No. _____

In The

Supreme Court of the United States

TIMOTHY P. O'LEARY,

Petitioner,

v.

AETNA LIFE INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This petition presents one legal issue in two parts that have divided the courts of appeals regarding ERISA statute and regulations. Congress intended for fiduciaries to comply with ERISA statute and regulations to protect plan beneficiaries. Congress explicitly authorized the Department of Labor to police fiduciaries, implement regulations, authorize action for beneficiaries and courts upon fiduciary misconduct, all with the goal of protecting beneficiaries especially during benefit determinations.

O'Leary's questions are premised on an ERISA adverse benefits determination, when the fiduciary has discretionary authority over the plan and initially given deference by the court and the standard of review is deferential (arbitrary and capricious) but then it is revealed that the fiduciary failed to comply with ERISA statute and regulations claims-procedures textual requirements thus failing to provide a "full and fair review" of the claim which are codified in 29 C.F.R. § 2560.503-1.

The Questions Presented Are:

1. Does a fiduciary who is given deference "entitle" the fiduciary's decision priority over compliance with ERISA statute and regulations or does compliance have priority over fiduciary's decision and if found in violation of compliance with claims-procedures, is fiduciary's decision "arbitrary and capricious"?

QUESTIONS PRESENTED—Continued

2. Does a fiduciary lose its deference and the standard of review revert back to *de novo*, when claims-procedures are violated as directed by the Department of Labor and held by the Second Circuit?

Resolving the first question as petitioned by O'Leary will bring the Eleventh Circuit in uniformity with all the other Circuits.

Resolving the second question as petitioned by O'Leary will bring all Circuit Courts in uniformity with the Second Circuit, which is the first Circuit Court in over 40 years to fully comply with the directives of the Department of Labor regarding how to properly address fiduciary violations of claims-procedures. If addressed, this will be the first time this issue will have come before the Supreme Court.

PARTIES TO THE PROCEEDING BELOW

Petitioner is Timothy P. O'Leary, the plaintiff-appellant below.

Respondent is Aetna Life Insurance Company, the defendant-appellee below.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Timothy P. O'Leary respectfully petitions for a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The order denying rehearing and rehearing en banc (App. 32) is unreported. The Opinion of the court of appeals (App. 1) is unreported. The district court's judgement (App. 13) is unreported. The district court's order (App. 14) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on October 1, 2018. The court of appeals denied a petition for rehearing and rehearing en banc on October 31, 2018. On January 24, 2019, Justice Clarence Thomas extended the time to file a petition for certiorari to and including March 29, 2019. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

5 U.S.C. § 553(c):

> "(a) This section applies, according to the provisions thereof, except to the extent that there is involved—
>
> (1) a military or foreign affairs function of the United States; or
>
> (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.
>
> (b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—
>
> (1) a statement of the time, place, and nature of public rule making proceedings;
>
> (2) reference to the legal authority under which the rule is proposed; and
>
> (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.
>
> Except when notice or hearing is required by statute, this subsection does not apply—
>
> (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except—

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule."

29 U.S.C. § 1001(a):

"(a) BENEFIT PLANS AS AFFECTING INTERSTATE COMMERCE AND THE FEDERAL TAXING POWER—The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to

the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness."

29 U.S.C. § 1001(b):

"PROTECTION OF INTERSTATE COMMERCE AND BENEFICIARIES BY REQUIRING DISCLOSURE AND REPORTING, SETTING STANDARDS OF CONDUCT, ETC., FOR FIDUCIARIES—It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of

financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

29 U.S.C. § 1132(a)(1)(B):

"to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;"

29 U.S.C. § 1132(a)(2):

"by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;"

29 U.S.C. § 1132(a)(3):

"by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;"

29 U.S.C. § 1133(2):

"afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."

29 C.F.R. § 2560.503-1(h)(1):

> "*In general.* Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination."

29 C.F.R. § 2560.503-1(h)(2)(iv):

> "Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination."

29 C.F.R. § 2560.503-1(h)(3)(iii):

> "Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;"

29 C.F.R. § 2560.503-1(h)(4):

> "Plans providing disability benefits. The claims procedures of a plan providing

disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section."

29 C.F.R. § 2560.503-1(l):

"Failure to establish and follow reasonable 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."

U.S. Constitution—Article III—Section 2:

"The judicial power shall extend to all cases, in law and equity, arising under this Constitution, the laws of the United States, and treaties made, or which shall be made, under their authority;—to all cases affecting ambassadors, other public ministers and consuls;—to all cases of admiralty and maritime jurisdiction;—to controversies to which the United States shall be a party;—to controversies between two or more states;—between a state and citizens of another state;—between

citizens of different states;—between citizens of the same state claiming lands under grants of different states, and between a state, or the citizens thereof, and foreign states, citizens or subjects."

INTRODUCTION

This petition cleanly presents an exceptionally important issue of law in two parts under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1133 & 29 C.F.R. § 2560.503-1, which have divided the courts of appeals and caused confusion in lower courts across the nation.

Although the instant case is non-precedential, this Court has granted certiorari before on important unpublished opinions. In *Muhammad v. Close*, 540 U.S. 749 (2004), the **Supreme Court reversed an unpublished decision** that was flawed "as a matter of law", because the opinion took what the Supreme Court regarded as the wrong side of a circuit split. (Id. at 754) And "was flawed as a matter of fact", suggesting that the facts were neither clear nor straightforward. O'Leary asserts this Court will find these same flaws exist in the Opinion in the instant case also.

O'Leary received assistance from a group of volunteers (which he refers to as his "disability support group" in previous documents). They assisted in legal research and document creation, including this filing.

O'Leary is challenging the Eleventh Circuit's standing on a legal issue. O'Leary asserts that the panel that decided the Opinion is composed of legal experts and when they choose between two conflicting binding precedents it was with intent and conviction from their circuit's holding on the matter. The Eleventh Circuit standing ultimately decided the instant case when the panel chose between two conflicting binding precedents. O'Leary requested a rehearing to address these two precedents directly, but that rehearing was denied.

