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

RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether this Court should grant the petition to consider whether an ERISA plan administrator waives a ground for denial of benefits not stated in the initial denial letter, where, in this case, the plan administrator intentionally abandoned that ground for denial during the administrative process, did not raise it in the district court, did not raise it during appellate briefing or argument, and then raised it for the first time in post-argument briefing.

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INTRODUCTION

In the courts below, this case for benefits under the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a), concerned whether petitioner Blue Shield's exclusion for residential care in the operative ERISA plan violated California's Mental Health Parity Act. After oral argument, Blue Shield asked the Ninth Circuit to remand the matter for further administrative review so that it could consider whether the treatment at issue met the Plan's medical necessity requirements. Blue Shield had not raised medical necessity as a defense before the district court or in briefing or argument on appeal. During the administrative process, respondent Jeanene Harlick had submitted four letters supporting the medical necessity of the treatment. Blue Shield had reviewed the treatment facility's medical records four times, advanced but then abandoned medical necessity as a basis for denial, and specifically advised both Harlick and California's Department of Managed Health Care that it was *not* relying on medical necessity as a basis for denying the claim. For these reasons, the Ninth Circuit properly concluded that Blue Shield had waived the right to assert medical necessity as a defense at that late stage of the appellate proceedings.

The questions stated in the petition are not presented in this case. The Ninth Circuit did not hold, as the first question implies, that Blue Shield could not assert or investigate a ground that was not asserted in the initial denial letter. Nor is it true, as

the second question implies, that Blue Shield "did not have sufficient facts to have asserted the additional basis for denial when it denied the claim." Rather, as the Ninth Circuit held, 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.

Other circuits that have addressed the issue have agreed with the Ninth Circuit that the waiver doctrine applies in ERISA benefit litigation, although the question of waiver in any given case necessarily turns on the specific facts. Contrary to Blue Shield's statement, no circuit has held that the waiver doctrine never applies. Blue Shield's suggestion that there is a conflict in the circuits is simply wrong, and the petition for certiorari should be denied.

STATEMENT OF THE CASE

Jeanene Harlick has suffered from anorexia for over two decades. In 2006, her condition became life threatening, and her doctors recommended that she be admitted to Castlewood Treatment Center in St. Louis (Castlewood), one of the few facilities in the country qualified to treat her. Harlick's ERISA plan, issued by Blue Shield, began to pay for her treatment as hospital care, and it seemed that she might finally be on the road to recovery. After ten days, however, Blue Shield denied further coverage on the ground that the plan did not cover residential treatment. In

letters to Harlick's mother, Robin Watson, Blue Shield changed its coverage position several times, eventually conceding that the treatment was medically necessary. Nevertheless, Blue Shield refused to cover the residential treatment. Watson argued that the refusal to cover residential treatment violated California's Mental Health Parity Act (Parity Act).[1] Harlick's family scraped together money for the lifesaving treatment, drawing from a home equity line and refinancing their home.

Harlick brought an action for ERISA benefits under 29 U.S.C. § 1132 (a)(1)(B). Blue Shield moved for summary judgment before the district court, defending its denial on the same grounds it had during the administrative process: that the plan did not cover residential treatment, and the Parity Act did not require it do so. Harlick argued, among other things, that the Parity Act required coverage of her residential treatment at Castlewood. Blue Shield did not argue that Harlick's treatment at Castlewood was not medically necessary, and did not suggest that the district court should remand for consideration of medical necessity if the court ruled against it on the

[1] The California Mental Health Parity Act requires that every health care service plan contract and insurance policy issued in California that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age. Severe mental illnesses are defined to include anorexia nervosa and bulimia nervosa. Cal. Ins. Code § 10144.5; Cal. Health & Safety Code § 1374.72.

statutory issue. The district court granted judgment in favor of Blue Shield, without reaching the question of whether the Parity Act required coverage. Pet. App. 133.

Harlick appealed. Again, Blue Shield argued that the plan did not, and was not required to, cover residential treatment, but, again, Blue Shield did not argue that the treatment was not medically necessary or that the matter should be remanded if the Ninth Circuit ruled against it.

