No. 12-457

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

BRIEF OF THE BLUE CROSS BLUE SHIELD ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*[1]

The Blue Cross Blue Shield Association ("BSBSA") is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield companies ("BCBSA Member Companies"). Together, the 38 independent, community-based and locally operated BCBSA Member Companies provide health insurance benefits to nearly 100 million people – almost one-third of all Americans – in all 50 states, the District of Columbia, and Puerto Rico. The BCBSA Member Companies offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses, and individuals.

The BCBSA Member Companies are subject to regulations under a variety of federal and state statutes, including the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* This case concerns whether, in an ERISA suit brought under 29 U.S.C. § 1132(a)(1)(B), plan administrators can defend a denial of benefits on the basis of an additional alternative ground that was not provided during the administrative review process. The Court of Appeals held that an ERISA plan administrator waives the right to defend a denial of benefits based on lack of medical necessity

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[1] Pursuant to Rule 37.2, both parties received notice of the filing of this brief more than 10 days prior to the due date. A letter of consent from each party accompanies this filing. Pursuant to Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity, other than *amicus* and its counsel, made a monetary contribution to the preparation or submission of the brief.

unless it was cited as the reason for the denial during the administrative review process.

On behalf of their national account customers, the BCBSA Member Companies are responsible for administering in multiple states the ERISA claims review process for participants and beneficiaries. Further, consistent with industry practice, the ERISA plans that BCBSA Member Companies administer or insure, in addition to containing other coverage requirements, typically limit coverage to medically necessary treatments and procedures. The BCBSA Member Companies have an interest in a uniform approach to whether a lack of medical necessity defense is deemed waived if not raised in the administrative claims review process. Clear, predictable rules are necessary to the efficient operation of multi-state plans.

BCBSA also has a further interest specifically in the Court's rejection of the Ninth Circuit's waiver rule. If the Court of Appeals' waiver rule is allowed to stand, the BCBSA Member Companies would be compelled routinely to conduct unnecessary, time-consuming, and expensive medical necessity reviews to avoid a waiver risk in the event a district court rejects the principal grounds for a denial.

SUMMARY OF ARGUMENT

There is a split in the circuits on the question whether, in an ERISA civil enforcement action under 29 U.S.C. § 1132(a)(1)(B), a plan administrator waives the right to invoke a basis for denial of benefits not raised during the administrative review process. Here, the Ninth Circuit – consistent with the Eighth and Tenth Circuits – adopted an automatic waiver rule. In contrast, the Fifth and Seventh Circuits have rejected a waiver rule and

have either remanded back to the plan administrator for development of the administrative record on the newly asserted ground or have authorized the district court to review the newly asserted ground under a de novo standard of review. Other circuits – specifically, the First and Second Circuits – have adopted a facts and circumstances approach to waiver, and have found waiver where there has been a risk of "sandbagging" the ERISA claimant by intentionally holding in reserve a ground for denial as to which the plan administrator has sufficient information to base a decision. The Court's review is warranted to resolve the range of approaches the courts of appeals have taken on a recurring issue of ERISA plan administration.

The Court's review also is warranted because the Ninth Circuit's decision is wrongly decided on a number of legal and policy grounds. First, the decision is inconsistent with the principle enunciated in *Conkright v. Frommert*, 130 S. Ct. 1640 (2010), that, where a plan provides the plan administrator with discretionary authority to interpret the plan, an administrator's initial, good-faith mistake in plan interpretation does not allow the reviewing court to divest the administrator of its discretion when considering a revised interpretation of the plan. Contrary to *Conkright*'s view of the pre-eminent role of plan administrators in interpreting the plan, the Ninth Circuit refused altogether to consider the administrator's alternate ground for denial of the benefits. Second, the Ninth Circuit's automatic waiver rule would produce boilerplate denial letters that include every possible basis for the decision, undermining the purpose of ERISA's notice provision, 29 U.S.C. § 1133, to communicate decisions clearly to the plan participants. Third, the

Court of Appeals erred in extending an automatic waiver rule to a denial based on lack of medical necessity, which involves a particularly fact-intensive inquiry. No other court of appeals has adopted such a rule, absent clear evidence of manipulative or bad-faith behavior on the plan's part (behavior that plainly did not occur in this instance).

