No. 21-4088

United States Court of Appeals
for the
Tenth Circuit

DAVID K., KATHLEEN K., *and* AMY K.,

Plaintiffs-Appellees,

– v. –

UNITED BEHAVIORAL HEALTH *and*
ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR
ACTIVE MANAGEMENT EMPLOYEES,

Defendants-Appellants,

On appeal from the
United States District Court for the District of Utah
Case No. 2:17-cv-01328-DAK

AMICUS BRIEF OF THE ERISA INDUSTRY COMMITTEE RESPONDING TO THE AMICUS BRIEF OF THE U.S. DEPARTMENT OF LABOR AND SUPPORTING NEITHER PARTY

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), undersigned counsel certifies that amicus ERISA Industry Committee is not a subsidiary of any other corporation and does not issue stock.

/s/ *Michael B. Kimberly*

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Cases—continued

Statutes and other authorities

Statutes and other authorities—continued

GLOSSARY

ACA	Patient Protection and Affordable Care Act
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act of 1974
IRO	Independent Review Organization

INTRODUCTION AND SUMMARY*

The dispute between the parties in this case is nearly a decade old, dating back to 2013. Now, for the very first time in this long-running litigation, the Department of Labor (DOL) has appeared and filed an amicus brief urging the Court to affirm on the basis of a novel and counter-textual "interpretation" of its own regulations. DOL's reframing of its regulations is flatly inconsistent with the plain regulatory text and, if adopted by this Court, would amount to a substantive amendment of those regulations without notice-and-comment rulemaking.

In *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019), the Supreme Court recently disapproved agency efforts to amend regulations through *amicus* briefs filed in court. *Kisor* confirmed what common sense suggests—that an agency's alteration of existing regulations must be made through the transparent and inclusive notice-and-comment procedures required by the Administrative Procedure Act, and not surreptitiously in court filings. The circumstances here prove the importance of that rule: There are compelling policy reasons for rejecting DOL's proposal to impose the same procedural requirements for health-benefits

* Pursuant to Rule 29(a)(4)(E), *amicus* states that no party's counsel authored this brief in part or in whole, and no party or party's counsel or individual other than *amicus* contributed financially to the preparation or submission of this brief. Pursuant to Rule 29(a)(2), counsel for *amicus* states further that he has conferred with counsel for the parties, and none opposes the filing of this brief.

determinations and disability-benefits determinations. *Amicus* the ERISA Industry Committee (ERIC) takes no position on the wisdom of those arguments. We instead submit this brief to make a simpler point—that agencies like DOL may not use briefs in litigation to bypass the APA and deprive members of the regulated public their opportunity to participate in rulemaking procedures. That is just what DOL is attempting in this case. At a minimum, therefore, the Court should not afford DOL's counter-textual approach any deference under *Kisor* or *Auer v. Robbins*, 519 U.S. 452 (1997). But more than that, the Court should reject it as plainly inconsistent with the regulations that DOL itself has adopted.

To be clear, if the DOL would like to amend its regulations to conform them to its newfound views, it may in theory do so—but only through the inclusive processes of notice-and-comment rulemaking, which would give ERIC and its members an opportunity to make their arguments and present their evidence in favor of or against the change. Short of that, the Court should reject the position announced in DOL's *amicus* brief.

ISSUE PRESENTED FOR REVIEW

Whether DOL's interpretation of its regulations, as announced for the first time in its *amicus* brief before this Court, is inconsistent with the regulatory text and should be rejected as an improper effort to circumvent the APA.

IDENTITY, INTERESTS, AND AUTHORITY OF AMICUS CURIAE

ERIC is a national nonprofit organization that exclusively represents large employers throughout the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every sector of the economy, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans for active and retired workers, as well as their families. The questions at issue here directly implicate ERIC's interests as they concern the requirements for benefit plans such as those sponsored by ERIC's members, which will bear on the costs and other key attributes of those plans.

