No. 16-20174

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

ARIANA M.,

Plaintiff-Appellant

v.

HUMANA HEALTH PLANS OF TEXAS, INCORPORATED,

Defendant-Appellee.

On Appeal from the United States District Court
for the Southern District of Texas
No. 4:14-cv-03206
Honorable Lee H. Rosenthal

Brief of the Secretary of Labor as Amicus Curiae in Support of Plaintiff-Appellant

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

QUESTION PRESENTED 1

SECRETARY'S INTEREST 1

STATEMENT OF THE CASE 2

SUMMARY OF THE ARGUMENT 5

ARGUMENT 6

I. *Pierre* is Not Consistent with the Supreme Court's Reasoning in *Firestone* 6

II. Subsequent Supreme Court and Circuit Court Decisions Undermine *Pierre's* Reasoning 12

III. Overturning *Pierre* Advances the Secretary's Interest in Ensuring Full and Fair Review of Benefits Denials and Uniform ERISA Enforcement 17

CONCLUSION 22

TABLE OF AUTHORITIES

Federal Cases:

Ariana M. v. Humana Health Plan of Texas, Inc.,
854 F.3d 753 (5th Cir. 2017) .... passim

Ariana M. v. Humana Health Plan of Texas, Inc.,
163 F. Supp. 3d 432 (S.D. Tex. 2016)...3

Conkright v. Frommert,
559 U.S. 506 (2010)...13

Crosby v. La. Health Serv. and Indem. Co.,
647 F.3d 258 (5th Cir. 2011) 16

Dutka ex rel Estate of T.M. v. AIG Life Ins. Co.,
573 F.3d 210 (5th Cir. 2009) 12

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989).. passim

Fontaine v. Met. Life Ins. Co.,
800 F.3d. 883 (7th Cir. 2015) 22 n.3

Gobeille v. Liberty Mut. Ins. Co.,
136 S. Ct. 936 (2017)..1, 17

Gulf Underwriters Ins. Co. v. Great W. Cas. Co.,
278 F. App'x 454 (5th Cir. 2008)...21

Halo v. Yale Health Plan, Director of Benefits & Records Yale Univ.,
819 F.3d 42 (2d Cir. 2016) 19

Federal Cases-(continued):

Heimeshoff v. Hartford Life & Acc. Ins. Co.,
134 S. Ct. 604 (2013).. 11, 16

Kinstler v. First Reliance Standard Life Ins. Co.,
181 F.3d 243 (2d Cir. 1999) 14

Luby v. Teamsters Health, Welfare & Pension Trust Funds,
944 F.2d 1176 (3d Cir. 1991) 7, 14

Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.,
168 F.3d 211 (5th Cir. 1999) 3

Metro. Life Ins. Co. v. Glenn,
554 U.S. 105 (2008).. 4, 12, 13, 16

Orndorf v. Paul Revere Life Ins. Co.,
404 F.3d 510 (1st Cir. 2005)..16

Pierre v. Conn. Gen. Life Ins. Co.,
932 F.2d 1552 (5th Cir. 1991) .... passim

Quesinberry v. Life Ins. Co.,
987 F.2d 1017 (4th Cir. 1993) 14, 16

Ramsey v. Hercules, Inc.,
77 F.3d 199 (7th Cir. 1996) 14, 15

Reinking v. Philadelphia Am. Life Ins. Co.,
910 F.2d 1210 (4th Cir. 1990), overruled on grounds by,
Quesinberry v. Life Ins. Co. of N. Am.,
987 F.2d 1017 (4th Cir. 1993) 14

Federal Cases-(continued):

Riedl v. General Am. Life Ins. Co.,
248 F.3d 753 (8th Cir. 2001) 7, 14

Rowan v. Unum Life Ins. Co. of Am.,
119 F.3d 433 (6th Cir. 1997) 14, 15, 16

Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002).................... 1,13, 14

S. Farm Bureau Life Ins. Co. v. Moore,
993 F.2d 98 (5th Cir. 1993) 19

Sec'y of Labor v. Fitzsimmons,
805 F.2d 682 (7th Cir. 1986) (en banc) 1

Shaw v. Conn. Gen. Life. Ins. Co.,
353 F.3d 1276 (11th Cir. 2003) 14

US Airways, Inc. v. McCutchen,
133 S. Ct. 1537 (2013)....................11

Varity Corp. v. Howe,
516 U.S. 489 (1996)....................13

Walker v. Am. Home Shield Long Term Disability Plan,
180 F.3d 1065 (9th Cir. 1999) 14