Finally, the Ninth Circuit's decision does not comport with the practical realities of the claims administration process, as set forth in the relevant Department of Labor ("DOL") claims-procedure regulations and recent regulatory guidance under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, § 1001 (amending the Public Health Service Act ("PHSA"), as codified at 42 U.S.C. § 300gg *et seq.*). For example, the pertinent regulations mandate short timeframes for resolving claims and internal appeals, and the time allotted in the claims administration process does not contemplate a leave-no-stone unturned approach to a review of the merits of the claim – an approach that the Ninth Circuit's automatic waiver rule compels. Moreover, by requiring a plan administrator to identify lack of medical necessity as a ground for denial or face waiving it, the Ninth Circuit's automatic waiver rule would have the unintended effect of triggering ACA's mandate for external review of final internal appeal determinations that involve medical judgment, thereby increasing costs to plans and plan participants and delaying the resolution of claims.

ARGUMENT

I. Review Is Necessary to Address a Split in the Courts of Appeals on an Important Question of ERISA Plan Administration

ERISA requires every employee benefit plan to "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." 29 U.S.C. § 1133(a). In addition, the plan administrator must provide any participant whose claim for benefits has been denied a "reasonable opportunity" for a "full and fair review by the appropriate named fiduciary of the decision denying the claim." *Id.* § 1133(b). In interpreting these two requirements, the courts of appeals have taken a variety of approaches as to whether ERISA plans waive their right to invoke a basis for denial not asserted during the administrative claims review process when defending an ERISA action for improper denial of benefits brought pursuant to 29 U.S.C. § 1132(a)(1)(B).

As detailed in the Petition, there is a split of authority over whether a waiver can occur. There are further splits of authority among the differing waiver and no waiver approaches. And among the courts favoring a waiver rule, there are conflicting views on what facts and circumstances give rise to a waiver. Among the courts rejecting the waiver rule, no consistency exists as to who evaluates the newly raised ground for denial in the first instance (the plan administrator or the court) and as to what standard of review applies. *See* Petition at 13-20.

With a majority of the courts of appeals having addressed the waiver issue and arriving at inconsistent conclusions, there is no prospect that the courts of appeals will develop a predictable, uniform rule without this Court's intervention.

Because many ERISA plans operate across jurisdictions, the array of approaches taken by the courts of appeals leaves the plans operating under conflicting rules about a basic aspect of plan administration – namely, whether to identify and investigate every potential basis for the denial of benefits or risk waiver. When, following *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Courts of Appeals produced a similarly fractured approach to the question of the standard of review that applies when an ERISA plan administrator who has discretionary authority both evaluates and pays claims, the Court inevitably took up the question in *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). The Court's review is similarly necessary here.

A. *The Ninth, Tenth, and Eighth Circuits Have Adopted an Automatic Waiver Rule*

In the decision below, the Ninth Circuit announced a "general rule" that a court may not "allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process." Cert. App. 43. The plan administrator had rejected Respondent Jeanene Harlick's claim for coverage for treatment for an eating disorder at a residential treatment facility on the basis that the plan explicitly excluded coverage of residential treatment for mental illness. Citing the exclusion provision in the plan, the district court granted summary judgment in favor of the plan. *Id.* at 132-34. On appeal, the Ninth Circuit

reversed, holding that the California Mental Health Parity Act overrode the plan exclusion and mandated coverage for medically necessary treatment for severe mental illnesses under the same financial terms as those applied to physical illnesses. *Id.* at 41-42. Rather than remanding to the plan administrator to determine whether Harlick's treatment was in fact medically necessary, the Ninth Circuit held that the plan had "forfeited the ability to assert that defense in the litigation now before us" because the plan had not asserted during the administrative process that medical necessity was a reason for denying Harlick's claim. *Id.* at 46.

The Tenth Circuit recently adopted a similar rule in *Spradley v. Owens-Illinois Hourly Employees Welfare Benefit Plan*, 686 F.3d 1135 (10th Cir. 2012). There, the court held that a district court reviewing a plan administrator's decision under an abuse of discretion standard may only consider the specific basis upon which the plan administrator relied in its administrative denial of benefits. *Id.* at 1141. In the Tenth Circuit's view, a plan may not decide a claim on one basis and, if that basis proves incorrect, "then later tr[y] to come up with a more plausible reason for the denial of benefits." 686 F.3d at 1142; *see also id.* (rejecting notion that "Plan administrator be given interminable opportunities to search for alternate grounds to deny benefits").