STATEMENT OF THE CASE

A. Legal background

The Employee Retirement Income Security Act of 1974 (ERISA) provides minimum standards for voluntarily established benefit plans in private industry. 29 U.S.C. § 1001 *et seq*. ERISA imposes fiduciary duties on plan administrators, requiring that they "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a); *see Metro Life Ins. Co. v. Glenn*, 5554 U.S. 105, 115 (2008). Consistent with this special standard of care, Section 503(2) of ERISA requires all employee benefit plans to "afford a reasonable opportunity to any participant whose claim for benefits has

been denied for a full and fair review." 29 U.S.C. § 1133(2). And to make sure these requirements have teeth, ERISA provides for "judicial review of individual claim denials." *Metro Life*, 554 U.S. at 115.

DOL has promulgated regulations to implement the "full and fair review" requirement. Those regulations establish a variety of substantive and procedural requirements for when a plan administrator seeks to deny a claim. 29 C.F.R. § 2560.503-1. All adverse benefit termination notifications must be written "in a manner calculated to be understood by the claimant" and must include "[t]he specific reason or reasons for the adverse determination" and "[r]eference to the specific plan provisions on which the determination is based." 29 C.F.R. § 2560.503-1(g)(1), (g)(1)(i)-(ii).

When a claim for ERISA-covered welfare benefits results in an adverse benefit determination "based on medical necessity," DOL regulations specify that the notification must include "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request." 29 C.F.R. § 2560.503-1(g)(1)(v)(B). The regulation establishes the same requirement regardless of whether the plan makes an adverse determination concerning health benefits or disability benefits—*except that* when the plan denies disability benefits, the notification must

also contain "an explanation of the basis for disagreeing with or not following" "[t]he views presented by the claimant to the plan of health care professionals treating the claimant." 29 C.F.R. § 2560.503-1(g)(1)(vii)(A)(i). The same is not required by the written regulation for notifications of denials of health benefits.

The different requirements for health-benefit and disability-benefit determinations grew out of the Affordable Care Act of 2010. *See generally* 81 Fed. Reg. 92,316 (Dec. 19, 2016). The ACA "enhance[d]" ERISA's requirements "with added procedural protections and consumer safeguards for claims for group health benefits," but not disability benefits. *Id.* DOL implemented the ACA by, among other things, promulgating a new rule in 2015, codifying "the right of claimants to respond to new and additional evidence and rationales and the requirement for independence and impartiality of the persons involved in making benefit determinations." *Id.* (citing 80 Fed. Reg. 72,192).

More than a year later, DOL separately updated its rules governing disability claims procedures so that those protections did not fall behind those in the health-benefit context. *Id.* at 92,317. Using "the amendments to the claims regulation for group health plans . . . as an appropriate model" (*id.*), DOL "carefully selected among the ACA amendments . . . and incorporated into the proposal only certain of the basic improvements in procedural protections and consumer safeguards." *Id.* at 92,318. The updated rule "also include[d] several adjust-

ments . . . to account for the different features and characteristics of disability benefit claims." *Id.* These adjustments resulted in the additional requirement being applicable only to notifications of denials of disability benefits.

B. Factual and procedural background

This case concerns the denial of health benefits (not disability benefits) by appellee United Behavioral Health as third-party administrator for appellee Alcatel-Lucent Medical Expense Plan for Active Management Employees. The plaintiffs in this case, Amy K. and her parents, allege, among other things, that UBH was required to but did not furnish an adequate explanation of the basis for disagreeing with or not following the views of Amy's treating physician.

After UBH's denial of benefits had been affirmed at every stage of internal review, appellees commenced suit in district court under ERISA. App. Vol. I at 27. The district court entered summary judgment for appellees. App. Vol. I at 66-67. In doing so, it chiefly faulted UBH for failing to provide its "full reasoning" to Appellees in its denial letters, including failure to give a sufficient explanation of the basis for disagreeing with the views of Amy's treating physician. App. Vol. I at 63. DOL did not file a statement of interest or take any other position in the litigation before the district court.

