Case No. 22-4082

In the

United States Court of Appeals

for the

Tenth Circuit

IAN C. AND A.C.,

Plaintiffs-Appellants,

v.

UNITEDHEALTHCARE INSURANCE COMPANY,

Defendant-Appellee.

Appeal from a Decision of the United States District Court for the District of Utah - Salt Lake City
Case No. 1:15-cv-00462-WYD-NYW · Honorable Martha Vasquez, U.S. District Judge

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANT-APPELLEE AND AFFIRMANCE

TARA MORRISSEY, ESQ.
U.S. CHAMBER LITIGATION CENTER
1615 H Street, NW
Washington, DC 20062
Telephone (202) 306-5111
TMorrissey@USChamber.com

MEAGHAN VERGOW, ESQ.
Counsel of Record
O'MELVENY & MYERS LLP
1625 Eye Street, NW
Washington, DC 20006
Telephone (202) 383-5300
mvergow@omm.com

Counsel for *Amicus Curiae*

COUNSEL PRESS · (213) 680-2300

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The Chamber of Commerce of the United States of America states that it is a non-profit, tax-exempt organization incorporated in the District of Columbia. The Chamber has no parent corporation, and no publicly held company has 10% or greater ownership in the Chamber.

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INTEREST OF *AMICUS CURIAE*[1]

The Chamber of Commerce of the United States of America (Chamber) is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases, like this one, that raise issues of concern to the nation's business community.

The Chamber's members include many employers that sponsor benefits plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, and companies that administer those plans. These businesses frequently defend against lawsuits involving ERISA claims, and have a strong interest in ensuring that courts apply the proper standard of review to benefit determinations.

The Supreme Court has long held that plan administrators must receive deference where they have exercised discretionary authority granted by the plan—a

[1] No counsel for a party authored this brief in whole or in part, and no party, party's counsel, or person other than the *amicus curiae*, its members, or its counsel contributed money that was intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(a)(4)(E). All parties have consented to the filing of this brief.

rule that promotes efficiency, predictability, and uniformity in the interpretation of ERISA plans.[2] Courts have likewise long recognized that the deferential standard of review applies when the administrator has departed from the procedural requirements promulgated by the Secretary of Labor, so long as that departure is insubstantial. In other words, if a plan administrator has substantially complied with ERISA's claims procedure regulation, 29 C.F.R. § 2560.503-1, a benefit determination that is not arbitrary and capricious will be upheld.

Appellants ask the Court to jettison this longstanding rule and hold that courts must review benefit determinations *de novo* following even insubstantial deviations from the claims procedure regulation. The absence of procedural errors in this case makes it a poor vehicle to consider a different standard of review. But if the Court were to reach appellants' arguments, the Court should reject them. Appellants' proposed rule is precluded by precedents in this Court and the Supreme Court, has no basis in the statute or the regulation, and would frustrate the statutory purposes that are served by the current standard. Procedural lapses that do not call into

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[2] Often, the "plan administrator" as defined by ERISA (*see* 29 U.S.C. § 1002(16)(A)(i)) is not the entity making individual benefits claim decisions. Rather, the plan fiduciary may have delegated that role to an entity known as a "claims administrator," who may be a fiduciary with discretion to make some or all claims handling decisions. *See id.* § 1002(21)(A)(iii)). Here, UnitedHealthcare was the claims administrator but not the plan administrator for all purposes. For ease of reading, however, in this brief the Chamber refers to the entity with discretion to make benefits decisions simply as the "plan administrator."

question the administrator's exercise of discretion do not support reading that discretion out of the plans—and enforcing benefit plans according to their terms serves ERISA's goal of encouraging employers to offer such plans in the first place.

SUMMARY OF ARGUMENT

I. This Court has long held that when a plan administrator has "substantially complied" with the claims procedure regulation, the Court reviews the administrator's decision under the deferential arbitrary and capricious standard of review. The Court has reaffirmed that rule since the promulgation of the 2000 and 2011 amendments to the regulation that appellants contend require a different standard of review. The Court's adherence to the substantial compliance doctrine aligns with the approach of a lopsided majority of the courts of appeals, which similarly hold that when a plan administrator has demonstrated substantial compliance with ERISA procedural regulations, the administrator's decision remains entitled to deference.