This petition exposes a circuit split, with the Eleventh Circuit on one side and the rest of the Circuit Courts on the other. This circuit split occurs when a fiduciary with "discretionary authority" decision is granted priority over compliance with ERISA Rules and Regulations of claims-procedures. The Opinion exposes a precedent that goes against all other Circuit courts, goes against this Court's guidance and violates the protections intended by Congress and directives of the Department of Labor.

The Opinion and the denied rehearing expose that the Eleventh Circuit holds that a fiduciary with "discretionary authority" has priority over compliance with ERISA statute and regulations claims-procedures textual requirements. ERISA requires fiduciaries to provide a "full and fair review" which encompasses claims-procedures rules and regulations codified in 29 C.F.R. § 2560.503-1. These requirements include the review of "all documents" and requires reviewing those documents by a qualified "health care professional who

has appropriate training and experience in the field of medicine involved in the medical judgment", as stated in 29 C.F.R. § 2560.503-1(h)(4), 29 C.F.R. § 2560.503-1(h)(1), 29 C.F.R. § 2560.503-1(h)(2)(iv) & 29 C.F.R. § 2560.503-1(h)(3)(iii). Failure to follow claims-procedures results in the fiduciary failing to provide the "full and fair review" requirements.

In this petition O'Leary will only address the pertinent facts of the instant case that expose the Eleventh Circuit split standing.

O'Leary's undisputed argument was that Aetna failed to properly review Dr. Holloway's neurological report, as admitted by Aetna's own neurological peer reviewing doctor (Dr. Heydebrand), who was the only one qualified representing Aetna to review this report. The Eleventh Circuit was aware of this argument and statement of Dr. Heydebrand, yet still held that Aetna's decision to terminate benefits was "reasonable" since Aetna was "entitled" to its decision because it had "discretionary authority" over the plan. The court gave deference to the fiduciary, due to this discretionary authority making the fiduciary's decision "not arbitrary and capricious". The panel did not hold Aetna accountable for not complying with ERISA rules and regulations claims-procedures.

O'Leary accordingly raises a cert-worthy issue in two parts that are critical to ERISA's regulatory enforcement scheme.

First, the instant case provides an ideal vehicle for the Court to resolve confusion over the first question

presented which addresses priority between fiduciary discretionary authority vs compliance of statute and regulations claims-procedures and if found in violation of compliance is the fiduciary's decision "arbitrary and capricious"?

The Eleventh Circuit not addressing or mentioning O'Leary's assertion that he did not receive a "full and fair review" in the Opinion due to discretionary authority, is particularly disruptive to ERISA and easily satisfies all the Court's traditional criteria for plenary review. ERISA claims-procedures violations are obviously important, and the Eleventh Circuit exposed a circuit split with its decision. The court's holding that the fiduciary's decision was "not arbitrary and capricious" due to fiduciary's "discretionary authority" which required the court to give "deference" to the fiduciary even though ERISA compliance violations occurred, conflicts with the standings of all the other Circuits. All the other Circuits hold that failure to comply with statute and regulation textual requirements of claims-procedures would or could result in an "arbitrary and capricious" ruling minimally, regardless of "discretionary authority". The violation of O'Leary's rights under ERISA is enough to show standing. There is no chance the Eleventh Circuit will reverse course as it ruled against this evidence during the Appeal and then again later denied rehearing en banc to address this issue directly.

This conflict will not be difficult for the Court to resolve. The Eleventh Circuit stands alone for good reason. Its position so far removes it from its sister

courts as to severely undermine ERISA's protections and the very rationale of not enforcing claims-procedures protections is inexcusable. The Opinion suggests, even if willful breach or serious error occur, the fiduciary decision stands if it has "discretionary authority". The court clearly held that a beneficiary has no recourse once deference is given to the fiduciary, even though Congress wanted to avoid this type of behavior by regulating claims-procedures minimums through the Department of Labor. Every other court of appeals which addresses the question has recognized, 29 C.F.R. § 2560.503-1 is not flexible to allow such a nonsensical reading.

A beneficiary suffers harm when the plan's fiduciary breaches its duties. Congress's choice of remedies fits well within the Article III boundaries that this Court has defined. ERISA implements centuries-old traditions of trust law that regularly allows to sue for relief and recovery of benefits when individual's suffer harm by fiduciaries.

Review is therefore warranted to restore uniformity to ERISA's claims-procedures and enforcement of the Department of Labor directives including the authority to remove deference from fiduciaries that fail to follow claims-procedures minimums and Congress authorized judiciary review of these violations.

Second, the instant case also provides an ideal vehicle for the Court to finally resolve the longstanding (over 40 years) confusion on the second question presented "Does a fiduciary lose its deference and the

standard of review revert back to *de novo*, when claims-procedures are violated, as directed by the Department of Labor and held by the Second Circuit?"

For decades, under Republican and Democratic administrations, the Department of Labor has given directives to the courts as a matter of doctrine and as a matter of policy repeated in multiple revision of ERISA, yet the circuits are at odds.

This issue will not be resolved without this Court's involvement. Further percolation accordingly would lack any meaningful benefit, and it is affirmatively harmful to beneficiaries if allowed to continue. Under the dominant view among the circuits, fiduciaries cannot brazenly abuse claims-procedures minimum requirements without fear of court intervention. If fiduciaries are allowed to abuse claims-procedures due to discretionary authority, puts countless beneficiaries at imminent risk. This contravenes ERISA's goals, and 29 C.F.R. § 2560.503-1 poses no obstacle to the judiciary to enforce fiduciaries to faithfully comply with ERISA's statute and regulations textual requirements. Review is warranted on this question.