After appellees filed their principal brief before this Court on appeal, DOL submitted an amicus brief supporting affirmance. Analogizing to the disability

claims context, DOL argues that ERISA regulations impose a heightened standard as to the information that claims administrators must include in their denial letters to claimants for health benefits. DOL Br. at 12-23. In effect, it has "interpreted" the regulations applicable to health-benefit denials to impose the same requirements as the very different regulations applicable to disability-benefit denials.

ARGUMENT

I. DOL MAY NOT REWRITE ITS REGULATIONS OUTSIDE OF NOTICE AND COMMENT RULEMAKING

The APA, long hailed as the fundamental charter of the administrative state, was designed "as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices." *United States v. Morton Salt Co.*, 338 U.S. 632, 644 (1950). At its core is the requirement that "an agency shall afford interested persons general notice of proposed rulemaking and an opportunity to comment before a substantive rule is promulgated." *Chrysler Corp. v. Brown*, 441 U.S. 281, 313 (1979). Thus, when an agency wishes to make a substantive policy change, it must publish the proposed rule in the Federal Register, allowing appropriate time and opportunity for the public to comment. 5 U.S.C. § 553(a).

That is, of course, not what DOL has done here. The requirements for claims administrators are governed by detailed, written regulations that were promulgated through the inclusive notice-and-comment rulemaking process. In its brief before this Court, DOL has adopted for the first time a radically new "interpretation" of those regulations that fundamentally changes claims administrators' obligations in health-benefits denial cases. That is precisely what the APA prohibits. DOL may not announce new, binding regulatory requirements in one-off amicus briefs filed in court—much less in cases in which it is not a direct participant. To allow agencies such a backdoor would vitiate the procedural protections that form the heart of the modern administrative state. The Court should thus reject DOL and Appellee's attempts to rewrite the regulations outside of Congress's prescribed mechanisms.

A. DOL's interpretation of its own regulations is inconsistent with the plain text of the regulations

In its *amicus* brief before this Court, DOL urges the Court to adopt a new extra-regulatory requirement that a claims administrator like UBH must "be able to demonstrate" engagement with the opinions of a claimant's treating providers "in the denial letter provided to the claimant, and not by simply citing

the evidence in the appeal denial letter." DOL Br. at 15-16.[2] In doing so, DOL is effectively attempting to import the different standards applicable to denial of disability benefits into the health-benefit context, asserting that the same rules should apply. But DOL's position is not an interpretation of the underlying regulations—it is a straightforward rewriting of them.

1. The regulations specify that where (as here) a health-benefit administrator denies a claim based on medical necessity, the administrator must provide "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances." 29 C.F.R. § 2560.503-1(g)(1)(v)(B). The requirements for "an adverse benefit determination with respect to disability benefits" are laid out in a different subsection of the regulation. *See* 29 C.F.R. § 2560.503-1(g)(1)(vii). As a starting point, it contains an identical requirement that denials based on medical necessity contain "an explanation of the scientific or clinical judgment for the determination." 29 C.F.R. § 2560.503-1(g)(1)(vii)(B). But the disability-

[2] The Department incorrectly asserts that its present interpretation is consistent with the "Secretary's longstanding position." DOL Br. at 16 n.1. For support, the Department cites a single brief in which it argued that "a plan administrator's failure to adequately address the well-reasoned and documented opinion of a physician may violate ERISA." *Id.* Nothing in that passage says anything about *where* or *how* an administrator must address such evidence, which is the question presented here.

specific subsection *also* requires that a disability-claim denial include "an explanation on the basis for disagreeing with or not following . . . [t]he views presented by the claimant to the plan of health care professionals treating the claimant." 29 C.F.R. § 2560.503-1(g)(1)(vii)(A)(i). The subsection applicable to health-claim denials omits this language.

Analogizing from the rules of statutory interpretation, it is beyond cavil that "where [an agency] includes particular language in one section of a [regulation] but omits it in another section of the same [regulation], it is generally presumed that [the agency] acts intentionally and purposely in the disparate inclusion or exclusion." *Bates v. United States*, 522 U.S. 23, 29–30 (1997) (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)). That alone is enough to resolve the regulatory interpretation question here. But there is more.