Only one court of appeals, the Second Circuit, has indicated that insubstantial procedural errors may trigger plenary review. But its decision to that effect, *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), rests on a flawed interpretation of the relevant regulation. The claims procedure regulation provides only that procedural irregularities will excuse a claimant's failure to comply with exhaustion requirements—*not* that irregularities require the use of a different standard of

review. In the seven years since *Halo*, the decision has failed to persuade, as other Circuits continue to uphold and apply the substantial compliance doctrine. Even if this Court were inclined to reconsider that standard, this case does not afford a vehicle in which to do so, because the district court found no procedural irregularities that would justify *de novo* review even under *Halo*.

II. As the Supreme Court has repeatedly held, deferential review of an administrator's plan decisions serves important purposes under ERISA. The standard helps promote the efficient resolution of benefit claims and ensures that plan terms are predictably and uniformly applied across the relevant participant population. It situates benefit decisions in institutions that are better equipped than courts to evaluate complex medical judgments. And it honors the decisionmaking framework built into a plan's terms, which in turn furthers ERISA's goal of encouraging employers to offer benefit plans. Nor is plenary review necessary to vindicate a participant's rights under a plan or to serve the purposes of the claims procedure regulation when an administrator has substantially complied with the necessary procedures; those considerations are built into the substantial compliance standard itself under this Court's precedents. The current standard of review helps employers offer more generous benefits and dedicate resources to the actual payment of benefits instead of to the litigation of benefit claims. That ultimately aids plan participants and beneficiaries.

III. The relevant Department of Labor ("DOL") regulations do not prescribe a standard of judicial review. Appellants cite provisions from the 2000 and 2011 regulations, but those provide only that procedural irregularities will excuse a claimant's failure to comply with exhaustion requirements—*not* that irregularities will trigger the use of a different standard of review. Nor would DOL be entitled to deference if it had attempted to prescribe a standard of review. The establishment of standards of judicial review lies outside DOL's expertise, and ERISA did not endow the Secretary of Labor with rulemaking authority over the proper standard of review for benefit plans. That is a judicial function, and it has been carried out by the many courts that have recognized that deferential review is appropriate when a plan administrator has substantially, but not strictly, complied with procedural requirements.

ARGUMENT

I. THE COURT'S APPLICATION OF THE SUBSTANTIAL COMPLIANCE DOCTRINE ALIGNS WITH THE PREVAILING APPROACH OF OTHER COURTS OF APPEALS

A. This Court employs the arbitrary and capricious standard of review when the administrator has substantially complied with procedural requirements.

For two decades, it has been the rule in this Court that a plan administrator's exercise of discretion warrants deferential review if the plan administrator has substantially complied with ERISA's claims procedure regulation. A plan administrator is in "substantial compliance" with ERISA procedural regulations if

its decision was made "in the context of an ongoing, good faith exchange of information between the administrator and the claimant." *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 635 (10th Cir. 2003). A plan administrator remains in "substantial compliance" even when "inconsequential violations of the deadlines or other procedural irregularities" are present in their decision. *Id.*; *accord Kellogg v. Metro. Life Ins. Co.*, 549 F.3d 818, 827 (10th Cir. 2008). Only when a plan administrator fails to substantially comply with ERISA procedural requirements does the Court apply a *de novo* standard of review. *Gilbertson*, 328 F.3d at 635.[3]

This Court has reaffirmed the substantial compliance doctrine even after the promulgation of the 2000 and 2011 amendments to the claims procedure regulation. For instance, in *Holmes v. Colorado Coalition for Homeless Long Term Disability Plan*, this Court applied the substantial compliance doctrine and held that review of the plan administrator's decision under the arbitrary and capricious standard was appropriate because the participant was not "prejudiced by technical violations of ERISA's notice and disclosure requirements." 762 F.3d 1195, 1212 (10th Cir. 2014) (upholding denial of benefits under 2000 regulation). Similarly, in *M.K. v. Visa*

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[3] In ERISA cases, the arbitrary and capricious standard of review is "interchangeable" with the abuse of discretion standard of review. *Foster v. PPG Indus., Inc.*, 693 F.3d 1226, 1231 (10th Cir. 2012). Under these standards of review, this Court will uphold a plan administrator's decision "unless it is not grounded on any reasonable basis." *Graham v. Hartford Life & Accident Ins. Co.*, 589 F.3d 1345, 1357 (10th Cir. 2009) (internal quotation marks omitted).

