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

REPLY IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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INTRODUCTION

Jeanene Harlick's Response to Petition for Writ of Certiorari demonstrates precisely why the Ninth Circuit's decision in this case warrants this Court's review to harmonize ERISA law. Blue Shield analyzed the cases by dividing them into groups to illustrate the disparate approaches adopted by the circuits on whether and how to apply the doctrine of waiver when ERISA plans seek to assert a ground for denial of a claim not previously raised. In her effort to eliminate those groupings, Harlick succeeds only in highlighting the inconsistency in the case law and the need for a uniform rule to govern the rights and responsibilities of ERISA plans when evaluating benefit claims.

A definitive ruling from this Court is needed, to provide guidance to courts across the circuits and to allow ERISA plans to operate, and to anticipate consistent results in different jurisdictions, in accordance with a uniform body of federal law.

I.

HARLICK'S PARSING OF THE INCONSISTENT CASES CONFIRMS THE EXISTENCE OF THE CONFLICT

Harlick asserts that there is no circuit conflict as to what to do when an ERISA plan raises a defense that it did not raise in the administrative process. She argues that *every* court has acknowledged the applicability of the same underlying rule of waiver.

Not only does her discussion of the cases fail to bear this out or to neutralize the circuit conflict, it highlights that conflict.

Harlick's characterization of the state of the law is off base. She says "[t]he courts of appeal agree that the doctrine of waiver applies to late-raised defenses in ERISA benefit litigation . . . ." (Resp. at 11.)[1] That is simply false. As the Petition explained, several circuits have found the doctrine of waiver is not applicable in this ERISA context. *See, e.g., Juliano v. Health Maint. Org. of N.J., Inc.*, 221 F.3d 279, 288-89 (2d Cir. 2000) ("'where the issue is the existence or nonexistence of coverage . . . , *the doctrine of waiver is simply inapplicable*'") (citation omitted; emphasis added); *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 131 (1st Cir. 2004) ("By contrast, other courts have held that *state common law doctrines of waiver have no place in review of ERISA claims . . .* ") (emphasis added); *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir. 1997) ("*the federal common law under ERISA . . . does not incorporate the principles of waiver and estoppel*") (emphasis added); *Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375, 381 (2d Cir. 2002) ("Other circuits have . . . left open the larger question of whether waiver might apply in the ERISA context while concluding that it did not in the

[1] *See also* Resp. at 17-18 ("the courts in fact are in agreement – an ERISA plan administrator may waive a ground for denial of benefits not raised during the administrative process, and whether such waiver occurs depends on the facts of the case").

specific case. . . . Of the circuits that have addressed the issue, only the Fifth Circuit has held that waiver is a viable argument under ERISA.").

These various statements of the law cannot be reconciled with the Ninth Circuit's opinion here, which Harlick herself describes as "simply [holding] that traditional concepts of waiver apply to late-raised defenses in ERISA benefit cases." (Resp. at 19.) Either waiver applies in this context (*Harlick*) or it does not (*Juliano*, etc.). That is a conflict that this Court should resolve.

Harlick's position that every court recognizes the same rule further is negated by the First Circuit's decision in *Glista*. *Glista* acknowledged the very conflict presented here, and recognized the divergent approaches that the circuits have taken. Specifically, *Glista* observed:

- "Some courts have simply engaged in de novo, non-deferential review of the previously unarticulated reason."

- "Other courts have limited the grounds for decision to those articulated by the plan administrator."

- "Some courts have held that the administrator waived defenses to coverage not articulated to the insured during the claims review process when the administrator had sufficient information to have raised those defenses if it so chose."

- "By contrast, other courts have held that state common law doctrines of waiver have no place in review of ERISA claims . . . ."

- Other courts have held that if state common law doctrines of waiver apply, "they did not bar ERISA plan administrators, on the facts of those particular cases, from raising new bases for the denial of benefits in litigation."

- "Still other courts have remanded to the plan administrator to consider new factual evidence or plan interpretations presented for the first time to the district court."

Glista, 378 F.3d at 130-31. Harlick does not even attempt to explain away the multiple conflicts described by the First Circuit in *Glista*.