First, under the *expressio unius* canon, it is understood that "expressing one item of [an] associated group or series excludes another left unmentioned." *NLRB v. SW General, Inc.*, 137 S. Ct. 929, 940 (2017) (quoting *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 80 (2002)). Here, DOL expressly stated a number of procedural requirements for health-benefits denials, but it did not include the requirement that the administrator explain the specific basis for disagreeing with the claimant's treating provider. *See* 29 C.F.R. 2560.503-1(g)(vii)(A)-(B). That implies a deliberate omission. Second, DOL's

interpretation would render paragraph (vii)(A)(i) superfluous. If, as DOL asserts, there were no need to state an express requirement that administrators explain their disagreement with the claimant's treating physician because such requirement is implicit in the broader regulatory scheme, then paragraph (vii)(A)(i) would accomplish nothing. A reading under which language is made "mere surplusage" is highly disfavored. *NAHB v. Defenders of Wildlife*, 551 U.S. 644, 669 (2007).

Is thus comes as no surprise that this Court, in *Mary D. v. Anthem Blue Cross Blue Shield*, 778 F. App'x 580, 589 n.7 (10th Cir. 2019), rejected the substance of DOL's position here.

2. DOL does not offer a persuasive account for its contrary rule. It asserts that "while subsection (g) separates regulations for disability and group health claims, many relevant provisions . . . apply to" all employee benefit plans. DOL Br. at 18. For evidence, DOL cites the regulation's requirement that "[e]very employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination." 29 C.F.R. § 2560.503-1(h)(1). This reasoning backfires—it shows only that the Secretary knew how to draft regulations applicable to all benefits determinations and did so when that was his intention; yet here, he

adopted a requirement expressly limited to disability-benefit denials, indicating an intent that the requirement *not* apply to health-benefit denials.

Nor does DOL's assertion that health and disability denials are subject "to the exact same requirements for 'full and fair' review of adverse benefit determinations on appeal" carry water. DOL Br. at 18. That "every employee benefit plan" must establish procedures for appeals, generally speaking, says nothing at all about the substantive standards that must be applied to claim denials on appeal. But that is the precise question here.

The regulatory history further undercuts DOL's position. In the 2016 Claims Procedure for Plans Providing Disability Benefits Rule, DOL explained that it intended to "revise[] paragraph[] g(1)(vii)(A) . . . to require that adverse benefit determinations on disability benefit claims contain a discussion of the basis for disagreeing with the views of health care professionals who treated the claimant." 81 Fed. Reg. 92,316, 92,321 (Dec. 18, 2016). In adopting these revisions, DOL noted its view that in many instances a claim administrator would be required to explain its reasoning if the claimant raised the issue "as part of an appeal of an adverse benefit determination." *Id.* It clarified that the explanation requirement was intended as "a process enhancement that removes unnecessary procedural steps for claimants to get an explanation of the reasons the plan disagrees with the views of its own consulting experts" or the claimant's medical

professionals. *Id.* DOL thus acknowledged that the 2016 disability rule changed where and when claim administrators were required to provide their reasoning for disagreeing with treating providers—a change with no parallel in the health-benefit context.

B. There are good policy reasons underlying differential treatment of healthcare and disability benefits determinations

The differences in the requirements for health-benefit and disability-benefit denials make good sense. DOL itself recognized as much, stating in the preamble to its 2016 rulemaking that it intended to "avoid creating differences in the text of parallel provisions in the rules" applicable to the two kinds of benefits determinations "absent a reason that addresses a specific issue for disability claims" and not health claims. 81 Fed. Reg. at 92,319. Its adoption of different requirements thus reflects a considered judgment that there were good "reason[s] that addresses a specific issue for disability claims" to explain the difference at issue here. *Id.*