Cigna Network POS Plan, this Court, without comment on the effect of the updated regulation, applied the substantial compliance doctrine and reviewed a plan administrator's decision under the arbitrary and capricious standard when "the purported procedural irregularity" was "nothing more than a technicality." 628 F. App'x 585, 591-92 (10th Cir. 2015) (upholding denial of coverage for claim filed in 2012).

Appellants observe that this Court has questioned whether the substantial compliance doctrine remains good law in the wake of the 2000 regulations, which deemed claims exhausted when the administrator has failed to comply with procedural requirements (*see infra* at 17-18). App. Br. 20. But as appellants concede, the language they cite is dicta: the Court has never actually held that the amendments to the regulation effected a change to the standard of review. *See, e.g.*, *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1316-17 (10th Cir. 2009) ("Because AIG has failed *Gilbertson*'s substantial compliance test, as we discuss below, we need not decide whether a minor violation of the deadlines or other procedural irregularities would entitle the claimant to de novo review under the 200[0] amendments."); *Kellogg*, 549 F.3d at 828 ("We find it unnecessary to conclusively decide the continuing validity of the 'substantial compliance' rule because, even assuming its continued existence, there can be little doubt that MetLife was not in 'substantial compliance' with the ERISA deadlines."). And as explained

within, a reasoned analysis compels the conclusion that the substantial compliance doctrine remains valid: deferential review of administrator decisions that substantially comply with procedural requirements comports with the Supreme Court's repeated calls for deference, serves the purposes of ERISA and the interests of plan participants and beneficiaries, and is the better reading of the applicable DOL regulation.

B. Other courts of appeals likewise continue to apply the substantial compliance doctrine.

Like the Tenth Circuit, most other Circuits agree that when a plan administrator has demonstrated "substantial compliance" with ERISA's procedural regulation, the administrator's exercise of discretion remains entitled to deference.

In the Fifth Circuit, "technical noncompliance with ERISA procedures will be excused so long as . . . the beneficiary [has been afforded] an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial." *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 154 (5th Cir. 2009) (internal quotation marks and citations omitted); *see also Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 694 F.3d 557, 567 (5th Cir. 2012) ("Absent potential wholesale or flagrant violations that evidence an 'utter disregard of the underlying purpose of the plan,' this court does not heighten the standard of review from abuse of discretion to de novo." (quoting *Lafleur*, 563 F.3d at 159)).

Similarly, in the Eighth Circuit, "the mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential standard of review." *Trs. of Electricians's Salary Deferral Plan v. Wright*, 688 F.3d 922, 927 (8th Cir. 2012) (internal quotation marks and citations omitted). "For a less deferential standard of review to apply, [a claimant] must demonstrate [that] a serious procedural irregularity caused a serious breach of [the Plan's] fiduciary duty. Additionally, the heightened standard is only warranted where the procedural irregularity has a connection to the substantive decision reached." *Id*. (internal quotation marks and citations omitted); *see also Waldoch v. Medtronic, Inc.*, 757 F.3d 822, 830 (8th Cir. 2014) (same).

The Ninth Circuit has also held that ERISA "procedural irregularity does not alter the standard of review [from abuse of discretion to *de novo*] except in 'situations in which procedural irregularities are so substantial' as to make doing so necessary, such as '[w]hen an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA.'" *O'Rourke v. N. Cal. Elec. Workers Pension Plan*, 934 F.3d 993, 998 (9th Cir. 2019) (quoting *Abatie v. Alta Health and Life Ins.*, 458 F.3d 955, 965, 971 (9th Cir. 2006) (en banc)). The same is true for other courts of appeals.[4]

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[4] *See James v. Int'l Painters & Allied Trades Indus. Pension Plan*, 738 F.3d 282, 283 (D.C. Cir. 2013) (per curiam) (holding that "procedural irregularities do not alter the standard of review"); *O.D. v. Jones Lang Lasalle Med. PPO Plus Plan*, 772 F.

The First Circuit applies a more nuanced test, but that test still does not apply plenary review whenever an administrator has departed from the claims procedure regulation in insubstantial ways. Rather, the court analyzes the effect of procedural violations on a case-by-case basis to "tailor . . . resolution of the issues to the unique facts presented." *Bard v. Boston Shipping Ass'n*, 471 F.3d 229, 236 (1st Cir. 2006).