The Eighth Circuit also has adopted a rule that a court reviewing an ERISA plan administrator's denial of benefits under an abuse of discretion standard should not consider "after-the-fact plan interpretations devised for purposes of the litigation." *Marolt v. Alliant Techsystems Pension and Ret. Admin. Comm.*, 146 F.3d 617, 620 (8th Cir.

1998). The Eighth Circuit allows consideration of grounds not relied upon by the plan administrator at the time the denial was made only if the district court is exercising de novo review of the denial of benefits. *See Hillstrom v. Kenefick*, 484 F.3d 519, 528 (8th Cir. 2007); *see also Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 659 (8th Cir. 1992) (affirming district court's holding that ERISA claimant had not met its burden of establishing medical necessity even though insurer had not identified medical necessity as a basis for denying the benefits, where denial decision was subject to de novo review).

B. *The Fifth and Seventh Circuits Have Adopted a No Waiver Rule*

In sharp contrast to the approaches taken by the Eighth, Ninth, and Tenth Circuits, the Fifth and Seventh Circuits allow district courts reviewing benefits denials for abuse of discretion to consider rationales for the denial not provided during the administrative review process. *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998); *Loyola Univ. v. Humana Ins.*, 996 F.2d 895 (7th Cir. 1993).

In *Schadler*, the plan administrator had denied benefits under an accidental death and dismemberment policy on the ground that there was no policy in force. The district court upheld the denial of benefits based on a reason the plan argued for the first time in litigation – that a policy exclusion for self-inflicted injury applied. On appeal, the Fifth Circuit held that the plan had not waived its right to invoke the exclusion. The court emphasized that, at the administrative review phase, the administrator had invoked a "non-frivolous" argument that there was no policy in effect and

"therefore was not called upon to make any further benefits determinations or even to interpret the terms of the Plan at all in concluding that Mr. Schadler was not covered." 147 F.3d at 396.[2] The court of appeals then held that the district court should not have engaged in de novo review of the applicability of the self-inflicted injury exclusion but rather should remand to the plan administrator. *Id.* at 397-98.

In *Loyola*, the plan administrator had denied coverage for a heart transplant on the ground that the insured did not meet Medicare's guidelines for being a good heart transplant candidate. 996 F.2d at 896. In litigation, the plan argued for the first time that the insured was not entitled to benefits because he failed to comply with the plan requirement that he obtain prior approval for the procedure. *Id.* at 901. The Seventh Circuit found that the plan had not waived its right to invoke the prior approval provision, explaining that "[t]he mere omission of a defense in a letter to a plan beneficiary does not constitute a waiver of a defense." *Id.* In the absence of any evidence that the plan expressed "an intention to surrender its right to enforce other applicable provisions of the policy," the plan was not limited to relying on the basis for denial asserted by the plan administrator. *Id.*; *accord Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991) (plan administrator's reason for denial of benefits "first

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[2] The court left open the possibility that a waiver might occur if the administrator "asserted one plan exclusion at the administrative level and trial counsel then bolstered the administrator's position before the district court with other exclusions." *Schadler*, 147 F.3d at 396.

identified on appeal in the District Court" could be considered but is subject to de novo review).

C. *The First and Second Circuits Have Adopted a Waiver Rule That Turns on Whether the Plan Administrator Had Sufficient Information to Assert the Basis for Denial*

The circuits adopting the automatic waiver rule reason that the rule is needed to avoid "sandbagging" ERISA claimants in litigation with post hoc rationales. *See* Cert. App. 42-44; *Spradley*, 686 F.3d at 1140; *Marolt*, 146 F.3d at 620. Rather than adopting a blanket no waiver rule to avoid sandbagging, the First and Second Circuits have limited the waiver rule to those situations that create the greatest risk of sandbagging – specifically, where the plan has all necessary information to deny benefits on a particular basis but chooses not to cite that basis until litigation.

In *Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375 (2d Cir. 2002), First Unum had denied disability benefits on the "questionable" basis that Lauder was not covered by the policy on the date of her injury. *Id.* at 382. In litigation, when its lack of coverage ground was rejected, First Unum argued lack of disability as a new ground for denial. On appeal, the Second Circuit declined to adopt a blanket waiver rule in the ERISA context and instead endorsed a "case-specific analysis." *Id.* at 381. Citing its "unwillingness to endorse manipulative strategies," the court of appeals treated First Unum's lack of disability defense as waived. The court of appeals emphasized that First Unum "had all [of Lauder's] evidence of her disability before it, and could easily have evaluated that evidence to assert a lack of

disability defense" rather than resting on "the questionable – but cheapest – argument of lack of coverage." *Id.* at 382.