STATEMENT

A. Statutory Background

1. The financial security of millions of Americans hangs on ERISA. As of 2006 ERISA plans covered over 132 million people. See, William Pierron & Paul

Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage, Emp. Benefit Research Inst. at 11 (Feb. 2008) & 29 U.S.C. § 1001(a).

Billions of dollars are at stake in reimbursement and denial of benefits disputes. In the disability context alone, 653,000 beneficiaries received more than $9.8 billion in disability replacement income in 2014. See, Council for Disability Awareness, 2014 Long Term Disability Claims Review (2014).

According to Lex Machina (Legal Analytics platform) 83,000 ERISA litigation cases were filed in the federal district courts from 2009-2018.

2. The instant case is subject to the ERISA 2000 regulations that were issued Nov. 21, 2000 (65 FR 70245).

In the ERISA 2000 final regulations the Department of Labor stated in its preamble:

> "The proposal contained a provision setting forth the Department's view of the consequences that ensue when a plan fails to provide procedures that meet the requirements of section 503 as set forth in regulations . . . The Department's intentions in including this provision in the proposal were 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**." (emphasis added)

To enforce fiduciary duties, ERISA relies heavily on private litigation. 29 U.S.C. § 1132(a)(1)(B) authorizes "civil action" to "recovery benefits". As the Department of Labor has explained across administrations, this private right of action is crucial: "The Secretary depends on participant suits to enforce ERISA, because it lacks the resources to do so singlehandedly, and plan fiduciaries are commonly defendants." Sec'y of Labor Amicus Br. at 12, *David v. Alphin*, No. 11-2181 (4th Cir. Dec. 28, 2011) & Sec'y of Labor Amicus Br. at 1-2, *Thole v. U.S. Bank*, No. 16-1928 (8th Cir. May 2, 2017).

Given ERISA's history, the statutory design is unsurprising. Congress simply adopted the longstanding common-law rule that trust beneficiaries may sue to remedy a trustee's breach of fiduciary duty. See, Austin W. Scott, Importance of the Trust, 39 U. Colo. L. Rev. 177, 177-79 (1966-1967) (tracing suits to the 15th century).

B. Facts And Procedural History

1. O'Leary was involved in a motorcycle accident on 7/12/2006 resulting in seventeen (17) broken bones (Cervical Spine Vertebrae (C6), Nine Thoracic Spine Vertebraes (T2-T9), Five Broken Ribs, Collar Bone (left) and One finger), Collapsed Lung (right), Bleeding in the Brain and Bruising of the Brain (Traumatic Brain Injury).

O'Leary's injuries resulted in two (2) permanent disabilities (both neurological and physical) that keep him from performing his "Own Occupation" (Director of Information Technology) or "Any Reasonable Occupation".

For the first six months O'Leary qualified for STD and then Aetna approved O'Leary for LTD in January 2007. On January 9, 2009 O'Leary was approved for Social Security Disability (SSD). Aetna paid benefits from 7/12/2006-5/12/2015 (nine years) and then terminated his benefits. SSD has paid disability benefits continuously since the onset of O'Leary's disabilities.

O'Leary without his LTD benefits, applied for emergency assistance from Medicaid for state disability benefits in 2015. Medicaid is a Social Security Administration (SSA) program administered by MassHealth in Massachusetts. In order to confirm neurological disabilities MassHealth, through Disability Evaluation Services, sent O'Leary to Dr. Holloway to perform neurological testing to obtain official diagnosis of any existing cognitive disability. After receiving Dr. Holloway's report confirming neurological findings (including Major Neurocognitive Disorder due to Traumatic Brain Injury, Memory Impairment, and other neurological diagnoses), SSA also considered O'Leary's additional neurological and orthopedic medical documents. SSA approved O'Leary for benefits due to his confirmed neurological and physical disabilities.

Later in 2015 Aetna upheld their termination of benefits. O'Leary accordingly filed suit in federal

district court and lost on Summary Judgement. O'Leary appealed the decision to the Eleventh Circuit. In that appeal, O'Leary argued further on his preserved claims including what Standard of Review should be used and the many critical flaws in the peer review reports, including a pivotal undisputed argument based on a statement by Dr. Heydebrand (Aetna's neurological peer review doctor) which stated:

> "An assessment by R. Holloway, Ed.D. On 9/16/2015 for disability indicates administration of the Weschsler Memory Scale III. **Only 1 page** of the report could be located in the file; no test results or conclusions from the report were available for review". (emphasis added)

O'Leary's other undisputed argument was that Dr. Holloway's full report is in the record, furthermore that full report is in the record three (3) times. The full report contained test results and conclusions.

After arguing that Dr. Heydebrand (who was Aetna's one and only person qualified to perform a neurological review) admitted to only having "one page" of Dr. Holloway's neurological report, which made her report "flawed" and "unreliable", O'Leary argued he did not receive a "full and fair review" and that Aetna's decision was "arbitrary and capricious". O'Leary then quoted the following binding precedent to support his claim. (based on compliance with ERISA statute and regulation claims-procedures) *Oliver v. Coca Cola Company*, 497 F.3d 1181, 1199 (11th Cir.), vacated in non-pertinent part 506 F.3d 1316 (11th Cir. 2007):

> "An ERISA defendant acts arbitrarily and capriciously when it "rel[ies] on [a] flawed peer review as a basis for denying [plaintiff's] benefits claim" and "fail[s] to review relevant medical evidence that support[s] [plaintiff's] claim."

2. The Opinion had a six-step process in deciding the instant case. At the "second step" the panel concluded that Aetna had "discretionary authority", which made the appeal Standard of Review "Arbitrary and Capricious".