And indeed there were. Disability benefits are intended to replace lost income over a long term. Health benefits, by contrast, are intended to reimburse the costs of necessary medical treatment in the immediate term. Thus, when DOL undertook its rulemaking in 2016, it was motivated by a disparity in the level of protections afforded to claimants between the two contexts. In its Final

Rule, DOL explained that the ACA's relevant amendments to ERISA were motivated by concerns "regarding conflicts of interest impairing the objectivity and fairness of the process for deciding claims for group health benefits," prompting additional "procedural protections and consumer safeguards for claims for group health benefits." 81 Fed. Reg. 92,316. But rather than adopt the ACA's procedural safeguards for all benefits determinations, DOL opted to import "a carefully selected set of the requirements applicable [only] to group health plans." 81 Fed. Reg. 92,333. The disability regulations thus omit, for example, the requirement that plans make review by an IRO available, as guaranteed in the health-benefit context. 45 C.F.R. § 147.136(d).

DOL's explanation of its changes, coupled with the resulting regulatory language, demonstrates a clear and reasonable approach. Rather than try to solve related problems in two very different contexts with the same blunt instrument, DOL opted to tweak and adapt its approach to meet the specific needs in each. It explicitly considered—as ultimately came to pass—that certain protections would apply in one context but not in the other. Rather than anathema to the regulatory scheme, the difference in standards between these contexts is completely consistent with DOL's intentional and well-considered approach.

C. DOL's interpretation of the regulations in its amicus brief is not entitled to deference under *Auer* and *Kisor*

Against this background, the Court at minimum should not defer to the positions in DOL's *amicus* brief. The reasons why are plain. "First and foremost, a court should not afford *Auer* deference unless the regulation is genuinely ambiguous." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415 (2019). That is, an agency's interpretation of its own regulation would only even be entitled to deference if the Court had "exhaust[ed] all the 'traditional tools' of construction" and found an ambiguity. *Id* at 2448. (quoting *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984)). We have just shown that there is none here: The regulation's plain text expressly distinguishes between the disability-benefits and health-benefits contexts, and the full toolbox of the canons of statutory interpretation confirms that the distinction was deliberate and must be given effect. "The regulation then just means what it means—and the court must give it effect, as the court would any law." *Id.* at 2415.

Second, even if the Court were to find ambiguity in the regulation, it could defer to DOL's interpretation only if it is "reasonable." *Kisor*, 139 S. Ct. at 2415 (quoting *Thomas Jefferson University v. Shalala*, 512 U.S. 504, 515 (1994)). That is, DOL's interpretation is only owed deference if it "come[s]

within the zone of ambiguity the court has identified after employing all its interpretative tools." *Id.* at 2416. Respectfully, DOL's anti-textual position is unreasonable: It ignores differences in regulatory text, reduces the core language to a redundancy, and renders the *expressio unius* principle meaningless.

Finally, a variety of the contextual factors that the Supreme Court identified in *Kisor* foreclose deference here. For one, courts "should decline to defer to a merely 'convenient litigating position.'" 139 S. Ct. at 2417 (quoting *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 155 (2012)). Moreover, "a court may not defer to a new interpretation, whether or not introduced in litigation, that creates 'unfair surprise' to regulated parties." *Id.* at 2417-18. Applying these factors in the past, the Supreme Court has refused to credit agency interpretations that upset regulated parties' settled expectations. *Id.* The same is warranted here: DOL's new interpretation would dramatically alter the required content of claim denial letters, forcing health benefit plans to reshape their processes. A counter-textual reading of a regulation—one announced for the first time in litigation and that disrupts the settled expectations of regulated entities—is owed no deference.

II. PERMITTING DOL TO REWRITE ITS REGULATIONS IN AN *AMICUS* BRIEF WOULD UNDERMINE THE APA

DOL could in theory adopt the rule that it has announced for the first time in its brief before this Court. But to do so, it would have to comply with the APA. That is a matter of substance, not hollow procedure. When complied with, the APA guarantees public participation and thus government transparency and accountability—protections that are essential given the stunning range of substantive law now settled by regulation rather than statute. All this is especially problematic in a case such as this, where the values protected in the APA are fully implicated.