Nor can Harlick explain away the fact that other courts, given their views on waiver, would have reached a different result from that reached by the Ninth Circuit on the same facts. The Ninth Circuit held that Blue Shield waived the right to consider medical necessity by not asserting it as an alternate ground for denial, when it denied the coverage on the ground that the plan did not cover any residential treatment at all (regardless of medical necessity). The court did so without any finding that Blue Shield had intentionally relinquished the right to later

determine medical necessity in the event residential treatment was found to be covered.[2] By contrast:

- The Second Circuit, applying the analysis of *Juliano*, would have concluded: "'where the issue is the existence or nonexistence of coverage (e.g., the insuring clause and exclusions), *the doctrine of waiver is simply inapplicable*.' Medical necessity is required for the [member's] reimbursement under the terms of the Contract and is therefore analogous to 'the existence or nonexistence of coverage' of an insurance policy under insurance law." *Juliano*, 221 F.3d at 288-89 (citation omitted; emphasis added).

- The Eighth Circuit, applying the analysis of *Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653 (8th Cir. 1992), would have concluded that waiver is "'a voluntary and intentional relinquishment of a known right' and nothing in [the plan's] letters expresses any intention to surrender its right to enforce applicable provisions of the policy other than the ones cited in those letters." *Id.* at 659 (rejecting the contention that the plan waived the right to rely on the medical necessity clause by not raising it when denying coverage).

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[2] Harlick flatly misstates the opinion when she says that "the Ninth Circuit held [that] Blue Shield specifically considered a ground for denial, intentionally abandoned that ground and, having done so, waived the right to raise it again after oral argument on appeal." (Resp. at 2.) The opinion says nothing of the kind, and in fact includes no holding that would support a conclusion of an intentional relinquishment of a known right.

- The Seventh Circuit, applying the analysis of *Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 901-03 (7th Cir. 1993), would have concluded that: "The mere omission of a defense in a letter to a plan beneficiary does not constitute a waiver of the defense. Nothing in [the plan's] letters expresses an intention to surrender its right to enforce other applicable provisions of the policy." *Id.* at 901 (citation omitted).

- The Fifth Circuit, applying the analysis of *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998), would have concluded that because "the [plan] advanced a non-frivolous argument that [there was no coverage under the policy, 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.

Moreover, even if it were true that every other court in fact did hold that waiver is available in an *appropriate* ERISA case, the Ninth Circuit here applied a *blanket* rule of waiver, inconsistent even with the courts that have viewed waiver as situationally appropriate. *See* App. 42-43 ("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.") (emphasis added).

This ruling was unequivocal and without regard to any case-specific facts, including whether the plan had possession of sufficient information at the time of denial to assert the alternate ground. Had the court examined the particular facts of this case and considered and applied the case-by-case analysis that Harlick asserts is the uniform approach in federal courts, the court could not have found waiver because Blue Shield took no intentional action to give up its known rights.

Harlick also quotes the cases out of context and mischaracterizes them in an effort to support her point. For instance, she quotes the *Juliano* opinion's acknowledgement of a general rule of waiver in insurance law, but ignores the opinion's next sentence: "We are reluctant to impose that rule in the case at bar" – as well as its explanations: (1) that the rule has *no application* when the issue is the *existence* of coverage (including medical necessity) and (2) ERISA's notice provisions require a meaningful explanation of the reasons for denial – not "meaningless catalogs of every conceivable reason" to deny the claim. *Juliano*, 221 F.3d at 288; *see also Lauder*, 284 F.3d at 380 (distinguishing *Juliano* in part because there, "medical necessity . . . was a required element for coverage and thus *could not be waived*") (emphasis added). By contrast, "Lauder's case does not raise the same concern. Waiver here would not create coverage where none would otherwise exist . . . ."). *Id.* at 381.

Harlick also ignores the unequivocal statement in *Loyola University* that "[t]he first waiver argument

fails. The mere omission of a defense in a letter to a plan beneficiary does not constitute a waiver of the defense." *Loyola University*, 996 F.2d at 901. Harlick instead quotes (Resp. at 14) from a separate discussion about whether an employee's affirmative statements could constitute a waiver – a very different question from that presented here.

In short, a circuit conflict exists as outlined in the Petition. It requires this Court's review.

II.

HARLICK DOES NOT ADDRESS THE NEGATIVE PRACTICAL IMPACT OF A BROAD WAIVER RULE

The inquiry into the proper rule to apply in these circumstances is not merely an academic exercise. The applicability or nonapplicability of waiver has real consequences in terms of time and money that impact consumers and ERISA plans alike.