Similarly, in *Glista v. Unum Life Ins. Co.*, 378 F.3d 113 (1st Cir. 2004), the First Circuit, adopting a facts and circumstances approach, treated the plan's newly asserted ground for denial as waived. Among the key factors was the court's finding that the plan administrator had sufficient information to raise the basis for denial during the administrative review process but declined to do so. *Id.* at 132.

With the Ninth Circuit adopting an automatic waiver rule, the circuit conflict is now sufficiently sharp and well-developed to warrant the Court's intervention. This circuit split is particularly disruptive because many ERISA plans are national in scope, creating the likelihood that plans will be enforced differently based on where the case is litigated.

II. The Court of Appeals' Decision Is Legally Incorrect and Problematic from a Practical and Policy Standpoint

Not only is the Ninth Circuit's approach at odds with other circuits, the decision is – for numerous reasons – infirm legally, practically, and as a matter of ERISA and other federal policy. More specifically, the Ninth Circuit's waiver rule is contrary to a very recent precedent of this Court, is inharmonious with the objectives of ERISA's requirement for administrative review prior to judicial review, needlessly requires investigation of fact-intensive medical necessity grounds for determining a claim, and is inconsistent both with regulations issued by the DOL governing ERISA-plan claims procedures and with the regulatory regime established by ACA.

A. *The Ninth Circuit's Automatic Waiver Rule Is Contrary to Conkright v. Frommert*

As this Court recently observed: "People make mistakes. Even administrators of ERISA plans." *Conkright v. Frommert*, 130 S. Ct. 1640, 1644 (2010). Indeed, ERISA plan administrators face a difficult task in their decision-making: ERISA is "an enormously complex and detailed statute, and the plans that administrators must construe can be lengthy and complicated." *Id.* (internal citation and quotation marks omitted).

Here, the Ninth Circuit adopted a punitive rule that the plan administrator gets one chance to review a benefits denial decision and waives any grounds for denial not identified during the administrative review process – *even if* the administrator had no reason to expect that the reviewing court would reject the asserted rationale for denial, *even if* the administrator lacked sufficient factual information to assert the alternate grounds for denial, and *even if* the administrator made its decision based upon a fully developed record relating to the primary ground relied upon. The Ninth Circuit's approach is inconsonant with the leniency *Conkright* instructs with respect to plan administrator decision-making; hence, with plenary review, the Court can both resolve a circuit split *and* correct a clear legal error.

In *Conkright*, the plan administrator adopted a particular method for determining how past lump sum distributions of retirement benefits would be accounted for in determining the current pension benefits of employees who had left the company and were then later rehired. During the first round of

judicial review, the Second Circuit held that the plan administrator's interpretation of the pension plan was unreasonable. *See* 130 S. Ct. at 1645. On remand, the plan administrator proposed a new interpretation of the plan. Even though the plan gave the administrator discretionary authority to interpret the plan, the district court conducted de novo review and rejected the administrator's new interpretation in favor of an interpretation proposed by the ERISA claimants. On appeal, the Second Circuit affirmed, holding that a court need not apply a deferential standard of review where the administrator's previous construction of the same plan terms had been rejected. *Id.* at 1646.

Taking up the issue, this Court roundly rejected the Second Circuit's "one-strike-and-you're-out" approach, holding that the court of appeals' decision was not supported by "the terms of the plan, principles of trust law, and the purposes of ERISA." *See id.* at 1647. First, the Court noted that the plan at issue granted the administrator general authority to construe the plan, and "[n]othing in that provision suggests that the grant of authority is limited to first efforts to construe the Plan." *Id.* Second, under trust law, a court should not strip a trustee of his discretion unless "there is a reason to believe that he will not exercise that discretion fairly – for example, upon a showing that the trustee has already acted in bad faith." *Id.* Third, the dual purposes of ERISA in (1) striking a balance between ensuing fair and prompt enforcement of rights under a plan and encouraging the creation of such plans, and (2) avoiding a patchwork of different interpretations of a plan that covers different jurisdictions are furthered by "permitting an employer to grant primary interpretive authority over an ERISA plan to the

plan administrator." *Id.* at 1649. As the Court explained, "the interests in efficiency, predictability, and uniformity – and the manner in which they are promoted by deference to reasonable plan construction by administrators – do not suddenly disappear simply because a plan administrator has made a single honest mistake." *Id.*