C. The outlier *Halo* decision has limited persuasive value.

Appellants base their argument that the Tenth Circuit should abandon the substantial compliance test on the Second Circuit's decision in *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016). App. Br. 21-24. This argument is unavailing because the interpretive analysis in *Halo* is flawed.

In *Halo*, the Second Circuit vacated a district court opinion that had applied arbitrary and capricious review to claim denials that substantially complied, but failed to "strictly" comply, with the ERISA regulation governing the substance and timing of those decisions. *Halo*, 819 F.3d at 45-47. The court arrived at this decision through a three-step analysis.

App'x 800, 805 (11th Cir. 2019) (applying arbitrary and capricious review because the ERISA plan administrator substantially complied with ERISA procedural regulations); *Becknell v. Severance Pay Plan of Johnson & Johnson & U.S. Affiliated Cos.*, 644 F. App'x 205, 213 (3d Cir. 2016) ("Applying *Firestone* deference here is consistent with the majority of our sister circuits who have weighed in on this issue, as the BCC's late decision does not rise to the level of a severe procedural violation.").

First, the Second Circuit found the relevant 2000 regulatory provision—subsection (*l*)— ambiguous because it was silent as to the standard of review that courts should apply to plan administrators' decisions when the plan violates ERISA's procedural requirements. *Id*. at 54. Next, the court applied *Auer* deference,[5] and gave "substantial deference" to DOL's interpretation of the regulation "as contained in the regulation's preamble," which stated "'that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference.'" *Id*. at 53-54 (quoting 65 Fed. Reg. 70,246, 70,255 (2000)). Based on the substantial deference it afforded the preamble, the court "concluded that a plan's otherwise discretionary denial of a claim that fails to comply with [DOL's] claims-procedure regulation is not entitled to deference." *Id*. at 56. Third, the court considered "whether a plan need only substantially comply with or must strictly adhere to the regulation to obtain the more deferential arbitrary and capricious standard of review." *Id*. On this question, the court considered DOL's choices during the drafting of subsection (*l*) to be conclusive. *Id.* The Second Circuit "reject[ed] the substantial compliance doctrine" as "inconsistent with the Department's regulation" and held "a plan's failure to comply with [DOL's] claims-procedure regulation will result in that claim being reviewed *de novo* in federal court,

[5] *Auer v. Robbins*, 519 U.S. 452, 461 (1997), concerned the deference owed to agency interpretations of their own regulations—a standard the Court clarified further in *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019). *See infra* at 19-20.

unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulation in the processing of a particular claim was inadvertent *and* harmless." *Id*. at 57-58 (citation omitted).

The *Halo* court erred out of the box by finding subsection (*l*) ambiguous. As numerous in-circuit district court decisions have pointed out, subsection (*l*) is *not* ambiguous, because it "is susceptible to only one meaning: when the plan or its administrator fails to provide for or follow its own procedures in compliance with the regulations, the claim is exhausted, allowing the claimant to seek judicial review or any other available remedy." *Joel S. v. Cigna*, 356 F. Supp. 3d 1305, 1312 (D. Utah 2018);[6] *cf. Jake's Fireworks Inc. v. Acosta*, 893 F.3d 1248, 1261 (10th Cir. 2018) ("A regulation is ambiguous if it is reasonably susceptible to more than one interpretation or capable of being understood in two or more possible senses or ways." (internal quotation marks omitted)); *see also infra* at 18-19. The Secretary

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[6] *Accord James C. v. Aetna Health & Life Ins. Co.*, 499 F. Supp. 3d 1105, 1116 (D. Utah 2020) ("Because the regulation does not address the applicable standard of review, its language is not susceptible to more than one interpretation on this point. Where uncertainty does not exist, . . . [t]he regulation then just means what it means—and the court must give it effect, as the court would any law.' The regulation is not ambiguous and the court declines to apply the *Halo* standard." (alterations in original) (quoting *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415 (2019))); *Peter E. v. United Healthcare Servs., Inc.*, 2021 WL 5962259, at *7 (D. Utah Dec. 16, 2021) (same); *Bruce M. v. Aetna Life Ins. Co.*, 2021 WL 5522554, at *8 (D. Utah Nov. 24, 2021) (same); *J.L. v. Anthem Blue Cross*, 510 F. Supp. 3d 1078, 1085 (D. Utah 2020) (same).

of Labor did not venture to impose a different standard of review, and seven years on, *Halo* remains an outlier: no other court of appeals has joined the Second Circuit in holding that the claims procedure regulation requires plenary review of substantially compliant administrator decisions.