Oral argument took place on May 11, 2011. On May 13, 2011, Blue Shield's counsel sent a letter to the Ninth Circuit, requesting additional briefing "regarding certain matters that were raised and not fully addressed at the argument and that were not addressed in the parties' briefs to this Court or below," including whether Blue Shield had made any administrative determination in regard to medical necessity or had conceded the issue.

Subsequently, in a supplemental brief, Blue Shield *for the first time in litigation* argued that there was insufficient information in the record to determine whether Harlick's treatment at Castlewood was medically necessary and that the matter should be remanded to Blue Shield to consider this issue. This argument was in sharp contrast to the briefs it had filed with the district court and the Ninth Circuit, in

which it stated that it had reviewed the Castlewood medical records on *four separate occasions*.[2]

On August 26, 2011, the court of appeals reversed the district court decision. Although the court agreed with the district court's determination of the issues that it had reached, the Ninth Circuit also addressed the Parity Act and held that the Act required Blue Shield to pay for Harlick's treatment at Castlewood. After a thorough analysis, the Ninth Circuit concluded that "the most reasonable interpretation of the Parity Act and its implementing regulation is that plans within the scope of the Act must provide coverage of all 'medically necessary treatment' for the nine enumerated 'severe mental illnesses' under the same financial terms as those applied to physical illnesses." Pet. App. 102-03. Turning to whether the treatment was medically necessary, the court held that "Blue Shield is foreclosed from asserting that Harlick's residential care at Castlewood was not medically necessary," because, during the administrative process, Blue Shield had told Harlick, her mother, and

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[2] According to Blue Shield, the first review was conducted by a Blue Shield medical director after receipt of the records on or about September 20, 2006. The second review was conducted by a registered nurse and another Blue Shield medical director after receipt of the November 13, 2006 appeal. The third review was conducted in January 2007 by a third Blue Shield medical director, after receipt of approximately 800 pages of medical records from Castlewood. The fourth review was conducted in response to Watson's March 6, 2007 letter. Pet. App. 123, 125; ER 831-35, 848, 850.

the California Department of Managed Health Care that lack of medical necessity was not the basis for denial. Pet. App. 107.

Blue Shield petitioned for panel rehearing and rehearing *en banc*. On the issue of whether Blue Shield could assert "medical necessity," Blue Shield argued *only* that the Ninth Circuit decision conflicted with *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006 (9th Cir. 1997) (*en banc*), in which the court found no waiver by the plan administrator of a late-asserted ground for denial. On June 4, 2012, the Ninth Circuit withdrew its prior opinion and issued a new opinion. As the new opinion explained, in *Vizcaino,* "the plaintiffs explicitly waived, in both the district court and the court of appeals, any objection to that reason being asserted in federal court in defense of the administrator's denial. Indeed, after initially objecting in the district court, plaintiffs 'urged the magistrate judge to address' the plan administrator's late-raised argument." Pet. App. 43. Here, the court noted that it appeared that Harlick's treatment was medically necessary, given that her doctors believed outpatient treatment was insufficient, she entered Castlewood at 65% of her ideal body weight and she needed a feeding tube while at Castlewood. However, the court concluded that it did not need to reach that issue, as Blue Shield had "forfeited the ability to assert that defense in the litigation now before us." Pet. App. 46.

REASONS FOR DENYING REVIEW

I. THIS CASE DOES NOT PRESENT THE QUESTION STATED BY PETITIONER

The first question stated in the petition asks whether the doctrine of waiver applies when an ERISA plan administrator denies a claim on the ground that the plan does not provide coverage, and "later wants to assert or investigate a ground not stated in the initial denial letter." Here, however, the plan administrator did state during the administrative process the ground for denial it now seeks to reassert, and later explicitly disclaimed reliance on that ground.

Harlick was admitted to Castlewood on April 17, 2006 and remained there for approximately 191 days. Pet. App. 111. Blue Shield paid for Harlick's first eleven days at Castlewood because, it later explained, it mistakenly regarded Castlewood as a "Preferred Hospital" due to a "coding error." Pet. App. 111, 129. Blue Shield *never* challenged the medical necessity of the first eleven days of treatment; it denied subsequent treatment on the ground that Castlewood was not a "hospital" but a "residential treatment center."

On November 13, 2006, Watson, Harlick's mother, appealed Blue Shield's denial. Enclosed with the appeal were three letters from professionals who were treating Harlick, demonstrating the medical necessity of her treatment at Castlewood. Pet. App. 123; ER 831-35. On December 12, 2006, Blue Shield

upheld the denial of coverage on the ground that the plan did not cover residential care. Pet. App. 7.