The Ninth Circuit, in this case, adopted the very "one-strike-and-you're-out" approach rejected in *Conkright*. In fact, the Ninth Circuit adopted a more extreme version of the "one-strike-and-you're-out" approach than that adopted by the Second Circuit. In *Conkright*, after the Second Circuit rejected the administrator's first interpretation of the plan, the court of appeals gave the administrator the opportunity to develop a new interpretation. The Second Circuit's error was in refusing to provide the second interpretation a deferential standard of review. The Ninth Circuit has refused even to allow the administrator a second opportunity to interpret the plan. Just as the Second Circuit's approach found no support in the plan, trust law, or the purposes of ERISA, the Ninth Circuit's approach is equally – if not more – insupportable.

As in *Conkright*, there is here no evidence that the plan's grant of discretionary authority to the administrator is limited to first efforts to construe the plan. *See id.* at 1647. In addition, as the Court noted in *Conkright*, trust law does not support stripping the administrator of a second opportunity to interpret the plan, especially in the absence of a showing that the administrator acted in bad faith. *See id.* Last, as the Court held in *Conkright*, ERISA's purposes are best furthered by honoring an employer's decision to "grant primary interpretive

authority over an ERISA plan to the plan administrator" even when the administrator's first interpretation is wrong. *Id.* at 1649. The Ninth Circuit, having rejected the administrator's reliance on the exclusion for residential treatment of mental illnesses, improperly divested the administrator of primary authority for interpreting the plan by refusing even to consider a new ground (lack of medical necessity) for denying the benefits at issue.

B. *The Automatic Waiver Rule Undermines the Purpose of ERISA's Notice Provision*

As noted above, ERISA requires that every employee benefit plan "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." 29 U.S.C. § 1133(1). The purpose of the notice provision is to "spawn meaningful dialogues between plan administrators and plan members" (*Juliano v. Health Maint. Org. of N.J., Inc.*, 221 F.3d 279, 288 (2d Cir. 2000)) and to facilitate an internal review process that minimizes the number of frivolous lawsuits, encourages consistent treatment of claims, provides a non-adversarial dispute resolution process, and reduces the cost and time of claims settlement. *See Glista*, 378 F.3d at 129; *Powell v. AT&T Comm., Inc.*, 938 F.2d 823, 826 (7th Cir. 1991).

In order to avoid the Ninth Circuit's automatic waiver rule, plan administrators would be required to take a "kitchen-sink" approach to claims denial notices. As the Second Circuit observed, under an automatic waiver rule, "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." *Juliano*, 221 F.3d at 288.

By requiring a plan administrator to identify every potential reason for denial, an automatic waiver rule would transform the administrative claims process in a manner inconsistent with the statutory purpose of the notice provision. The notice is intended to allow the plan administrator and participant to engage in a meaningful dialog, through a non-adversarial process, about why the claim was denied. Administrators faced with an automatic waiver rule will be compelled to provide the participant essentially boilerplate claims denial letters with an exhaustive list of bases for denial. As a result, the notices will be less susceptible to being "written in a manner calculated to be understood by the participant," as required by 29 U.S.C. § 1133(1). Moreover, participants will have no meaningful notice of the principal basis for the claims denial, making it considerably more difficult for the participant substantively to engage in the administrative review process.

C. *The Ninth Circuit, at a Minimum, Erred in Applying an Automatic Waiver Rule When the Plan Had No Ill-Intention in Not Initially Raising the Lack of Medical Necessity*

The Ninth Circuit's decision below represents the first instance in which a court of appeals has treated a defense of lack of medical necessity as waived. That is, even in those circuits where plan administrators have been deemed to waive grounds

not asserted during the administrative claims process, the courts have – correctly – made an exception for the lack of medical necessity defense.