This is not the case in which to consider importing *Halo* to this Circuit in any event, because deferential review of the administrator's decision would still be appropriate under the Second Circuit's approach. The district court considered each of the six alleged procedural violations offered by plaintiffs and found "no serious procedural irregularities." App.Vol.2:071. That finding supported application of the arbitrary and capricious standard under the Tenth Circuit's law, but the same conclusion follows under *Halo* because plaintiffs identified no intentional, harmful procedural errors at all. *Halo*, 819 F.3d at 57.

II. DEFERENTIAL REVIEW SERVES IMPORTANT PURPOSES UNDER ERISA

As the Supreme Court has repeatedly emphasized, deferential judicial review of plan administrators' decisions best effectuates the congressional intent embodied in ERISA. ERISA reflects Congress's "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)). A deferential standard of review is critical to preserving that balance: "Ensuring that reviewing courts respect the

discretionary authority conferred on ERISA fiduciaries encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans—something they are not required to do." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 120 (2008) (Roberts, C.J., concurring).

In the landmark decision *Firestone Tire & Rubber Co. v. Bruch*, the Supreme Court held that an ERISA plan administrator with discretionary authority to interpret a plan is entitled to deference in exercising that discretion. 489 U.S. 101, 115 (1989). Nearly two decades later, the Supreme Court "expanded *Firestone*'s approach" in *Metro Life Insurance Co. v. Glenn*. *Conkright v. Frommert*, 559 U.S. 506, 512 (2010) (characterizing *Glenn*). In *Glenn*, the Court held that when the terms of a plan grant discretionary authority to the plan's administration, a deferential standard of review can remain appropriate in the face of a conflict of interest. 554 U.S. at 118. The Court recognized the practical danger of "adopting a rule that . . . could bring about near universal review by judges *de novo*—*i.e.*, without deference—of the lion's share of ERISA plan claims denials." *Id*. at 116. A framework of *de novo* review would stretch the institutional competence of judges—who are not doctors or medical experts, and who are not as well situated as physician reviewers to assess complex medical records or determine whether a certain level of care is warranted for a certain time period—and would be at odds with the statute itself. *See id.*

In *Conkright v. Frommert*, the Supreme Court again affirmed broad deference to ERISA plan administrators' decisions, holding that a "single honest mistake in plan interpretation" does not justify "stripping the administrator" of deference she is otherwise entitled "for subsequent related interpretations of the plan." 559 U.S. at 509. The Court recognized that deference promotes three critical goals—efficiency, predictability, and uniformity:

> Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions—a result that "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."

Id. at 517-18 (2010) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987)). The "Supreme Court has never suggested that the standard of review applied to ERISA administrators' benefits determinations should change because of procedural irregularities." *James*, 738 F.3d at 283.[7]

[7] This Court's substantial compliance standard examines whether the procedural error prevented the claimant from obtaining a decision of her claim on the merits, or

It is also fundamental under ERISA that plan terms should be enforced as written—including plan terms vesting plan administrators with discretion. The plan "is at the center of ERISA." *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013) (quoting *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013)). Employers "have large leeway to design disability and other welfare plans as they see fit." *Id.* (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003)). Enforcement of the "written terms of the plan is the linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Id.* (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). Respecting the benefit determination frameworks adopted by employers in their plans helps ensure that employers will create and continue to maintain those plans. A rule that would increase the volume and burdens of federal court benefits litigation, in contrast, inhibits plan creation while consuming plan sponsor resources that could otherwise be devoted to actually providing benefits to American workers. *See Conkright*, 559 U.S. at 517.

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whether it still permitted the claimant a "fair and reasonable" opportunity for internal review. *See, e.g.*, *Holmes*, 762 F.3d at 1214.