Federal Statutes:

Labor Management Relations Act:

29 U.S.C. § 186(c) 8

Federal Statutes-(continued):

Employee Retirement Income Security Act of 1974,
as amended, 29 U.S.C. § 1001 et seq.:

Section 2, 29 U.S.C. § 1001 1

Section 402(a)(1), 29 U.S.C. § 1102(a)(1) 16

Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) .... passim

Section 502(a), 29 U.S.C. § 1132(a) 19

Section 502(e), 29 U.S.C. § 1132(e) 9

Section 503, 29 U.S.C. § 1133 .... 1, 18

Section 503(2), 29 U.S.C. § 1133(2) 18

Public Health and Welfare (Title 42):

42 U.S.C. § 300gg-19 .... 2 n.2

State Regulations:

Cal. Ins. Code § 10110.6 20

Ill. Admin. Code tit. 50, § 2001.3 20

Tex. Ins. Code § 1701.062 20

Miscellaneous**:**

29 C.F.R. § 2560.503-1 18

29 C.F.R. § 2560.503-1(a) 18

Miscellaneous-(continued):

29 C.F.R. § 2560.503-1(l) 18

29 C.F.R. § 2590.715–2719 .... 20 n.2

29 C.F.R. § 2590.715–2719(d)(2)(iii)(A)(1) 20 n.2

29 C.F.R. § 2590.715–2719(d)(2)(iii)(B)(5).. 20 n.2

29 C.F.R. § 2590.715–2719(d)(3)(iii)(B) 20 n.2

29 C.F.R. § 2590.715–2719(c)(2)(ix) 20 n.2

Claims Procedure, 65 Fed. Reg. 70246-01, 70255-56 (2000) 18, 19

Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208-01, 37213 (2012) 19

H.R. Rep. No. 93–533 (1974),
as reprinted in, 1974 U.S.C.C.A.N. 4639, 4642-43 9

Bradley R. Duncan, Judicial Review of Fiduciary Claim Denials Under ERISA: An Alternative to the Arbitrary and Capricious Test,
71 Cornell L. Rev. 986 (1986)..8

Robert W. Klein, Insurance Regulation in Transition, 62 J. Risk & Ins.,
373 (1995) 20, 21

Restatement (Second) of Trusts § 4 cmt. d (Am. Law Inst. 1959) 10

Restatement (Second) of Trusts § 187 (Am. Law Inst. 1959) 12

QUESTION PRESENTED

In Pierre v. Connecticut General Life Insurance Co., 932 F.2d 1552 (5th Cir. 1991), this Court held that a plan administrator's factual findings made in the course of denying a claim for benefits should be reviewed by a district court for abuse of discretion in actions under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., even where the plan does not expressly grant the administrator discretion to decide benefit claims. The question presented here is whether the Court should overturn Pierre and hold that factual findings made by a plan administrator that has not been granted discretion in deciding benefit claims should be reviewed de novo.

SECRETARY'S INTEREST

The Secretary of Labor bears primary responsibility for interpreting and enforcing Title I of ERISA, 29 U.S.C. § 1001 et seq. Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 691 (7th Cir. 1986) (en banc). In this role, the Secretary has a substantial interest in ensuring that plan participants receive full and fair review of benefit denials as ERISA requires. See 29 U.S.C. § 1133. He also has a strong interest in ensuring that protections provided by ERISA are implemented uniformly across the nation. See Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943–44 (2016); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385 (2002).

STATEMENT OF THE CASE

On November 7, 2014, Plaintiff-Appellant Ariana M. filed an action for medical benefits under an ERISA-governed employee benefit plan against Defendant-Appellees Humana Health Plan of Texas, Inc. ("Humana") and Eyesys Vision Inc. Plan ("Plan"). Humana insures and administers the Plan, under which Ariana M. was eligible for benefits as the dependent of a plan participant. Compl. ¶¶ 3, 7. Ariana M. suffered from mental illness, including a six-year history of an eating disorder, and needed medical treatment. Id. ¶ 8. Humana initially approved her claim for partial hospitalization, but, after a series of extensions, Humana denied continued partial hospitalization based on its determination that hospitalization was no longer "medically necessary." Id. ¶¶ 10–25. After exhausting her appeals with Humana, Ariana M. brought suit, claiming that she was wrongfully denied medical benefits. Id. ¶ 33.