A. Notice-and-comment rulemaking serves important values, including transparency and accountability to the public

"Congress enacted the APA in 1946 . . . to serve as 'the fundamental charter of the administrative state." *Kisor*, 139 S. Ct. at 2418. The APA was a "working compromise, in which broad delegations of discretion were tolerated as long as they were checked by extensive procedural safeguards." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 537 (2009).

Courts have long recognized that the APA's notice-and-comment procedures serve important policy goals. Chief among them is the value of public participation in lawmaking. *See* 5 U.S.C. § 553(c) ("[T]he agency shall give interested persons an opportunity to participate in the rule making through submis-

sion of written data, views, or arguments."). In particular, notice-and-comment procedures "reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies." *Batterton v. Marshall*, 648 F.2d 694, 703 (D.C. Cir. 1980).

Public participation in the administrative lawmaking process comes with a host of benefits, one of which is transparency. In the shadow of World War II, the APA's lead sponsor, Senator Pat McCarran, boasted that the Act "light[s] up our democratic processes at a time when we need to know that our system continues to function despite gathering darkness on other continents." Pat McCarran, *Three Years of the Federal Administrative Procedure Act—A Study in Legislation*, 38 Geo. L. J. 574, 589 (1950).

Additionally, the APA's notice-and-comment procedures "enable[] the agency promulgating [a] rule to educate itself before establishing rules and procedures which have a substantial impact on those who are regulated." *Batterton*, 648 F.2d at 704 (quoting *Texaco v. FPC*, 412 F.2d 740, 744 (3d Cir. 1969)). When an agency is required to collect, consider, and respond to public comments, there is a greater chance that "the agency will have before it the facts and information relevant to a particular administrative problem, as well as suggestions for alternative solutions." *AHA v. Bowen*, 834 F.2d 1037, 1044 (D.C. Cir. 1987) (quoting *Guardian Fed. Savings & Loan Assoc. v. Fed. Savings &*

Loan Ins. Corp., 589 F.2d 658, 662 (D.C. Cir. 1978) (cleaned up)). The "notice-and-comment procedures of the Administrative Procedure Act" similarly were "designed to assure due deliberation," improving substantive legal outcomes. *Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 741 (1996).

In the end, all of the virtues of the notice-and-comment system serve the ends of legitimacy. "Public rulemaking procedures increase the likelihood of administrative responsiveness to the needs and concerns of those affected." *Guardian Fed. Savings & Loan*, 589 F.2d at 662. Thus, "[i]n enacting the APA, Congress made a judgment that notions of fairness and informed administrative decisionmaking require that agency decisions be made only after affording interested persons notice and an opportunity to comment." *Chrysler Corp. v. Brown*, 441 U.S. 281, 316 (1979). These aspects of "public participation tend[] to promote acquiescence in the result even when objections remain as to substance. *Guardian Fed. Savings & Loan*, 589 F.2d at 662.

For all of these reasons, courts have carefully policed agencies' attempts to elude the APA's notice and comment requirements. In *Christenson v. Harris County*, 529 U.S. 576 (2000), for example, the Supreme Court declined to defer to DOL's interpretation of a regulation in an opinion letter on the basis that deference would "permit the agency, under the guise of interpreting a regulation, to create *de facto* a new regulation." *Id.* at 588; *accord Kisor*, 139 S. Ct. at

2415. Attempts such as these frustrate the core purposes of notice-and-comment rulemaking. *Christopher*, 567 U.S. at 159. The Court should not countenance the DOL's attempt here.

B. DOL's effort to circumvent the APA with a late-stage *amicus* brief is especially problematic in this case

There are especially important reasons that the regulated public should be afforded an opportunity to weigh in before DOL makes the significant substantive regulatory change reflected in its *amicus* brief here.