As discussed in the Petition, the practical import of the Ninth Circuit's rule would mean that in *every case* (at least, within the jurisdiction of the Ninth Circuit) where a plan denies benefits as not covered by the policy, (1) the plan still must obtain the medical facts to conduct a full medical necessity review (as well as a full review of any other alternate grounds for denial); and (2) the plan member will be entitled to invoke independent medical review. This could create the anomalous situation in which, if the independent medical reviewer found the treatment to be

medically necessary, the plan member could argue that the plan is bound to cover it *even if it were excluded by the plan*.[3]

Harlick's response is simply to point out that not every claim will also be deniable on medical necessity grounds. (Resp. at 21.) Of course, that is true; but it is also true that scores of claims that are denied on coverage grounds *also* may not be medically necessary. If plans must now also assert the absence of medical necessity at the outset, every one of these cases will be entitled to independent medical review. Members may claim that the plan is required to cover any service the reviewer finds to be medically necessary, even when the primary basis for the denial is that the service is not covered by the express terms of the plan.

Furthermore, even as to those many other claims that a plan denies for one reason but that it concedes *are* medically necessary, that concession/determination may only be made after a plan incurs the cost, time and burden of undertaking full analysis of the medical records. Such cost, inevitably, will be

[3] That is because the IMR statute makes the independent review process available to any claim denied "in whole or in part due to a finding that the service is not medically necessary," Cal. Health & Saf. Code § 1374.30(b), and obligates the plan to pay if the reviewer determines that the medical necessity criteria are met. Cal. Health & Saf. Code § 1374.34(a). The Affordable Care Act's independent review provisions are similar. 45 C.F.R. § 147.136.

passed onto employers and then employees; such delay will impact plan members who want or need a prompt decision. Absent that full review, a plan can never be confident that it is not waiving its right to claim an alternate ground for denial if the member brings litigation and successfully challenges the true reason for denial.

III.

THE "QUESTIONS PRESENTED" ARE SQUARELY PRESENTED IN THIS CASE

Harlick argues that this case does not fit within the parameters of the issues presented in the Petition. She argues that this is not a case where Blue Shield did not have sufficient information to deny the claim based on medical necessity, because Harlick's doctors provided medical records to Blue Shield. However, as the record shows, the review of certain medical records was conducted in an effort to ascertain, and then confirm, whether the treatment was in fact *residential treatment not covered under the plan*, or some other category of treatment that might be covered, such as hospitalization. Moreover, the *Harlick* court itself never made such a distinction, instead applying a blanket and unequivocal rule of waiver without regard to whether the plan did or did not have access to the relevant information.

Harlick makes much of the fact that one early denial letter from Blue Shield mentioned absence of medical necessity as the third in a list of three

grounds for denying the claim. This is a trivial red herring. The totality of the administrative record establishes conclusively that Blue Shield did not contend that medical necessity was the reason for the denial – as confirmed by the very communications Harlick quotes. Harlick could not have been laboring under any misconception about that.[4]

The *Harlick* court itself did not consider that letter significant in the least, as it stated: "During the administrative process, Blue Shield never said that it was denying Harlick's claim on the ground that treatment at Castlewood was not medically necessary. Only once during its extensive communication with Harlick and Watson did Blue Shield even suggest that medical necessity might be an issue." (App. 44.) Thus, the *Harlick* court used this fact to support its conclusion that Blue Shield had *never asserted medical necessity as a basis for denial*; in contrast, Harlick attempts to use that same fact to imply intentional waiver. The Ninth Circuit clearly did not reach such a conclusion itself, further undermining the factual support necessary for the legal conclusion of waiver.

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[4] The assertion in the Response that "[b]ecause Blue Shield had raised medical necessity as a defense, Watson requested an Independent Medical Review" (Resp. at 8-9) is contrary to the record below. She sought assistance from the agency, but not an IMR, and a supposed claim of lack of medical necessity did not appear to be her motivation.

As discussed, Blue Shield consistently took the position that the treatment was denied because residential care was not covered under the contract. Harlick repeatedly stresses that very fact as if it supports her argument, but that is precisely the point that demonstrates the illogic of the decision here. Blue Shield did not inform Harlick that the claim was denied on the ground of lack of medical necessity because *the claim was not denied on the ground of lack of medical necessity*. Blue Shield never "conceded" that the treatment was medically necessary (*see* Resp. at 3); it never had to, and therefore did not, consider the question at all. There was no reason for it to do so.[5]

[5] It should be borne in mind that this was not a case in which Blue Shield held the medical necessity ground "in reserve" and strategically raised it in defense late in the game. As the Petition explains, the issue of medical necessity was always irrelevant to this case until the Ninth Circuit raised it for the first time at oral argument. Moreover, Blue Shield has not taken the position that Harlick's services were not medically necessary – only that Blue Shield must have the ability to make that evaluation in the first instance, rather than having it imposed by the Ninth Circuit as a matter of law based upon its own fact-finding.

CONCLUSION

This Court's resolution of the conflict is necessary, and certiorari should be granted.

Respectfully submitted,

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