During proceedings before the district court, Ariana M. filed a motion to determine the standard of review, arguing that the court should employ a de novo standard in reviewing Humana's decision to deny her claim for benefits. Ariana M. v. Humana Health Plan of Texas, Inc., 854 F.3d 753, 756 (5th Cir. 2017) (panel decision). In response, Humana conceded the standard of review for its interpretations of the plan's terms is de novo, id., because Humana "did not argue to the District Court that any provision in the Plan granted it discretion," Humana

Panel Br., at 10. But Humana argued that, under this Court's precedent, its factual findings should be reviewed under an abuse of discretion standard whether or not the Plan included a valid discretionary clause. Ariana M., 854 F.3d at 756.[1] The district court agreed with Humana's arguments. Id. Humana then filed for summary judgment, which the court granted. See Ariana M. v. Humana Health Plan of Texas, Inc., 163 F. Supp. 3d 432, 443 (S.D. Tex. 2016) (district court decision). Though acknowledging that Humana's construction of plan terms is to be reviewed de novo, the district court reviewed Humana's factual findings for abuse of discretion, citing Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc., 168 F.3d 211, 213 (5th Cir. 1999), which relied on Pierre. Id. at 439. The district court concluded that Humana had not abused its discretion in finding that continued partial hospitalization treatment for Ariana M. was not medically necessary. Id. at 442.

Ariana M. appealed to this Court, arguing in part that the district court erred in reviewing Humana's factual findings for abuse of discretion, instead of de novo. Ariana M., 854 F.3d at 756. A panel of this Court noted that while the text of ERISA does not directly address the standard of review to be applied in reviewing plan-administrator's benefits decisions, the Supreme Court did so in Firestone Tire

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[1] A "discretionary clause" is a provision that delegates discretionary authority to the plan administrator or other fiduciary to decide plan benefits, and where those clauses apply to a benefits decision, courts review those decisions for an abuse of discretion. Ariana M., 854 F.3d at 756.

& Rubber Co. v. Bruch, 489 U.S. 101 (1989). Ariana M., 854 F.3d at 756. The panel then discussed this Circuit's decision in Pierre, which interpreted Firestone to "not require de novo review for factual determinations" and found instead that "an abuse of discretion standard of review is appropriate." Id. (quoting Pierre, 932 F.2d at 1553). The panel held that this deferential standard of review applies even if the plan document does not grant the plan administrator discretionary authority to decide plan benefits. Id. at 756–57. Accordingly, the panel affirmed the district court's decision that Humana did not abuse its discretion in denying Ariana M.'s benefits. Id. at 762.

Though it affirmed the district court, the panel lent credence to Plaintiff's critique of Pierre. Id. at 757 n.2. The panel acknowledged, "Plaintiff is not alone in her criticism of Pierre; indeed, Pierre has been rejected by most other Circuit Courts." Id. The panel also explained that as states increasingly ban discretionary clauses in insurance policies—leaving courts to supply the standard of review—Pierre's impact is likely only to grow. Id. Indeed, all three judges on the panel joined a special concurrence in which they questioned the continued viability of Pierre. Id. at 763. The concurrence listed the weaknesses of Pierre, including its incongruence with the post-Firestone Supreme Court decision in Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008), its potential mischaracterization of trust law,

and its faulty analogy to appellate review of trial court and administrative agency decisions. Id. at 763–765 (Costa, Prado, & Higginson, JJ., specially concurring).

Ariana M. successfully petitioned for rehearing en banc. Her petition argued that the panel incorrectly deferred to the factual findings of the benefit plan administrator, contrary to decisions by the Supreme Court and other Circuit Courts. These decisions, she contends, support de novo review of the factual findings underlying Humana's denial of benefits.

SUMMARY OF ARGUMENT

ERISA does not specify the standard of review a district court should apply in reviewing a plan administrator's benefits determination in a suit pursuant to 29 U.S.C. section 1132(a)(1)(B). In Firestone Tire & Rubber Co. v. Bruch, the Supreme Court held that the default standard is de novo review, unless a plan provision grants discretionary authority for deciding benefit claims to the plan administrator or another fiduciary, in which case the standard is more deferential. 489 U.S. at 115. This Circuit interpreted Firestone to hold that even where a plan does not grant the administrator discretion, its factual findings are nonetheless reviewed for abuse of discretion, whereas the administrator's interpretation of plan terms is reviewed de novo. Pierre, 932 F.2d at 1558.