In *Juliano* (arising within the Second Circuit), the HMO denied the plan participant's request for reimbursement for at-home nursing care on the ground that it was more cost-effective to provide the nursing care in a skilled nursing facility. The district court, exercising de novo review, focused on the plan term limiting coverage for outpatient services to those that are medically necessary, and upheld the benefits denial because the participant had not met her burden of establishing that home care – as opposed to care in a skilled nursing facility – was medically necessary. On appeal, the Second Circuit affirmed, holding that the burden is on an ERISA plaintiff to establish medical necessity where the plan terms make it a prerequisite for entitlement to benefits. 221 F.3d at 288. The court observed that, under insurance law, an insurer is not deemed to waive arguments relating to the existence or nonexistence of coverage. Because medical necessity was a prerequisite to coverage under the terms of the plaintiff's contract, it is, the Second Circuit said, "therefore analogous to 'the existence or nonexistence of coverage' of an insurance policy under insurance law." *Id.*

Although the Second Circuit subsequently held that an ERISA plan can, depending on the facts and circumstances, be found to have waived the ability to rely on a ground for denial not asserted during the administrative review process, the court was careful to distinguish *Juliano*. *See Lauder*, 284 F.3d at 381. Where medical necessity is a required element of the policy, the ERISA claimant bears the burden of proof.

Id. Thus, "[i]n the Julianos' case, to deem the defense of medical necessity to be waived, and thereby to allow the Julianos to recover without providing an essential element of their claim under the policy, would improperly expand the coverage of that policy." *Id.*

Similarly, in *Farley*, the Eighth Circuit held that an ERISA insurer does not waive the ability to rely on medical necessity provisions in the insurance contract simply by failing to cite them during the administrative review process. Waiver, the court concluded, requires a voluntary and intentional relinquishment of a known right, and there was no evidence that the insurer communications to the plan participant "expresse[d] any intention to surrender its right to enforce applicable provisions of the policy other than the ones cited in those letters." 979 F.2d at 659.

In addition, the rationale cited by courts in support of a waiver rule – namely, avoiding supposed "sandbagging" of the participant – would not compel a waiver of Petitioner Blue Shield of California's lack of medical necessity defense in this case. Here, there was no evidence that Blue Shield of California viewed medical necessity as a ground for denial when the plan administrator denied the claim and purposefully withheld the ground from the participant. Nor is this case similar to *Lauder*, where the plan administrator relied on a "questionable" basis for denial with the expectation that it could rely on other grounds in litigation. Blue Shield of California relied on an explicit, non-ambiguous exclusion in the plan contract (a basis for denial even upheld by the district court), and there is no evidence it should have anticipated the Ninth

Circuit's ruling that a state statute abrogated the plan term.

In the end, the Ninth Circuit's approach of authorizing coverage under an automatic waiver theory – when further investigation may show that a coverage exclusion applies and when the plan administrator had no ill-intention in the initial adjudication of the claim – harms all of the plan participants not involved in the litigation. They are entitled to administration of the plan "solely in the interests of the participants and beneficiaries" and "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1). Yet, the Ninth Circuit's approach potentially results in coverage where explicit terms (such as a medical necessity exclusion) in the written plan would mandate denial. Funds otherwise available to pay (or increase) benefits and to defray plan expenses to the advantage of all participants will instead be used to provide coverage unauthorized under the plan's terms.

D. *The Ninth Circuit's Waiver Rule Is Unworkable in Light of the Statutory and Regulatory Claims Procedures Imposed Under ERISA and ACA*

The Ninth Circuit's automatic waiver rule is strikingly unworkable in light of ERISA's claims-procedure regulations and more recent regulatory requirements instituted pursuant to ACA. Under the DOL claims-procedure regulations, which have been in existence for over a decade, there are strict timeframes for completing initial benefits determinations and administrative appeals. *See* 29 C.F.R. § 2560.503-1. ACA, in turn, requires ERISA-governed group health plans and health insurance

issuers of group health plans to have in effect a review process that complies with the claims-procedure regulations earlier issued by the DOL and as supplemented subsequently pursuant to ACA. *See* ACA, Pub. L. No. 111-148, § 1001 (adding PHSA § 2719(a)(2)(A)). Implementing this ACA statutory provision, DOL (along with other agencies with oversight under ACA) has issued regulations adding in several respects to the claims and appeals procedures in the DOL claims-procedure regulations. *See* 29 C.F.R. § 2590.715-2719.