On March 6, 2007, Watson wrote again to Blue Shield, asking why the Parity Act did not require payment of Harlick's claim and enclosing a letter from the physician who had referred Harlick to Castlewood. Pet. App. 125; ER 848, 850. Blue Shield responded that it was standing by its decision to deny the claim for three reasons: (1) all inpatient psychiatric hospital care must be pre-authorized, except for emergency care, and this was not an emergency admission; (2) residential care is not a covered benefit; and (3) after the first eleven days, *the medical necessity of the treatment had not been established*, but the professional fees would be eligible for coverage if claims were submitted and met medical necessity guidelines. Pet. App. 8-9.

Blue Shield wrote again on April 30, 2007, correcting what it claimed were two errors in its prior letter: (1) the preauthorization requirement does not apply to facilities outside California; and (2) professional fees would not be covered unless the professionals billed Castlewood independently. Blue Shield also wrote that the Plan did not cover residential treatment for mental *or* medical conditions, and therefore did not violate the Parity Act. Pet. App. 9.

Because Blue Shield had raised medical necessity as a defense, Watson requested an Independent

Medical Review,[3] which was forwarded to California's Department of Managed Healthcare (DMHC). Pet. App. 10. Blue Shield then *abandoned* its reliance on medical necessity as a ground for denial. In response to the DMHC's inquiry regarding the reason for its denial, Blue Shield *checked* "benefit/coverage" but *did not* check "medical necessity." ER 2651. The DMHC concluded that, although Harlick had been given conflicting information from the Plan regarding the basis for the denial, Blue Shield had denied coverage because the Plan did not cover residential care. Pet. App. 11.

Confirming that the Plan had abandoned any reliance on lack of medical necessity as basis for denial of the claim, on August 3, 2007, Blue Shield's Senior Manager of the Law Department explained to Watson that

> *The Plan is not arguing that Jeanene was not in need of care and treatment for her condition.* However, it is the Plan's position that Jeanene was in a residential treatment program at Castlewood and according to the terms of her Shield Spectrum PPO Plan, residential care is not covered. Pet. App. 10, 45 [emphasis added].

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[3] Under California law, a claimant has the right to an independent medical review when a claim for health benefits is denied on the ground that the treatment was not medically necessary. The independent medical review is performed by the DMHC where, as here, the coverage is provided by a health care plan. *See* Cal. Health & Safety Code § 1374.30.

Consistent with Blue Shield's decision not to press medical necessity as a basis for denying coverage, Blue Shield's motion for summary judgment in the district court did *not* raise the issue of lack of medical necessity, and did not ask for a remand to determine the medical necessity of Harlick's treatment if the district court found that the treatment was otherwise covered. Similarly, in its appellate brief, Blue Shield did not ask for a remand to determine medical necessity. The first time Blue Shield raised the defense of medical necessity was *after* oral argument in the court of appeals. Pet. App. 42.

Thus, Blue Shield raised, and then specifically abandoned, medical necessity as a basis for denial of Harlick's claim during the administrative process. The first question posed by the petition is simply not presented on the facts of this case.

Similarly, Blue Shield's second question also is not presented here. That question asks whether a plan administrator can waive reliance on a defense where it had insufficient facts to have asserted that defense. Here, however, Harlick offered, during the administrative process, the opinions of four different professionals supporting the medical necessity of the Castlewood treatment. And as Blue Shield represented to the district court and the court of appeals in its briefs, Blue Shield had Harlick's Castlewood medical records reviewed *four times*. *See supra*, note 2.

Thus, Blue Shield's suggestion that it did not have sufficient information to address the medical

necessity of Harlick's treatment is wrong. The second question stated in the petition is also not presented by the facts of this case.