This Circuit should overturn Pierre and hold that de novo review applies to both a plan administrator's factual findings and interpretations of plan language,

and that an abuse of discretion standard is applied to both only if the plan grants discretionary authority to the administrator to decide claims. Reviewing a plan administrator's factual findings for abuse of discretion even where the plan does not confer discretion is undermined by post-Firestone Supreme Court precedent and is inconsistent with case law in nearly every sister circuit and with policy rationales recognized by those circuits. By aligning this Circuit's law with that of other circuits, this Court could promote compliance with the Department of Labor's claims-procedure regulation, which implements the statutory requirement that plans provide participants and beneficiaries a full and fair review of denied claims, as well as the uniform enforcement of ERISA.

ARGUMENT

I. *Pierre* is Not Consistent with the Supreme Court's Reasoning in *Firestone*

In Firestone, the Supreme Court stated, "we hold that a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. On its face, the phrase "a denial of benefits" is not limited to denials based on interpretation of plan terms, but also encompasses denials based on factual determinations. And the phrase "to determine eligibility for benefits" similarly encompasses interpretive and factual bases for the determination. See

Riedl v. Gen. Am. Life Ins. Co., 248 F.3d 753, 756 (8th Cir. 2001) ("Often an employee's eligibility for benefits under a plan depends both on an administrator's determination of certain facts, and on the application of those facts to the terms of the plan.").

Pierre read Firestone more narrowly, seizing on Firestone's earlier statement that "[t]he discussion that [sic] follows is limited to the appropriate standard of review in § 1132(a)(B)(1) [sic] actions challenging denials of benefits based on plan term interpretations," Pierre, 932 F.2d at 1556 (emphasis in original) (quoting Firestone, 489 U.S. at 108), which this Court interpreted as leaving it free to hold that a different standard of review should apply to factual findings. But read in context, the earlier Firestone statement was merely distinguishing between actions under section 1132(a)(1)(B) and actions under other provisions of ERISA, not between benefit decisions that implicate plan terms and those that do not. See Firestone, 489 U.S. at 108 ("We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA."); Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1183 (3d Cir. 1991). Pierre's adoption of a default rule of abuse of discretion review of factual findings made by a plan administrator in determining benefit decisions—even where the plan does not confer such discretion—was therefore based on a questionable reading of Firestone.

Moreover, Pierre did not fully consider Firestone's rationales for de novo review as a default standard, which apply with the same force to an administrator's factual findings as they do to its plan term interpretations. The Court first grounded its decision in Firestone on the right to judicial review that ERISA confers on plan participants. The Court explained that unlike the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 186(c), whose arbitrary-and-capricious standard lower courts had grafted onto their review of ERISA claims, "ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans." Firestone, 489 U.S. at 109–10. Because ERISA grants plan participants a private right of action and the LMRA does not, the Court concluded that "LMRA principles offer no support for the adoption of the arbitrary and capricious standard insofar as § 1132(a)(1)(B) is concerned." Id. at 110. "This contrast—between the questionable (if not fictional) basis for review under the LMRA and ERISA's unambiguous grant of review authority—weakens the argument for perpetuating § 302(c)(5)'s arbitrary and capricious test under ERISA." Bradley R. Duncan, Judicial Review of Fiduciary Claim Denials Under ERISA: An Alternative to the Arbitrary and Capricious Test, 71 Cornell L. Rev. 986, 994 n.40 (1986) (cited by Firestone, 489 U.S. at 110). Of course, ERISA's right to judicial review of decisions denying benefits does not depend on whether

the participant is challenging the plan administrator's factual findings or its plan interpretations.

If anything, Pierre's adoption of a deferential standard for a fiduciary's factual determinations for ERISA section 502(a)(1)(B) claims, far from being justified by ERISA's right to judicial review, is in some tension with it. Not only does ERISA allow participants and beneficiaries to bring claims for plan benefits in court, 29 U.S.C. § 1132(a)(1)(B), as the Court in Firestone noted, it also specifically identifies "ready access to the Federal courts" as one of its policies, id. § 1001(b), and provides concurrent jurisdiction over benefit claims to both state and district courts, id. § 1132(e). In fact, Congress intended ERISA to provide more protection and oversight over "rights and benefits due to workers" than the pre-existing law. E.g., H.R. Rep. No. 93-533 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4642–43. Under pre-existing law, denials of benefits "were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claims as it would any other contract claim—by looking to the terms of the plan and other manifestations of the parties' intent." Firestone, 489 U.S. at 112–13. The Supreme Court thus explained that adopting a default deferential standard of review, as Pierre adopted for factual findings, "would require us to impose a standard of review that would afford less protection to

employees and their beneficiaries than they enjoyed before ERISA was enacted." Id. at 113–14. These principles favor a default de novo standard of review with respect to the entire ERISA right of action, including actions challenging factual findings.