The Opinion's circuit split precedent and reasonings are exposed in the "third step" (App. 8). The Opinion first states that "reasonable" grounds exist that support Aetna's decision. The Opinion then admits that there is some evidence ("some" meaning four (4) doctors confirmed O'Leary's neurological and physical disabilities in 2015) which supports O'Leary's claim of disabilities and "entitled to benefits", but then the Opinion back-tracks and states that since Aetna had "discretionary authority" over the claim the court must give "deference" to Aetna's decisionmaking authority because Aetna was "entitled to rely on the surveillance evidence and the assessments . . . by independent physicians who reviewed . . . medical files" resulting in Aetna's decision "not arbitrary and capricious" and supported its decision by referencing a binding precedent (based on discretionary authority and deference): *Turner v. Delta-Care Disability & Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002):

> "concluding that administrator's decision that claimant was no longer eligible for benefits was not arbitrary and capricious when it relied on, among other evidence, surveillance reports."

The panel being fully aware of O'Leary's argument and binding precedent, then evaluated the above binding precedent, resulting in the panel needing to decide between them. Although the Opinion failed to comment or mention O'Leary's contending binding precedent directly, it favored the above binding precedent and concluded that Aetna was "entitled" to its decision, exposing the Opinion's circuit split precedent showing "discretionary authority" had priority over ERISA compliance in the Eleventh Circuit.

The Opinion then stated:

> "O'Leary also argues that Aetna decision to terminate benefits was unreasonable because it was inconsistent with the determination of the Social Security Administration and MassHealth (Massachusetts's state Medicaid administrator) that he was disabled and entitled to benefits."

And continues stating:

> " . . . O'Leary's argument fails because he cannot show that Aetna refused to consider MassHealth's decision or the records that were before MassHealth . . . Aetna stated that it had considered 'every piece of information' in his file . . . Aetna discussed the findings of the psychologist who evaluated O'Leary at

> MassHealth's request. Given the substance of Aetna's decision on appeal, we reject O'Leary's argument . . . ".

O'Leary's argument that "failed" and "we reject" according to the Opinion, was based on Aetna's own peer review neurological doctor's statement (Dr. Heydebrand) claiming she only had "one page" of Dr. Holloway's full report, which made her report and conclusions "flawed" and "unreliable". Even with this information, the Opinion clearly supported Aetna's statement that they considered "every piece of information". The panel's support was due to Aetna's discretionary authority, which reaffirms the Eleventh Circuit stance that Aetna's decision had priority over ERISA compliance. Although it is true that Aetna does discuss Dr. Holloway's report, the fact remains that those comments (that were echoed in the Opinion) were from unqualified healthcare representatives, showing Aetna did not comply with ERISA's requirement that a qualified "health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment". (29 C.F.R. § 2560.503-1(h)(3)(iii)) Dr. Holloway's neurological report was never examined by Dr. Heydebrand. This meant not "all documents" were reviewed properly by Aetna, which resulted in the fiduciary not providing a "full and fair review" as required by ERISA. 29 C.F.R. § 2560.503-1(h)(4), 29 C.F.R. § 2560.503-1(h)(1) & 29 C.F.R. § 2560.503-1(h)(2)(iv).

The panel being experts of law and being fully qualified to judge ERISA legal matters, knew ERISA

requirements and the Eleventh Circuit stance. By allowing any type of examination and review by Aetna and treating that review as valid shows the Eleventh Circuit holds that "discretionary authority" has priority over ERISA requirements when the two are in conflict. Showing without a doubt the Eleventh Circuit split precedent and standing. This circuit split is prime for review.

REASONS FOR GRANTING THE PETITION

I. Review Of The First Question Presented Is Warranted.

The Opinion exposes a precedent and the Eleventh Circuit stance that an ERISA plan beneficiary lacks grounds to challenge fiduciary compliance if the fiduciary has discretionary authority. That holding exposed a conflict with all other Circuit Courts. See: *Denmark v. Liberty Life Assurance Co. of Boston*, 566 F.3d 1, 7 (1st Cir. 2010), *Halo v. Yale Health Plan*, 819 F.3d 42 (2nd Cir. 2016); *Michaels v. The Equitable Life Assurance Soc'y of the United States Employees, Managers, and Agents Long-Term Disability Plan*, 305 F. App'x 896 (3d Cir. 2009), *Meiburger v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, 261 Fed. Appx. 522 (4th Cir. 2008), *Salley v. E. I. DuPont de Nemours & Co.*, 966 F.2d 1011 (5th Cir. 1992), *Spangler v. Lockheed Martin Energy Systems, Inc.*, 313 F.3d 356, 362 (6th Cir. 2002), *Hess v. Hartford Life & Acc. Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001), *Cox v. Mid-Am. Dairymen, Inc. Ret.*

Plan, 965 F.2d 569, 571-72 & n.3 (8th Cir. 1992), *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1472 (9th Cir. 1993), *Caldwell v. Life Insurance Co. of North America*, 287 F.3d 1276, 1282 (10th Cir. 2002) & *Wagener v. SBC Pension Benefit Plan—Non-Bargained Program*, 407 F.3d 395, 402 (D.C. Cir. 2005). These courts have explicitly held that if the fiduciary violates statute and regulations requirements its decision is or could be "arbitrary and capricious" at the minimum. These courts allow a beneficiary to assert that the fiduciary violated a specific fiduciary duty owed to the beneficiary and the court would discern if the facts support the assertation.

This Court stressed statute priority in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 (2002):

> "Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations."

The Eleventh Circuit's position undermines the uniformity of law that is paramount under ERISA and severely hamstrings Congress's carefully designed ERISA enforcement regime, leaving the Department of Labor to perform a task of policing fiduciary misconduct, which it has repeatedly said it cannot do without the help of suits like O'Leary's. This entrenched conflict on a substantial question of federal law is

accordingly the archetypal question warranting this Court's review.

A. The Eleventh Circuit's Resolution On The First Question Presented Exposed A Circuit Conflict.

1. O'Leary's assertation about claims-procedures violations should have been fully investigated regardless of discretionary authority. O'Leary suing in any other Circuit would have allowed his assertion that a violation of claims-procedures existed, and the other Circuits would have investigated the claim. The plausibility of Aetna breaching their fiduciary duties of the plan is recognized by 29 U.S.C. § 1001(b).

