir. 1994) (declining to rule whether waiver would be applied in ERISA cases).

288; *Lauder*, 284 F.3d at 380. Similarly, estoppel is inapplicable in any case where the participant cannot establish reliance on any representations of the plan. *See, e.g., Farley*, 979 F.2d at 659-60.[7]

Finally, the Ninth Circuit's formulation would lead to scores of premature and needless proceedings. Under the Affordable Care Act, health plans and insurers must provide participants with the opportunity for an external, independent medical review of claims denied on any basis involving medical judgment. *See* 42 U.S.C. § 300gg-19(b); 45 C.F.R. § 147.136. Plans operating in states that already provide an external review procedure that includes certain minimum consumer protections must continue to use the state's process. *See* 45 C.F.R. § 147.136(c)(1)(i). California is such a state. Cal. Health & Safety Code §§ 1374.30-36.

Under the federal law, the independent medical review process must be invoked within four months (in California, six months) of final denial of a claim or else it will be deemed waived by the plan participant. *See* 45 C.F.R. § 147.136(c)(2)(vi); *id.* (d)(2);

---

[7] *See also Manneck v. Lawyers Title Ins. Corp.*, 28 Cal. App. 4th 1294, 1303 (1994) ("[t]he rule is well established that the doctrines of implied waiver and of estoppel, based upon the conduct or action of the insurer, are not available to bring within the coverage of a policy risks not covered by its terms, or risks expressly excluded therefrom . . . ") (citations omitted).

Cal. Health & Safety Code § 1374.30(k).[8] That is why it was important for Blue Shield to specifically inform Harlick that the denial of her claim was *not* based on lack of medical necessity. Any confusion on that point would have prematurely triggered the independent medical review process. Under the Ninth Circuit's rule here – where a plan preserves its rights only by making a full medical necessity judgment to accompany every denial of a claim for any other reason – the independent review process will be put into motion prematurely and unnecessarily, well before any judicial decision is rendered on the coverage ground for denial.

In addition, under both federal and state law, the independent reviewer's determination that a service is medically necessary is binding on the plan. *See* 45 C.F.R. § 147.136(c)(2)(xi); Cal. Health & Safety Code § 1374.34(a). Deployment of the external review process when lack of medical necessity is simply an alternative basis, not the primary basis, for denying a claim that is not covered under the plan terms will inevitably result in further delay and cost, leading to increased cost of health coverage. At a minimum,

[8] *See also* Uniform Health Carrier External Review Model Act § 8, a document that is available at http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.

it results in needless medical necessity investigations by the plan and the external reviewer.

CONCLUSION

Certiorari should be granted so this Court can standardize the rules applicable to ERISA plans that deny a claim on one basis where other bases may exist.

Respectfully submitted,

MICHAEL M. BERGER*
**Counsel of Record*
MANATT, PHELPS & PHILLIPS, LLP
11355 West Olympic Blvd.
Los Angeles, CA 90064
(310) 312-4000
mmberger@manatt.com

Counsel for Petitioner
California Physicians' Service
dba Blue Shield of California