Any relaxation in the standard of review of ERISA benefit-claim denials, according to the Supreme Court in Firestone, should be "guided by principles of trust law." Id. at 110. Those trust-law principles, which animate the Congressional intent underlying many of ERISA's requirements, place a primacy on the plan sponsor's intent with respect to the plans' benefits as embodied in the terms of the governing trust instruments. Id. at 111–12 ("The terms of trusts created by written instruments are 'determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust as is not inadmissible.'" (quoting Restatement (Second) of Trusts § 4 cmt. d (1959)). Under trust law, when determining the benefits and rights under a trust agreement, the standard for judicial review over a trustee's decision turns on whether the trust agreement delegates discretionary authority over that decision to the trustee. Id. at 111. If no delegation exists, courts construe terms in trust agreements as they would contractual provisions: "without deferring to either party's interpretation." Id. at 112. In short, Firestone made clear that the standard of review to apply to plan

administrator's denials of benefits turns only on whether or not the plan delegates discretion to the plan administrator, not on the type of decision—factual or interpretive—a plan administrator makes. See id.

Firestone's conclusion that the plan document, not the nature of the decision, controls the standard of review for benefits determinations is consistent with the principle that "[t]he plan, in short, is at the center of ERISA." US Airways, Inc. v. McCutchen, 133 S.Ct. 1537, 1548 (2013). The primacy Firestone places on the plan document for benefit claims also is consistent with the Court's subsequent ERISA cases concerning benefit claims. E.g., Heimeshoff v. Hartford Life & Acc. Ins. Co., 134 S. Ct. 604, 616 (2013) ("[T]he parties' agreement [on the limitations period for benefit claims] should be enforced unless the limitations period is unreasonably short or foreclosed by ERISA."). The Supreme Court's focus on the plan's language is rooted in the ability of the drafters of plan documents, like trust agreements, to define the parameters for resolving disputes over claims arising out of its terms. Firestone, 489 U.S. at 115 ("Neither general principles of trust law nor a concern for impartial decisionmaking, however, forecloses parties from agreeing upon a narrower standard of review.").

Finally, Pierre's rule that factual findings are always reviewed for abuse of discretion, regardless of what the plan says, could actually confer on the plan administrator a power that the plan sponsor did not intend the trust agreement to

confer. Under the logic of Pierre, a plan sponsor could refuse to delegate discretion over fact-finding to the plan administrator, but the court would still accord deference to the plan administrator. Such an outcome certainly is at odds with the Firestone decision as well as the principles of ERISA and trust law. Compare Firestone, 489 U.S. at 111–113 ("Whether 'the exercise of a power is permissive or mandatory depends upon the terms of the trust.'") (citation omitted); 29 U.S.C. § 1102(a)(1) ("Every employee benefit plan shall be established and maintained pursuant to a written instrument."); Restatement (Second) of Trusts § 187 (1959) ("Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion."), with Dutka ex rel. Estate of T.M. v. AIG Life Ins. Co., 573 F.3d 210, 212 (5th Cir. 2009) ("[T]his Circuit reads [Firestone] as speaking only to questions of law; thus, with or without a discretion clause, a district court rejects an administrator's factual determinations in the course of a benefits review only upon the showing of an abuse of discretion.").

II. Subsequent Supreme Court and Circuit Court Decisions Undermine *Pierre*'s Reasoning

The Supreme Court has re-affirmed in subsequent cases that the standard of review of plan administrators' benefits decisions depends on the terms of the plan document, not on whether the decision at issue is factual or interpretive in nature. As the Court put it in Glenn, "[p]rinciples of trust law require courts to review a

denial of plan benefits 'under a de novo standard' unless the plan provides to the contrary." 554 U.S. at 111 (quoting Firestone, 489 U.S. at 115); see Conkright v. Frommert, 559 U.S. 506, 512 (2010) ("We recognized that, under trust law, the proper standard of review of a trustee's decision depends on the language of the instrument creating the trust."); accord Varity Corp. v. Howe, 516 U.S. 489, 514 (1996) ("[C]haracterizing a denial of benefits as a breach of fiduciary duty does not necessarily change the standard a court would apply when reviewing the administrator's decision to deny benefits."). The Supreme Court has repeatedly interpreted the Firestone holding requiring de novo review of plan-administrator decisions to encompass a "denial of benefits" generally, not just a construction of plan terms. See, e.g., Metro. Life Ins. Co., 554 U.S. at 111.