II. OTHER CIRCUITS THAT HAVE CONSIDERED THE ISSUE AGREE THAT THE DOCTRINE OF WAIVER APPLIES TO LATE-RAISED DEFENSES IN ERISA BENEFIT LITIGATION

"Waiver is the intentional relinquishment or abandonment of a known right or privilege." *Johnson v. Zerbst,* 304 U.S. 458, 464 (1938). The courts of appeals agree that the doctrine of waiver applies to late-raised defenses in ERISA benefit litigation, but that is not to say that every court finds a waiver in every case. Rather, the determination of whether there has been a waiver "must depend, in each case, upon the particular facts and circumstances surrounding that case. . . ." *Id. See, e.g., Spradley v. Owens-Illinois Hourly Employees Welfare Benefit Plan,* 686 F.3d 1135 (10th Cir. 2012) (plan waived late-raised defense that claimant did not qualify for total disability life benefits where denial was repeatedly based on health plan language); *Glista v. Unum Life Ins. Co.,* 378 F.3d 113, 132 (1st Cir. 2004) (declining to consider the merits of a defense not articulated to the claimant in the claims review process where plan "had the burden, obligation, and opportunity to do so"); *Lauder v. First Unum Life Ins. Co.,* 284 F.3d 375 (2d Cir. 2002) (plan waived the right to contest whether claimant was disabled, where plan had

documentation of disability but chose not to investigate to save money); *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 391 (5th Cir. 1998) (finding waiver not appropriate where factual record regarding late-raised defense was not developed during administrative process); *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) ("We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation.") *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 696 (7th Cir. 1992) (rejecting plan's "*post hoc* attempt to furnish a rationale for denial of benefits.").

Misunderstanding that waiver is a case-specific inquiry, Blue Shield parses the appellate decisions, attempting to create a circuit conflict where none exists. Citing *Juliano v. The Health Maint. Org. of N.J., Inc.*, 221 F.3d 279 (2d Cir. 2000), Blue Shield asserts that the Second Circuit has adopted a "no waiver" rule. In fact, the *Juliano* court recognized that "under the law applicable to insurance policies, an insurer may be barred from raising defenses not asserted in communications to the insured denying coverage." *Id.* at 288 (citation omitted). Indeed, the Second Circuit has unequivocally stated its disagreement with Blue Shield's characterization of *Juliano*: "[I]t is important to note that *Juliano* did not hold that the doctrine of waiver never applies to an ERISA claim. Rather, the court acknowledged that an insurer could waive certain defenses, but that

waiver had not occurred in that particular case." *Lauder,* 284 F.3d at 381. Moreover, in *Lauder,* the Second Circuit found, based on the facts of that case, that the plan waived the late-asserted defense. *See id.* at 382. ("First Unum knew of Lauder's claim of disability, chose not to investigate it, and chose not to challenge it. It therefore waived its right to rely on lack of disability as a defense to Lauder's claim.")

Blue Shields' claim that the Fifth, Seventh and Eighth Circuits have "no waiver" rules is similarly infirm. In *Marolt,* 146 F.3d at 620, the Eighth Circuit acknowledged application of the waiver doctrine in ERISA benefit cases, holding that it was "free to ignore ERISA plan interpretations that did not actually furnish the basis for a plan administrator's benefits decision" because it would not "permit ERISA claimants denied the timely and specific explanations to which the law entitles them to be sandbagged by after-the-fact plan interpretation devised for purposes of litigation." Blue Shield's reliance on an earlier Eighth Circuit decision in *Farley v. Benefit Trust Life Ins. Co.,* 979 F.2d 653, 659 (8th Cir. 1992) is misplaced, as the *Farley* court specifically *declined* to decide whether waiver could be applied to a late-raised defense in that ERISA benefit case.

The Seventh Circuit cases are to similar effect. For example, in *Halpin,* 962 F.2d at 696, the court rejected the plan's "'*post hoc* attempt to furnish a rationale for denial of benefits.'" (citation omitted.) *See also Reich v. Ladish Co. Inc.,* 306 F.3d 519, 524 (7th Cir. 2002) (rejecting plan's attempt to "add new

reasons" for denial during litigation). In *Loyola University of Chicago v. Humana Ins. Co.,* 996 F.3d 895, 902 (7th Cir. 1993), relied upon by Blue Shield,[4] the court specifically acknowledged that a plan could waive a defense in an ERISA benefits case but held that, under the facts of that case, Humana had not done so because its conduct during the administrative process was "consistent with its intent to adhere to, not waive, the plan's requirements that prior approval for the heart transplant was a condition precedent to coverage."