2. All other Circuits agree that a beneficiary has standing to assert ERISA violations took place based on a breach of fiduciary duty specifically codified by ERISA. In holding otherwise, the Eleventh Circuit stands in conflict with every other circuit.

B. The First Question Presented Frequently Recurs, And The Department Of Labor Has Repeatedly Explained Its Exceptional Importance To ERISA's Enforcement Scheme.

An ERISA plan beneficiary's ability to sue and assert claims-procedures compliance violations is an obviously important question that arises with a frequency commensurate with that magnitude.

First, this Court has emphasized the significance of maintaining uniformity in the ERISA context. See, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002). The Eleventh Circuit alone holds that discretionary authority and deference have priority over compliance with ERISA statute and regulation. A violation that ERISA so carefully guards against. That misunderstanding of Article III's case and controversy requirement leaves a gaping hole in the enforcement of ERISA's protections.

Second, claims like O'Leary's are critical to ERISA's comprehensive regulatory scheme. ERISA's overriding purpose is to protect employee benefits and give beneficiaries the tools to enforce those protections. 29 U.S.C. § 1001(b) allows a beneficiary to seek restoration of losses caused by fiduciary breach. That is precisely why Congress broadly authorized beneficiaries "to recover benefits due to him under the terms of his plan . . . " 29 U.S.C. § 1132(a)(1)(B). The concern of the Eleventh Circuit's Opinion standing without challenge is that fiduciary breaches and violations will go unchecked unless the fiduciary does not have discretionary authority.

In amicus briefs across multiple administrations, the Secretary of Labor has confirmed the need for these violation claims: "The Secretary depends on participant suits to enforce ERISA, because she lacks the resources to do so singlehandedly, and plan fiduciaries are commonly defendants in such cases." Sec'y of Labor Amicus Br. at 12, *David v. Alphin*, No. 11-2181 (4th Cir. Dec. 28, 2011) & Sec'y of Labor Amicus Br. at 1-2, *Thole*

v. U.S. Bank, N.A., No. 16-1928 (8th Cir. May 2, 2017). The Secretary has further explained that "[t]he constraints on the Secretary's ability to bring suit are recognized by the statute's authorization of suits by private litigants as well as its legislative history." Sec'y of Labor Amicus Br. at 12, *David*, No. 11-2181. If not challenged "permit[s] obvious harms to plans to go unremedied except in the relatively few cases the Secretary is able to pursue." Ibid.

Third, the Eleventh Circuit has "no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given." *Sprint Commc'ns, Inc. v. Jacobs*, 571 U.S. 69, 77 (2013); See, *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 134 S.Ct. 1377, 1386 (2014) (while Congress may not expand federal courts' jurisdiction beyond its constitutional limits, "a federal court's obligation to hear and decide' cases" that are within its jurisdiction "is virtually unflagging"). The Eleventh Circuit's refusal to address assertations of violations of claims-procedures, which Congress has authorized, is in contrast with every other circuit, warrants review.

Fourth, considering the obvious importance of beneficiaries to bring suits for remedying ERISA violations, it is no surprise that this issue frequently recurs, as noted above. The issue's frequent recurrence, coupled with Congress's and the Secretary's reliance on such suits to enforce ERISA, confirms the need for this Court's review.

C. The Lower Court's Resolution On The First Question Presented Is Incorrect.

Review is warranted because the Eleventh Circuit's decision is incorrect. Congress's reliance on beneficiaries to file suits to remedy ERISA violations was not of its own creation. That enforcement mechanism derives from the centuries-old trust-law tradition of beneficiaries suing breaching trustees. See, H.R. Conf. Rep. 93-1280, 1974 U.S.C.C.A.N. 5038, 5087 (1974) (explaining that ERISA's "prohibited transaction rules . . . correspond to the traditional focus of trust law and of civil enforcement of fiduciary responsibilities through the courts"). This tradition shows that Congress stayed well within the bounds of Article III in authorizing such lawsuits.

Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) clearly states, based on a lack of compelling evidence from the fiduciary, *Firestone Tire and Rubber Co.*, that "the wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted," and that "even under the arbitrary and capricious standard an employer's denial of benefits could be subject to judicial review."

1. To ensure courts stay within Article III's cases and controversies limit, this Court has "established that 'the irreducible constitutional minimum' of standing consists of three elements. The plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that

is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 136 S.Ct. 1540, 1547 (2016) (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992)).

The issue here primarily concerns "injury in fact, the 'first and foremost' of standing's three elements." *Spokeo*, 136 S.Ct. at 1547 (quoting *Steel Co. v. Citizens for Better Env't*, 523 U.S. 83, 103 (1998)) (brackets omitted). The Court has made clear that, in the eyes of Article III, intangible injuries can be no less concrete than straightforward, tangible economic or physical injuries. *Spokeo*, 136 S.Ct. at 1549.

"In determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." Ibid. "Congress [has the] power to define injuries and articulate chains of causation that will give rise to a case or controversy." Ibid. (quoting *Lujan*, 504 U.S. at 580 (Kennedy, J., concurring in part and concurring in judgment)). And courts also must "consider whether an alleged intangible harm has a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit in English or American Courts." Ibid.; See, *Sprint Commc'ns Co. v. APCC Servs., Inc.*, 554 U.S. 269, 274 (2008); *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 774 (2000).

2. History and Congress's judgment show Congress permissibly authorized beneficiaries to seek suits against fiduciary misconduct including compliance violations of statute and regulations.

a. First, it is beyond reasonable dispute that Congress authorized suits like this one to vindicate beneficiaries' concrete, real-world and, common-sense interest in having ERISA plans free from fiduciary misconduct and abuse. This Court has observed that "the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators and that ERISA was designed to prevent these abuses in the future." *Russell*, 473 U.S. at 140 n.8; See, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 114 (2008); H.R. Rep. No. 533, 93d Cong., 1st Sess. 1, 3 (1973). Congress expressly declared ERISA's goal of protecting beneficiaries from such malfeasance "by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); See, *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004).