Rush Prudential HMO, Inc. v. Moran is instructive. 536 U.S. 355 (2002). In Rush, the insurer argued that a state law interfered with the supposedly deferential standard by which courts reviewed benefit denials under ERISA. Id. at 384. The law provided for independent medical review of certain benefit denials, including whether a treatment was medically necessary. See id. at 359, 383. The Court rejected the premise that ERISA entitled insurers to deferential review, stating that ERISA merely requires "a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations." Id. at 385 (emphasis added). The Court then

explained that de novo review, the default standard, becomes deferential review only "if the ERISA plan itself provide[s] that the plan's benefit determinations were matters of high or unfettered discretion." Id. at 385–86 (citing Firestone, 489 U.S. at 115). But under Pierre, because the question of "whether a proposed treatment is medically necessary is a factual determination," it is "therefore reviewed for abuse of discretion" regardless of the level of discretion accorded by the plan. Ariana M., 854 F.3d at 761.

And as the panel in this case pointed out, Ariana M., 854 F.3d at 757 n.2, the majority of circuit courts have held that, under Firestone, de novo is the appropriate default standard for reviewing plan-benefits denials, often explicitly rejecting any distinction between review of a plan administrator's factual findings and its interpretations of plan terms. See Shaw v. Conn. Gen. Life. Ins. Co., 353 F.3d 1276, 1285 (11th Cir. 2003); Riedl, 248 F.3d at 756; Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 249–251 (2d Cir. 1999); Walker v. Am. Home Shield Long Term Disability Plan, 180 F.3d 1065, 1069 (9th Cir. 1999); Rowan v. Unum Life Ins. Co. of Am., 119 F.3d 433, 435 (6th Cir. 1997); Ramsey v. Hercules, Inc., 77 F.3d 199, 204 (7th Cir. 1996); Luby, 944 F.2d at 1183; Reinking v. Phila. Am. Life Ins. Co., 910 F.2d 1210, 1213–14 (4th Cir. 1990), overruled on other grounds by Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017 (4th Cir. 1993). For example, in adopting a de novo default standard of

review for both factual determinations and plan interpretations, the Sixth and Seventh Circuits explained how trust law did not support the distinction between the two made in Pierre. See Rowan, 119 F.3d at 436 ("The Restatement [(Second) of Trusts] language on which the Fifth Circuit relied does not provide any basis for distinguishing between court review of factual determinations and review of interpretations of claim language."); Ramsey, 77 F.3d at 203–04 (noting how the Fifth Circuit's conclusion that factual determinations by plan administrators are always reviewed under a deferential standard is "fundamentally inconsistent with trust law"). As both decisions recognized, under the law of trusts, courts review the trustee's decisions as a whole under a single standard of review. See Ramsey, 77 F.3d at 203 ("Under general principles of trust law, courts do not alter the standard under which they review a trustee's decision based on the characterization of that decision as interpretive or factual." (citing authorities)).

Moreover, the panel in this case and other courts have also called into question Pierre's rationales for according deference to factual findings: Pierre's analogy to the deference given to administrative adjudicators and its fear that a more onerous standard of review would lead to a flood of litigation. See Ariana M., 854 F.3d at 764–65 (Costa, Prado, & Higginson, JJ., specially concurring) (discussing the rationales in Pierre, 932 F.2d at 1558–59). With respect to the former rationale, this Court explained in Ariana M. that whereas administrative

adjudicators are neutral factfinders, "ERISA plan administrators often have conflicts of interest as many both decide and pay claims." Id. The Supreme Court, far from supporting Pierre's analogy to administrative adjudicators, has "reinforced" the distinction between administrative adjudicators and plan administrators by holding that a plan administrator's conflict should be taken into account even under abuse of discretion review. Ariana M., 854 F.3d at 764 (discussing Metro. Life Ins. Co., 554 U.S. at 115). Granting conflicted decisionmakers deference even when the plan does not call for it would afford plan participants less protection than they enjoyed before ERISA was enacted. Id. at 764–65; Rowan, 119 F.3d at 436.