Contrary to Blue Shield's contention, the Fifth Circuit did not announce a "no waiver" rule in *Schadler,* 147 F.3d 388. Rather, the court considered the claimant's argument that Anthem had waived reliance on the exclusion for self-inflicted injuries, but found, on the facts of the case specifically, that a factual record regarding the defense had not been developed during the administrative process that a finding of waiver was not warranted. *Id.* at 397-98.

Blue Shield alleges that a different "approach," which it calls the "limited waiver" rule, is followed by the First Circuit. In fact, *Glista,* 378 F.3d 113, on which Blue Shield relies, illustrates the same

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[4] In *Gallo v. Amoco Corp.,* 102 F.3d 918 (7th Cir. 1997), cited by Blue Shield as an example of the "no waiver" rule, no new reasons for denial were raised after the administrative process. The Seventh Circuit merely stated that the administrator has to give the participant the reason for denial but "he does not have to explain to him why it is a *good* reason." *Id.* at 923.

case-specific approach followed by the other appellate courts when considering late-raised defenses in ERISA benefits cases. In *Glista,* the claimant, diagnosed with primary lateral sclerosis, filed a claim for long term disability benefits under a plan administered by Unum. Unum found that Glista was disabled but denied the claim, based on a pre-existing condition, relying on the Plan's "treatment clause." At trial, Unum invoked for the first time the Plan's "symptoms clause." Glista argued that Unum should not be allowed to rely on the "symptoms clause" because Unum did not rely on that clause during the administrative process. The court noted that Unum had sufficient information to raise the "symptoms clause" during the administrative process, offered no explanation as to why it did do so, and that the goals of the ERISA statutes and regulations 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." *Id.* at 128-29. The First Circuit thus found Unum barred from raising the new clause during litigation, as it had failed to raise it "in the claims review process even though it had the burden, obligation, and opportunity to do so." *Id.* at 132. *Accord Bard v. Boston Shipping Assoc.,* 471 F.3d 229 (1st Cir. 2006).

Finally, Blue Shield contends that the Third and Seventh Circuits follow a "de novo review" rule, under which the late-asserted defense is subject to *de novo* rather than abuse of discretion review. Blue Shield

relies in this regard on *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002). That case, however, is inapposite here. Rather, in *Gritzer,* the Third Circuit addressed the proper standard of review when a plan confers discretionary authority on the plan fiduciary but the fiduciary does not exercise that discretion. The Third Circuit held that the *de novo* standard applies because "in these circumstances, there simply is no analysis or 'reasoning' to which the Court may defer under the arbitrary and capricious standard." *Id.* at 296. *Gritzer* thus reflects the general rule that, where the plan administrator fails to exercise its discretion, the standard of review is *de novo*. *Accord Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 109 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan,* 349 F.3d 1098, 1110 (9th Cir. 2003); *Gilbertson v. Allied Signal, Inc.,* 328 F.3d 625, 632 (10th Cir. 2003). Any challenge to the proper standard of review in a case where the plan administrator does not exercise its discretion cannot be raised here.

Blue Shield's reliance on *Matuszak v. Torrington Co.*, 920 F.2d 320 (7th Cir. 1991) in this regard is similarly misplaced. In that class action, the court reviewed *de novo* and rejected a position first advocated by defendants during litigation. Plaintiffs did not argue that defendants had waived this position. *Id.* at 322 n.3. Moreover, as noted above, the Seventh Circuit has recognized that the waiver doctrine may apply to bar a plan administrator from raising a new

defense in litigation. *See Reich,* 306 F.3d at 524; *Halpin,* 962 F.2d at 696.

Nor does this line of appellate cases, adopting the waiver doctrine in ERISA benefit cases, conflict with decisions holding that claimants cannot assert waiver or estoppel to modify the terms of an ERISA plan. For example, in *White v. Provident Life & Acc. Ins. Co.,* 114 F.3d 26 (4th Cir. 1997), relied upon by Blue Shield, White was covered under a group life insurance policy that provided that he could not simultaneously have group and individual life coverage from Provident. Provident erroneously issued an individual policy to White, who was already covered by a group policy. When it discovered the error, the company repaid all premiums and demanded return of the policy. White refused to accept the repayment or return the policy, and filed a declaratory relief action, arguing that Provident's mistaken acceptance of premiums constituted a waiver of its right to deny dual recovery. The Fourth Circuit disagreed, holding that ERISA preempted a waiver claim that would result in an unwritten modification to the ERISA plan. *Id.* at 29. This situation is not implicated here or in the other cases that recognize that a plan's failure to assert a defense during the administrative process may constitute a waiver of that defense, under appropriate facts.