Congress's judgment is thus clear: Fiduciary breaches harm beneficiaries' interests and should be redressable in the federal courts regardless of discretionary authority. Section 1132(a)(1)(B) is accordingly a straightforward exercise of Congress's "power to define injuries and articulate chains of causation that will give rise to a case or controversy." *Spokeo*, 136 S.Ct. at 1549 (quoting *Lujan*, 504 U.S. at 580 (Kennedy, J., concurring in part and concurring in judgment)).

b. Congress did not break new ground in permitting suits like O'Leary's. Similar suits have been

permitted at common law for centuries. See, Scott, supra, 39 U. Colo. L. Rev. at 177-179.

O'Leary asserts that Aetna violated the fiduciary duty of loyalty by violating claims-procedures. It is blackletter law that a trust beneficiary may sue a fiduciary for breach of the fiduciary duty of loyalty showing harm to the beneficiary's economic interest in the trust corpus. This is known as the "no further inquiry" rule. See, 3 Austin W. Scott et al., Scott and Ascher on Trusts § 17.2 (5th ed. 2007) ("[A] trustee who has violated the duty of loyalty is liable without further inquiry into whether the breach has resulted in any actual benefit to the trustee . . . [or] whether the breach has caused any actual harm to either the trust or its beneficiaries."); Restatement (Third) of Trusts § 78 cmt. b. (2007) ("In transactions that violate the trustee's duty of undivided loyalty, under the so-called 'no further inquiry' principle it is immaterial that the trustee may be able to show that the action in question was taken in good faith, that the terms of the transaction were fair, and that no profit resulted to the trustee."); Robert H. Sitkoff, Trust Law, Corporate Law, and Capital Market Efficiency, 28 J. Corp. L. 565, 573 (2003) "Under the no further-inquiry rule, even if the self-dealing transaction is objectively fair, the beneficiaries need only show the existence of the fiduciaries self-interest in order to prevail (which the Opinion agreed a conflict of interest does exist). Once the beneficiaries prove the fact of self-dealing, there is 'no further inquiry' and the transaction is voided" (footnote omitted); See, *Scanlan v. Eisenberg*, 669 F.3d 838, 845-847 (7th Cir. 2012)

(concluding under common law trust principles that a beneficiary has Article III standing to sue a trustee for breach of fiduciary duty even without harm to her monetary interest in the trust).

This historical tradition, alongside Congress's clear judgment, settle the matter with respect to injury in fact. It makes no sense to premise a beneficiary's ability to argue violations of statute and regulations on whether the fiduciary has discretion authority or not.

Such violations are particularly obvious here. O'Leary sought to address these violations as prescribed by Congress through ERISA statute and regulations only to be side-railed by a non-sensical denial of argument and conflicting binding precedent, which was reiterated in his petition for rehearing en banc, which was denied. Given the asserted ERISA violations, granting certiorari is entirely likely to redress O'Leary's injuries and recovery of his benefits.

D. The Instant Case Is The Ideal Vehicle To Address The First Question Presented.

The instant case provides a perfect vehicle to address the question presented. This issue was outcome-determinative on O'Leary's claim of violations of ERISA statute and regulations; it was the core basis for the Eleventh Circuit's decision; both sides of the issue were vetted by thorough arguments from both sides. The conflicting arguments and binding precedents were the core issues presented in the petition for rehearing en banc giving the court the opportunity to

resolve this conflict internally, but that rehearing was denied. The issue is thus perfectly teed up for this Court's resolution.

This conflict will not resolve itself through additional percolation. The Eleventh Circuit stands alone on this issue. The decision exposes the Eleventh Circuit's standing and its reasoning is laid out in the Opinion. Not mentioning or addressing O'Leary's arguments and binding precedent makes their decision reviewable, it will remain the court's last word unless this Court intervenes.

Given that all the other circuits to address the issue have agreed unanimously and repeatedly with the contrary view, it is inconceivable that every one of them will reconsider. Therefore, until this Court steps in, cases like this one will come out differently depending on the circuit in which they are filed. Such division is particularly intolerable in the context of ERISA. Review is warranted.

II. Review Of The Second Question Presented Is Also Warranted.

The instant case also cleanly presents a second, related question that warrants this Court's review: "Does a fiduciary lose its deference and the standard of review revert back to *de novo*, when claims-procedures are violated as directed by the Department of Labor and held by the Second Circuit?"

The lower courts are deeply confused about that question, and after the Eleventh Circuit's decision, this confusion has expanded and will persist without this Court's involvement.

For decades the Department of Labor has stated that fiduciaries have a "minimum standard" for claims-procedures requirements.

The Department issued its revised claims-procedure regulation in November 2000. See, ERISA Rules and Regulations for Administration and Enforcement; Claims Procedures, 65 Fed.Reg. 70,246 (Nov. 21, 2000). In a section of the regulation's supplementary information entitled "Consequences of Failure to Establish and Follow Reasonable Claims Procedures," the Department noted that "[m]any of the comments that the Department [had] received in response to the [request for information] asserted that plans often fail to follow the minimum standards for procedural fairness set by the [1977] regulation," and that "[t]he Department believe[d] it [was] important to make clear that the claims procedure regulation prescribes the minimum standards for an administrative claims review process consistent with ERISA." Id. at 48,397. The Department further explained that "claimants should not be required to continue to pursue claims through an administrative process that fails to meet the minimum standards of the regulation." Id.

The Department was of the "view that, in such a case, any decision that may have been made by the plan with respect to the claim is not entitled to the

deference that would be accorded to a decision based upon a full and fair review that comports with the requirements of section 503 of the Act." Id.

Among the many changes to the regulation, the most relevant was the addition of subsection (l), addressing the consequences for the "[f]ailure to establish and follow reasonable claims procedures." 29 C.F.R. § 2560.503-1(l):

> "Failure to establish and follow reasonable 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."