1. The public should be permitted to comment on the many crucial differences between the disability and health-benefit contexts. Commenters have emphasized these differences in the past. The NFL Player Disability & Neurocognitive Benefit Plan, for example, noted that after the APA, the health-benefits and disability-benefits claims processes had dramatically different statutory frameworks governing them. NFL Player Disability & Neurocognitive Benefit Plan, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits, at 4 (Jan. 19, 2016), perma.cc/8BM5-6GX7. It further noted that benefits in the disability and health contexts serve dramatically different purposes: "Disability benefits are intended to replace income, and generally involve a monthly stream of payments over a period of time, extending as

long as the recipient's life span. Health benefits generally involve payment for a product or service." *Id.* at 5.

The difference between disability and health benefits is also reflected in the posture in which claims typically arise. Health-benefits determinations typically occur against the backdrop of some ostensibly necessary medical care, which has consequences for a patient's health in the immediate term. These determinations must thus occur quickly, so claimants can have knowledge and certainty as to what care will be covered. Given the longer-term nature of disabilities, the claims process has a more collaborative and ongoing nature, with more voices involved.

The nature of claims processing also differs significantly between the two contexts. "Disability claims decisions require a sensitive, often much more complex holistic analysis of the claimant's physical and mental condition" whereas "[h]ealth claims decisions typically look only at whether the product or service sought to be covered is appropriate." NFL Plan Comment, *supra*, at 5. The result is that claims administrators responsible for adverse determination notifications in the health-benefit context are typically not medical experts (although reviewers responsible for medical necessity determinations do have formal medical training). *See* American Council of Life Insurers (ACLI), Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disabil-

ity Benefits, at 2 (Jan. 19, 2016) perma.cc/K3WZ-DU49. This is different from the disability context, in which "claims adjudication . . . requires multiple sources of information and the skilled input of many types of professionals." *Id.*

For its part, DOL historically has recognized the importance of these differences. In the 2016 disability rulemaking it acknowledged that "[t]he proposal, and final rule, also include several adjustments to the ACA requirements to account for the different features and characteristics of disability benefits claims." 81 Fed. Reg. at 92,318. Nor was this recognition new in 2016—"DOL [had] already accommodated differences between health and disability claims by allowing more time for decisions on disability claims." *Id.* n.12 (citing 29 C.F.R. § 2560.503-1(f)(2)-(3)).

This historical recognition yields yet another difference between the two contexts: DOL has declined to extend several of the most important claimant protection mechanisms from the health-benefit context to disability claims. Most notably, the ACA instituted a requirement that health benefit plans incorporate an option for independent, external review into their internal appeals processes. 42 U.S.C. § 300gg-19(b). DOL has promulgated rules implementing this statutory provision 45 C.F.R. § 147.136; 80 Fed. Reg. at 72,192. These provisions guarantee that any health-benefit claimant can obtain a full and fair review by an independent, qualified medical expert. Moreover, the regulations

go to great lengths to ensure that the external review is truly independent. Each plan or issuer "must contract with at least three (3) IROs for assignments . . . and rotate claims assignments among them." 45 C.F.R. § 147.136(d)(2)(iii)(2). Additionally, the "IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits." *Id.* § 147.136-(d)(2)(iii)(3). And the IRO review must be completely free for claimants. *Id.* § 147.136(d)(2)(iii)(4).

For one reason or another, DOL opted not to import these protections during the 2016 disability claim rulemaking. Instead, it designed and implemented a different set of protections. *See* 81 Fed. Reg. 92,319-20. The result was to "strengthen" the disability rules such that they provided a similar level or protection as in the health-benefit context, which had recently received an overhaul in the ACA. 81 Fed. Reg. at 92,317.

DOL evidently felt it achieved that goal. The result is that the two related (but different) contexts are covered by similar (but different) regulations that provide roughly equivalent levels of protection. This is a reasonable equilibrium that further rulemaking might upset. Importing additional procedural requirements from the disability-benefits context into the health-benefits context might be unnecessary, for example, because of the distinct but comprehensive IRO requirements that govern the latter but not the former.