In sum, although Blue Shield works to divide the Circuits into a variety of categories, 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 a waiver occurs depends on the facts of the case.

III. THE DECISION BELOW PROPERLY CONCLUDED THAT BLUE SHIELD WAIVED RELIANCE ON MEDICAL NECESSITY

The Ninth Circuit unanimously concluded that Blue Shield was not entitled to a remand to reopen the administrative process to determine whether Harlick's treatment was medically necessary. Pet. App. 720. This conclusion was based on the requirements of ERISA and the undisputed facts of the case.

As the court explained, ERISA requires that a "plan administrator who denies a claim must explain the 'specific reasons for such denial' and provide a 'full and fair review' of the denial." Pet. App. 42 (quoting 29 U.S.C. § 1133). In addition, "[t]he administrator must also give the claimant information about the denial, including the 'specific plan provisions' on which it is based and 'any additional material or information necessary for the claimant to perfect the claim.'" *Id.* (quoting 29 C.F.R. § 2560.503-1(g)). "ERISA and its implementing regulations 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."'" *Id.* (quoting *Glista* at 129).

In this case, "only once during its extensive communication with Harlick and Watson did Blue Shield even suggest that medical necessity might be an issue" but "in a letter a few weeks later, a different employee reiterated that Castlewood was not covered because it was a residential facility." Pet. App. 44. Thus, as the decision below noted, Blue Shield acknowledged that the Plan was "not arguing that Jeanene was not in need of care and treatment for her condition" and that "Blue Shield also told the DMHC that the denial was not based on medical necessity." Pet. App. 45. The Court correctly concluded:

> Blue Shield told both Harlick and her mother, as well as the DMHC, that medical necessity was not the reason for its denial of Harlick's claim. It cannot now bring out a reason that it has "held in reserve" and commence a new round of review. Pet. App. 46. *Accord Lauder* at 382 (plan administrator cannot rely on least expensive but questionable basis for denial and hold in reserve stronger defense); *Spradley* at 1140-41 (where plan administrator has sufficient information to assert defense, cannot hold it in reserve and treat the administrative process as a trial run).

Contrary to Blue Shield's contention, and as explained above, the Ninth Circuit did not adopt an "automatic waiver" rule. Rather, the court simply held that traditional concepts of waiver apply to late-raised defenses in ERISA benefit cases. Given

the obligation that ERISA fiduciaries owe to plan participants and beneficiaries, there is nothing remarkable about this conclusion. See *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105, 115 (2008) ("ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator 'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan, . . . it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators 'provide a "full and fair review" of claim denials . . . '" (citations omitted)).

Particularly given that the court of appeal's decision is in line with decisions going back to the early 1990s, the suggestion that the decision below will lead to "scores of premature and needless" independent medical reviews under state and federal law is absurd. ERISA fiduciaries are obligated to consider each individual claim on its merits, provide to the claimant the specific reasons that claim is being denied, with specific reference to plan provisions, a description of any additional information that may be necessary to perfect the claim, and an explanation of why that information is necessary. 29 C.F.R. § 2560.503-1(f). As *Booton v. Lockheed Med. Ben. Plan,* 110 F.3d 1461, 1463 (9th Cir. 1997) observed:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries.

> If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial; if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.

Not every claim raises issues of medical necessity, and only some of those will trigger the need for an independent medical review. If plan administrators such as Blue Shield comply with their obligations to communicate appropriately, there will not be "scores" of needless independent medical reviews.

As many courts of appeal have held, the waiver doctrine properly applies to preclude an ERISA fiduciary from failing to meaningfully communicate with a claimant by holding in reserve reasons for denial of a claim, and then marching those reasons out, one at a time, in an endless stream of administrative reviews. Any other rule would violate the fundamental principles of ERISA statutory and common law, would undermine this Court's decision in *Glenn,* and would deprive Harlick of receiving, after six long years, reimbursement for the life-saving treatment she received.

CONCLUSION

For the foregoing reasons, the petition for writ of *certiorari* should be denied.

Respectfully submitted,

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