The Department explained in the regulation's preamble that its "intentions in including this provision in the proposal were 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." 65 Fed.Reg. at 70,255.

The Department noted: "Inasmuch as the regulation makes substantial revisions in the severity of the standards imposed on plans, we believe that plans should be held to the articulated standards as

representing the minimum procedural regularity that warrants imposing an exhaustion requirement on claimants." Id. at 70,256.

This Court's review is warranted to resolve the circuit split over how to handle fiduciaries failure to comply with ERISA statute and regulations claims-procedures textual requirements.

A. The Second Question Presented Has Long Confounded The Lower Courts.

1. The circuits are hopelessly confused about how to handle fiduciaries failure to comply with ERISA statute and regulations claims-procedures. This question is cleanly presented here, and it has divided courts nationwide.

a. On one side of the issue are the Second Circuit and the Department of Labor. The Second Circuit decision falls in line with the Department of Labor directive and holds that failure to comply with the claims-procedures minimums will result in no deference being granted to fiduciary and the case being reviewed *de novo*. *Halo v. Yale Health Plan*, 819 F.3d 42 (2nd Cir. 2016) & Brief for Sec'y of Labor as Amicus Curiae Supporting Pl., *Halo v. Yale Health Plan*, No. 12-1447 (2d Cir. Jan. 28, 2013).

b. Contrary to the Second Circuit and the Department of Labor, all other circuits (except the Eleventh Circuit that stands alone in an inexcusable position) have precedents or leanings towards

"arbitrary and capricious" holdings at the least. The disagreement among the circuits is accordingly clear. This question of such importance warrants review by this Court.

c. The Eleventh Circuit has effectively removed itself from the debate. Its decision is thus percolation defeating; there is no longer any possibility the Eleventh Circuit will reconsider its position. The Second Circuit holding signals that its view will remain, and all the other Circuits precedents will remain entrenched unless this Court intervenes. It is clear this question will not be resolved without this Court's review.

The issues addressed today concerns the consequences from a plan's failure to comply with the Department's claims-procedures regulations when a beneficiary brings a civil action under ERISA Section 502(a)(1)(B).

The Standard of Review Applied to Claims under ERISA Section 502(a)(1)(B)

According to the Department of Labor, the standard of review that courts should apply to a claim under ERISA Section 502(a)(1)(B) when a plan fails to comply with claims-procedure regulations is addressed in the Department's regulation. The Department's preamble clarifies that when a fiduciary fails to comply with those minimum requirements, the fiduciary's decision denying a claim should not be entitled to deference in court. See, 65 Fed.Reg. at 70,255.

This Court has observed that "ERISA abounds with the language and terminology of trust law," and, therefore, "[i]n determining the appropriate standard of review for actions under § 1132(a)(1)(B), [courts] are guided by principles of trust law." Id. at 110-11; See, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 110-11, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008). Applying trust law principles, the *Firestone* Court held that "a denial of benefits challenged under § 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," then an arbitrary and capricious standard applies. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108-09, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) at 115. Trust law principles would therefore normally dictate that a federal court review such eligibility determinations under the highly deferential arbitrary and capricious standard.

This Court has recognized that "trust law does not tell the entire story. ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection." *Varity Corp. v. Howe*, 516 U.S. 489, 497, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996). Accordingly, "[a]lthough trust law may offer a 'starting point' for analysis in some situations, it must give way if it is inconsistent with the 'language of the statute, its structure, or its purposes." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447, 119 S.Ct. 755, 142 L.Ed.2d 881 (1999) (quoting *Varity*, 516 U.S. at 497):

> "courts may have to take account of competing congressional purposes, such as Congress' desire to offer employees 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."

In *Firestone*, this Court held that courts should defer to an administrator's discretionary decision, but this holding is premised on there being a decision to which a court may defer. Interpreting *Firestone*, many courts applying the 1977 regulation concluded that deference is not warranted if the plan failed to make a decision in the first place. Further seen in: *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 107 (2d Cir. 2005) ("[W]e may give deferential review only to actual exercises of discretion."); *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 632 (10th Cir. 2003) ("Deference to the administrator's expertise is inapplicable where the administrator has failed to apply his expertise to a particular decision."); *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3d Cir. 2002) ("Where a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." (citing *Moench v. Robertson*, 62 F.3d 553, 567 (3d Cir. 1995))); See, *Jebian v. Hewlett–Packard Co. Emp. Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1104 (9th Cir. 2003)

("Decisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the decisions notwithstanding."). For example, "[w]e previously concluded, based on [the 1977 regulation], that failure to respond to a plan participant's claim within the timeframe established by the Department of Labor's regulations rendered the claim 'deemed denied' and the participant's subsequent ERISA challenge to the benefits determination subject to de novo review." *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 624 (2d Cir. 2008) (citing *Nichols*, 406 F.3d at 105, 109).

"[n]ot only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002). Rather, the "general or default rule [is] *de novo* review." Id.

Bearing these principles in mind, we turn to trust law and then to regulatory and statutory purpose to determine the appropriate standard of review to apply when a plan fails to comply with the Department of Labor's claims-procedures regulation.

Trust Law Principles

Applying a *de novo* standard of review to claim denials that fail to comply with the minimum regulatory requirements agrees with trust law. The *Firestone* Court accorded deference to an administrator's

discretionary determinations based on the well-established trust law principle that, "[w]hen a trustee has discretion with respect to the exercise of a power, its exercise is subject to supervision by a court only to prevent abuse of discretion." Restatement (Third) of Trusts § 87 (Am. Law Inst.2007); See, *Firestone*, 489 U.S. at 111 (citing Restatement (Second) of Trusts § 187 (Am. Law Inst.1959) for the same principle). The principle that "a court may properly interpose if it finds that the trustee's conduct, in exercising a discretionary power, fails to satisfy the applicable standard of care, skill, and caution." Restatement (Third) of Trusts, § 87 cmt. c. Under ERISA, the Department of Labor's claims-procedures regulation provides the applicable standard of care, skill, and caution that plans must follow when exercising their discretion. Under trust law principles, then, courts may "interpose"—i.e., review a claim *de novo*.