Under the DOL claims-procedure regulations and the ACA implementing regulations as now in force, an ERISA plan generally must make initial benefits claims determinations within 15 or 30 days, depending on whether the claim is submitted prior to, or after, a medical service is incurred. *Id.* § 2560.503-1(f)(2)(iii)(A), (B). A plan, in general, must complete associated appeals within 15 to 60 days, depending again on the type of claim at issue and also on how many levels of appeal are available within the plan. *Id.* § 2560.503-1(i)(2)(ii), (iii). During the appeal process, a plan must consult with medical professionals on issues involving medical judgment, such as medical necessity. *Id.* § 2560.503-1(h)(3)(iii). Moreover, in the event a plan seeks to introduce a new ground on appeal in support of an initial benefits denial, the plan must notify the participant of any new rationale invoked (and any evidence supporting it) sufficiently in advance of the deadline for completing the appeal so as to allow the

participant a reasonable opportunity to respond. *See id.* § 2590.715-2719(b)(2)(ii)(C)(1), (2).[3]

ACA also added a new mandate for external review (*i.e.*, administrative review by officials or entities separate from the plan) of final internal appeal determinations that involve medical judgment. *See* ACA, Pub. L. 111-148, § 1001 (adding PHSA § 2719(b)). Depending both on whether the ERISA plan is self-insured by the employer or insured by an insurance company and on whether the plan's home state has in place its own external review law, the relevant external review may involve state officials, federal officials, or contractors known as "independent review organizations." *See id.*; 29 C.F.R. § 2590.715-2719(c), (d).

Against this backdrop, the Ninth Circuit's automatic waiver rule is impracticable. Within the tight time constraints under the applicable regulations for initial claims and appeals, a plan would need to determine and investigate all relevant bases for decision on a claim (both positive and negative to payment of the claim), or else risk waiving legitimate grounds for denial of the claim if judicial review is sought. For a claim such as the one at issue in this case that involved both questions of whether the medical service fit within the contractual array of coverages and questions

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[3] Extensions to the time periods applicable for claims decisions are available under certain circumstances. *See* 29 C.F.R. § 2560.503-1(f)(2)(iii)(A), (B). Additionally, for claims denominated as "urgent," much more abbreviated time periods apply overall. A plan generally must complete its initial determination on an urgent claim within 72 hours, and it likewise must complete any appeal within 72 hours. *See id.* § 2560.503-1(f)(2)(i); *id.* § 2560.503-1(i)(2)(i).

concerning medical judgment (*i.e.*, medical necessity), all investigation and decision-making on the claim initially would need to conclude within a matter of days for a pre-service claim, and a few weeks for a post-service claim. The time constraints for investigating and identifying grounds for deciding internal appeals are equally tight and are accompanied by the requirements that medical consultants be utilized where medical judgment is at issue and that any newly cited grounds must be disclosed to the member with sufficient time for response.

Most important, with an automatic waiver rule applying, the plan would be forced to waste its resources, along with those of the medical professionals with whom it consults. Even when there is an obvious eligibility impediment to the payment of benefits, the plan will feel the need to engage in the time-consuming task of identifying the full list of other grounds potentially pointing toward a denial of benefits, meaning that the plan will also occupy (and pay for) the time and effort of medical consultants to determine medical necessity even when the chances are only slight that a medical basis for the administrative decision would be reached on judicial review. Essentially, the Ninth Circuit's rule mandates that a plan make a mountain out of every claim that might be a mole hill, or else be prepared to pay benefits upon judicial review (and thereby expend the plan's limited funds).[4]

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[4] There is also the possibility that insured ERISA plans would need to accomplish all of the necessary steps in the claims and appeals process under even shorter timeframes than under the federal regulations. Because of ERISA's insurance saving clause (29 U.S.C. § 1144(b)(2)(A)), state prompt-pay and similar

Further, the time and resources of external reviewers will likewise be wasted on innumerable occasions. Because the plan will have identified, as a fail-safe, any medical grounds necessitating a denial of benefits even when there are plainer bases for a denial rooted in contractual coverage terms, participants likely will invoke external review upon the plan citing the alternative medical basis for decision. Justifiably, the participant will not wish to risk waiving his or her right to external review of denials with a medical basis by not timely invoking external review, notwithstanding that the medical issue is just an alternative basis for decision.

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laws might not be preempted for insured ERISA plans. If it were difficult to identify and investigate all possible bases for determining a claim within the schedule allotted in the federal regulations, it would be doubly difficult to do so under more stringent state laws.

CONCLUSION

The Court should grant the petition for writ of certiorari.

Respectfully submitted,

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