Further, the Pierre Court's fears have not come to fruition as other circuits have capably applied a de novo regime without being inundated by litigation. For example, district courts, including those in the Fifth Circuit, have generally limited their review of the merits of a benefits determination to the record at the time of the plan administrator's decision. See, e.g., Crosby v. La. Health Serv. and Indem. Co., 647 F.3d 258, 263 (5th Cir. 2011); Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 519 (1st Cir. 2005); Quesinberry, 987 F.2d at 1025; see also Heimeshoff, 134 S. Ct. at 614. Allowing de novo review in actions to recover plan benefits would not abrogate this Circuit's precedent that evidentiary review is ordinarily limited to the existing administrative record. See Crosby, 647 F.3d at 263. It

would also leave in place the discretion that district courts have in controlling discovery on other factual issues such as the completeness of the administrative record, whether the plan administrator complied with procedural requirements, and the existence and extent of a conflict of interest. See id. at 263–64; see also Ariana M., 854 F.3d at 765 (Costa, Prado, & Higginson, JJ., specially concurring) (noting that "[n]o administrative difficulties are evident from [other] circuit's de novo review of benefit denials that rest on factual determinations," and stating that "courts can appoint independent experts to evaluate complicated medical evidence").

III. Overturning *Pierre* Advances the Secretary's Interest in Ensuring Full and Fair Review of Benefits Denials and Uniform ERISA Enforcement

The circuit split presented here is of particular concern to the Secretary of Labor because it undermines the Secretary's regulatory mandate to ensure "full and fair review" of decisions to deny benefits and his interest in uniform ERISA enforcement. ERISA, which generally does not guarantee substantive benefits, creates "certain oversight systems and other standard procedures" to ensure that benefits provided by an employer are secure. Gobeille, 136 S. Ct. at 943–44. "Those systems and procedures are intended to be uniform." Id. One procedure that ERISA requires of employee benefit plans is to provide the plan's participants an opportunity for a "full and fair review" of decisions to deny benefits, 29 U.S.C. § 1133(2), as embodied in the Department of Labor's claims-procedure regulation.

See 29 C.F.R. § 2560.503-1. Not only does Pierre undercut ERISA's "full and fair review" guarantee and the regulation that implements it, it also creates a disuniform system of ERISA enforcement.

Congress specifically authorized the Secretary to promulgate regulations carrying out ERISA's "full and fair review" requirement. 29 U.S.C. § 1133. The Secretary, in turn, promulgated 29 C.F.R. section 2560.503-1, which "sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries . . . ." 29 C.F.R. § 2560.503-1(a). And if a plan does not satisfy those standards, the regulation provides that a claimant will be deemed to have exhausted administrative remedies and may seek immediate judicial review of the merits of the decision denying benefits. Id. § 2560.503-1(l). The Department of Labor specifically explained in its regulatory preamble that the purpose of the regulation's deemed-exhausted provision was "to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." Claims Procedure, 65 Fed. Reg. 70246-01, 70255 (2000) (emphasis added). It continued:

> In the view of the Department, the standards in the regulation represent essential aspects of the process to which a claimant should be entitled under section 503 of the Act [i.e., 29 U.S.C. § 1133]. A plan's failure to provide procedures consistent with these standards would effectively deny a claimant access to the administrative review process mandated by the Act. . . . At a minimum, claimants denied

> access to the statutory administrative review process should be entitled to take that claim to a court under section 502(a) of the Act for a full and fair hearing on the merits of the claim.

Id. at 70256 (emphasis added); see also Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208-01, 37213 (2011). Thus, where the plan administrator fails to provide reasonable procedures consistent with the claims-procedure regulation, reviewing courts in other circuits apply de novo review to the administrator's factual findings. See, e.g., Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ., 819 F.3d 42, 54–58 (2d Cir. 2016) (discussing cases).