III. THE DOL REGULATIONS DO NOT PRESCRIBE A STANDARD OF JUDICIAL REVIEW AND WOULD NOT BE ENTITLED TO DEFERENCE IF THEY PURPORTED TO DO SO

ERISA neither sets the judicial standard of review of a plan administrator's decision to deny benefits nor empowers DOL to do so by regulation. *See Firestone*, 489 U.S. at 109 ("ERISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations."). Rather, Congress left "to the courts the development of review standards," and courts have in turn rejected a system of "near universal review by judges *de novo*." *Glenn*, 554 U.S. at 116.

ERISA does include procedural requirements, 29 U.S.C. § 1133, and the Secretary of Labor has exercised regulatory authority under ERISA to promulgate a claims procedure regulation implementing those basic requirements, 29 C.F.R. § 2560.503-1. But that regulation, like ERISA itself, also does not set a judicial standard of review of an administrator's decision.

The 2000 version of the regulation provided that claims would be "deemed exhausted" when the administrator failed to follow the necessary claims procedures:

> In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503-1(*l*) (2002). And the text of the 2011 regulation likewise simply provided that claimants could proceed straight to federal court without exhausting administrative remedies in the event of a prejudicial procedural violation that lacked good cause:

> In the case of a plan or issuer that fails to strictly adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), except as provided in paragraph (b)(2)(ii)(F)(2) of this section. Accordingly the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1); *see id.* § 2590.715-2719(b)(2)(ii)(F)(2) (exempting "de minimis violations" that do not prejudice the claimant, occur for good cause, and are "in the context of an ongoing, good faith exchange of information between the plan and the claimant").

As discussed above, this regulatory provision is unambiguous. It sets requirements for "*internal* claims and appeals processes" and provides a route to judicial review when a plan fails to comply with ERISA and DOL regulations: if a

plan fails to follow mandated procedural requirements, then the claimant is deemed to have exhausted her administrative remedies and she may bring a federal lawsuit to vindicate her rights. *Id*. § 2590.715-2719(b)(2)(ii)(F) (emphasis added). That the claimant is deemed to have exhausted her administrative remedies and may vindicate her rights in court *is* the consequence for procedural irregularities in the administrator's decision. While the preamble to the 2000 regulation suggests that decisions rendered without the appropriate procedural protections should not receive deference, *see Halo*, 819 F.3d at 50, the Secretary included no such directive in the regulation; and the 2011 regulation's provision that a claim with procedural irregularities should be deemed denied "without the exercise of discretion" similarly does not prescribe a standard of review. The text of the regulation itself is clear, not ambiguous.

Even if the regulation were ambiguous and *de novo* review could be inferred as the Secretary's "interpretation" of its regulation, that interpretation would not be entitled to deference under *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019). In *Kisor*, the Supreme Court held that "not all reasonable agency constructions of those truly ambiguous rules are entitled to [*Auer*] deference." *Id*. at 2414. Even when a regulation is ambiguous, an agency's reading must be "reasonable," *id*. at 2415; "be the agency's authoritative or official position," *id*. at 2416; "in some way implicate its substantive expertise," *id*. at 2417; and "reflect fair and considered judgment," *id*.

(quotation marks omitted), to receive *Auer* deference. Here, establishing standards of judicial review lies far outside DOL's expertise, and ERISA did not endow the Secretary of Labor with rulemaking authority over the proper standard of review for benefit plans. Further, as the Supreme Court has repeatedly emphasized, the appropriate standard of review originates in trust law and properly exists within the province of the courts. *See Conkright*, 559 U.S. at 519; *Glenn*, 554 U.S. at 111; *Firestone*, 489 U.S. at 110-12.

CONCLUSION

The district court here examined the plan administrator process for substantial compliance with the regulation, and finding no substantial procedural error properly applied the deferential standard of review to appellee's benefit determination. The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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/s/ *Meaghan VerGow*

MEAGHAN VERGOW
Counsel of Record
O'MELVENY & MYERS LLP
1625 Eye Street, NW
Washington, DC 2006
(202) 383-5300

TARA MORRISSEY
U.S. CHAMBER LITIGATION CENTER
1615 H Street, NW
Washington, DC 20062
(202) 306-5111

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1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5), because it contains 4,845 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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/s/ *Meaghan VerGow*
MEAGHAN VERGOW

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MEAGHAN VERGOW

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I hereby certify that on April 3, 2023, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the appellate CM/ECF system.

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