Commenters have emphasized that "[i]t is precisely these distinctions that led to the claims procedure regulations being separated into two discrete components" more than two decades ago. ACLI Comment, *supra*, at 2. At a bare minimum, regulated members of the public—plans, their administrators and participants—all should have the opportunity to present their views about these differences before DOL undertakes the major policy changes reflected in its *amicus* brief in this case.

2. The public also must be allowed to comment on the administrative burdens that extending the disclosure requirements for disability-benefits determinations into the health-benefit context would impose on claim administrators. Commenters have historically highlighted these concerns as DOL has considered adopting or expanding claim denial protections. *See* NFL Plan Comment, *supra*, at 4-5; American Benefits Council, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits, at 1-2 (Jan. 19, 2016) perma.cc/VJB9-EHE2. And the Supreme Court has recognized the tensions at issue between

> Congress's desire to offer [claimants] enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.

Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).

Those concerns are implicated here, where DOL's rewrite of the regulations would drastically alter the requirements for health-benefit claim administration. As exemplified in this case, the industry practice is not to fully explain disagreements in medical necessity health-benefit denial letters. That is at least in part because the law does not currently require it. Extending the requirements from the disability context will thus impose burdens on claim administrators similar to those expressed by commenters on the 2016 disability rule. *See, e.g.*, National Business Group on Health, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits at 2-3 (Jan. 19, 2016), perma.cc/NLD9-4VQY. This would require claims administrators to perform "a task that [they] generally will not have sufficient information or expertise to complete." *Id* at 2.

Additionally, "explaining the basis for disagreeing with a third party's disability determinations will substantially lengthen and complicate notices of adverse benefit determination." *Id.* These concerns are heightened by the fact that "[t]o ensure compliance, plans will likely feel compelled to provide highly detailed, technical explanations" which will "cause confusion for plan participants and increase plan costs without providing additional information that would assist a participant in evaluating his or her claim under the plan at issue." *Id.* at 2-3.

Nor is it obvious that these additional burdens are at all justified by commensurate increases in benefits to claimants. Of course, DOL determined that the benefits were worth the costs when it adopted the procedural requirements for disability claims denials in 2016. But, again, the health-benefit context *already has* a set of procedural protections that are commensurate to those in the disability context. Given the myriad protections already afforded to claimants, it is unclear what additional benefits would accrue to claimants from DOL's proposed approach, if any—and how those benefits stack up against the costs.

Again, ERIC takes no position on these issues at this time. It reserves the right to develop its position following dialogue with its members—but only if DOL takes the steps necessary under the APA to trigger formal notice-and-comment rulemaking. The more basic point for now is simply that the APA long ago established a tried-and-true method for public participation in agency rulemakings, and DOL may not use this litigation as an end-run around the APA's promise of transparency, accountability, and public participation.

CONCLUSION

The Court should reject DOL's attempt to rewrite the governing ERISA regulations.

Dated: April 15, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Undersigned counsel for intervenors certifies that this brief (i) complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because it contains 5,654 words, including footnotes and excluding the parts of the brief exempted by Rule 32(f); and (ii) complies with the typeface requirements of Rule 32(a)(5) and Circuit Rule 32(A) and the type-style requirements of Rule 32(a)(6) because it has been prepared using Microsoft Office Word and is set in Century Supra in 14 points.

Dated: April 15, 2022 /s/ *Michael B. Kimberly*

CERTIFICATE OF DIGITAL SUBMISSION

Pursuant to 10th Circuit Rule 25, I hereby certify that with respect to the foregoing brief: (i) all required privacy redactions have been made in accordance with 10th Circuit Rule 25.5; (ii) if filing of hardcopies is required, this ECF submission is an exact copy of those documents; (iii) this digital submission has been scanned for viruses and it is free of viruses.

Dated: April 15, 2022 /s/ *Michael B. Kimberly*

CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of April, 2022, I electronically filed the foregoing with the Clerk of the Court of the United States Court of Appeals for the Tenth Circuit by using the CM/ECF system, and thereby accomplished electronic service on participants in this case.

Dated: April 15, 2022 /s/ *Michael B. Kimberly*