In contrast, the practical consequence of Pierre's rule is to effectively insulate the fiduciary's fact-finding from de novo review in all cases, even where the fiduciary violates the Secretary's regulations. See S. Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir. 1993) (concluding that, where a fiduciary violated pre-2000 claims-procedure regulation by failing to provide any written notice of a benefits denial, Pierre's abuse of discretion standard nevertheless applied, stating, "In our view, the standard of review is no different whether the claim is actually denied or is deemed denied. The role of the district court is the same in either event" (footnote omitted)). Overturning Pierre would thus not only give effect to ERISA's full-and-fair review requirement and the claims-procedure

regulation, it would also potentially eliminate this inconsistency in the way courts review benefits claims under ERISA.[2]

As the panel recognized, Pierre matters now much more than before because states, including Texas, have increasingly passed laws banning discretionary clauses from insurance policies, meaning that courts in the Fifth Circuit will increasingly be deferring to plan administrator decisions not by dint of the plan's terms but because of Pierre itself. Ariana M., 854 F.3d at 757 n.2; see, e.g., Cal. Ins. Code § 10110.6; Ill. Admin. Code tit. 50, § 2001.3; Tex. Ins. Code § 1701.062. The extensive regulation of insurance companies by states is based on the judgment that increased scrutiny is generally required "to prevent abusive practices—for example, false sales illustrations or failure to pay legitimate claims on a timely basis—that take unfair advantage of consumers." Robert W. Klein,

[2] The notion that plan administrators are not automatically accorded discretion is also consistent with recent regulations, applicable to non-grandfathered group health plans, regarding independent external review of adverse benefit determinations. 42 U.S.C. § 300gg-19; 29 C.F.R. § 2590.715–2719 (internal claims and appeals and external review processes). The federal external review process, for example, explicitly requires that plan determinations adverse to the claimant be reviewed de novo by an independent review organization ("IRO"). 29 C.F.R. § 2590.715–2719(d)(2)(iii)(B)(5); id. § 2590.715–2719(d)(3)(iii)(B). The regulations require that IROs be independent and free of bias. See id. § 2590.715–2719(c)(2)(ix) ("The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review"); id. § 2590.715–2719(d)(2)(iii)(A)(1) ("The plan or issuer must ensure that the IRO process is not biased and ensures independence."). This underscores the importance of ensuring unbiased, de novo judicial review of a benefits determination made by a plan administrator.

Insurance Regulation in Transition, 62 J. Risk & Ins. 363, 374 (1995). Indeed, the Attorney General of Texas explains as amicus curiae how Texas legislated to protect consumers and ensure effective review of benefit claims decisions and how Pierre negates those protections as they relate to a plan administrator's factual findings. Amicus Br. for the Tex. Dep't of Ins., at 2–4.

The advent of discretionary-clause bans also makes Pierre more likely to create disuniformity in how ERISA is enforced. An ERISA plan that is national in scope may well have its decisions reviewed de novo in most jurisdictions (due to the increasing prohibition of discretionary clauses), but for participants in that same plan who happen to bring their claims in the Fifth Circuit, the administrator will be entitled to deferential review of its factual findings. See Ariana M., 854 F.3d at 765 (Costa, Prado, & Higginson, JJ., specially concurring) ("[T]he circuit split on that default standard undermines the uniform treatment of ERISA plans—sometimes the same plan offered by employers in different states—that the federal statute seeks to achieve."). Overturning Pierre would eliminate such a disparity and give full effect to state discretionary-clause bans. This would also create uniformity with the de novo standard of review applicable to insurance policies outside of the ERISA context. E.g., Gulf Underwriters Ins. Co. v. Great W. Cas. Co., 278 F. App'x 454, 461 (5th Cir. 2008) (reviewing the factual dispute in an insurance coverage case without deference to the insurer). The growing

prevalence of such bans means that the default standard of review of benefits determinations—and the need to resolve the tension created by Pierre—is of increasing importance. A default de novo standard of review both inside and outside the Fifth Circuit would level the playing field on which participants, plans, insurers, and regulators operate.[3]

CONCLUSION

For the reasons set forth above, the Secretary requests the en banc Court to overturn Pierre and hold that the default standard of review of factual findings by a plan administrator in an action under 29 U.S.C. section 1132(a)(1)(B) is de novo.

Respectfully submitted,

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[3] The panel assumed that state discretionary-clause bans are not preempted, Ariana M., 854 F.3d at 765 (Costa, Prado, & Higginson, JJ., specially concurring), and the preemption question is not presented in this case. Cf. Fontaine v. Met. Life Ins. Co., 800 F.3d 883, 889 (7th Cir. 2015) (agreeing with the Sixth and Ninth Circuits that discretionary-clause bans fall within ERISA's insurance savings clause).

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Date: August 15, 2017

s/ Thomas Tso
THOMAS TSO