Regulatory and Statutory Purpose

Regardless of whether trust law would grant deference to a discretionary decision that failed to comply with the Department's claims-procedures regulation, one must consider whether such deference conflicts with the "language of the statute, its structure, or its purpose," bearing in mind "competing congressional purposes." *Varity*, 516 U.S. at 497. Congress entrusted the Department of Labor, not the courts, to issue claims-procedures regulation that appropriately addresses ERISA's competing purposes. The courts duty is to interpret that regulation, a task that requires

courts to examine the regulation's text in light of its purpose, as stated in the regulation's preamble, See, generally Kevin M. Stack, Interpreting Regulations, 111 Mich. L.Rev. 355 (2012), as well as the purpose of the regulation's authorizing statute, ERISA, See, *Varity*, 516 U.S. at 497.

The Regulation and Its Preamble

When issuing regulations, the Administrative Procedure Act requires agencies to "incorporate in the rules adopted a concise general statement of their basis and purpose," 5 U.S.C. § 553(c), a statement that is commonly known as the regulation's preamble. Based on this congressional command, "it does not make sense to interpret the text of a regulation independently from its" preamble. Stack, supra, at 361; See, *Fid. Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 158 n. 13, 102 S.Ct. 3014, 73 L.Ed.2d 664 (1982) ("[W]e look to the preamble for the administrative construction of the regulation, to which 'deference is clearly in order.'" (quoting *Udall v. Tallman*, 380 U.S. 1, 16, 85 S.Ct. 792, 13 L.Ed.2d 616 (1965))); *Wyo. Outdoor Council v. U.S. Forest Serv.*, 165 F.3d 43, 53 (D.C. Cir. 1999) ("While language in the preamble of a regulation is not controlling over the regulation itself, we have often recognized that the preamble to a regulation is evidence of an agency's contemporaneous understanding of its proposed rules." (citation omitted)).

The preamble in the regulation explains that the "Department's intentions in including this provision in

the proposal were 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." 65 Fed.Reg. at 70,255.

The Department's own interpretation of regulation, as contained in the regulation's preamble, is entitled to substantial deference based on the regulation's ambiguity and the timing, formality, and history of the preamble's interpretation.

The Regulation's Ambiguity

In *Auer v. Robbins* 519 U.S. 452, 461, 117 S.Ct. 905, 137 L.Ed.2d 79 (1997) (quoting *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359, 109 S.Ct. 1835, 104 L.Ed.2d 351 (1989)), this Court held that a Department's interpretation of its own regulation is "controlling unless 'plainly erroneous or inconsistent with the regulation.'" But in *Christensen v. Harris County* 529 U.S. 576, 588, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000), this Court clarified that "*Auer* deference is warranted only when the language of the regulation is ambiguous."

Subsection (l) of the regulation admittedly says nothing about standards of review. Some Circuits have read the absence of any reference to the standard of review in subsection (l) as unambiguously indicating that the arbitrary and capricious standard of review continues to apply to discretionary decisions even if

the plan fails to follow the Department's claims-procedures regulation; based on this ambiguity. These courts have declined to accord any deference to the regulation's preamble. See, *Kohut v. Hartford Life & Accident Ins. Co.*, 710 F.Supp.2d 1139, 1144-45 (D.Colo.2008); *Goldman v. Hartford Life & Accident Ins. Co.*, 417 F.Supp.2d 788, 804 (E.D.La.2006). These decisions, however, ignore the legal context in which the Department issued its regulation.

Subsection (l) states that a plan's failure to establish or follow reasonable procedures in accordance with the claims-procedures regulation means that "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). This language could be reasonably read as incorporating the logic of *Firestone* and its progeny that a claim is subject to *de novo* review if it is "deemed denied," the effective equivalent of being "deemed . . . exhausted" under the 2000 regulation, cf. *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 223 (2d Cir. 2006); *Torres v. Pittston Co.*, 346 F.3d 1324, 1132 n. 10 (11th Cir. 2003). Based on case law, subsection (l) is at least ambiguous with respect to the standard of review. Since the regulation is ambiguous, the Department's interpretation is "controlling unless 'plainly erroneous or inconsistent with the regulation.'" *Auer*, 519 U.S. at 461 (quoting *Robertson*, 490 U.S. at 359).

The Timing, Formality, and History of the Department's Interpretation

The timing, formality, and history of the Department's interpretation indicates that the Department's interpretation, in the regulation's preamble, is entitled to substantial deference. The preamble was issued contemporaneously with the regulation which demonstrates "the Secretary's intent at the time of the regulation's promulgation." *Gardebring v. Jenkins*, 485 U.S. 415, 430, 108 S.Ct. 1306, 99 L.Ed.2d 515 (1988). The preamble was part of a formal notice-and-comment rulemaking, formality that entitles an agency's interpretation greater deference. See, *Christensen*, 529 U.S. at 587 ("Here, however, we confront an interpretation contained in an opinion letter, not one arrived at after, for example, a formal adjudication or notice-and-comment rulemaking.").

Statutory Purpose

If plans comply with the regulation, which is designed to protect employees, the plans get the benefit of both an exhaustion requirement and a deferential standard of review (if discretionary authority was reserved) when a claimant files suit in federal court. Protections that will likely encourage employers to continue to voluntarily provide employee benefits. But if plans do not comply with the regulation, then fiduciaries are not entitled to these protections. This is not unnecessarily harsh, as those in favor of the substantial compliance doctrine have contended. The failure to

comply does not result in any oppressive consequence; plans will have to pay the claim only if it is a meritorious claim, which they are already contractually obligated to do. They will simply lose the benefit of the deference afforded by the arbitrary and capricious standard. This regulatory approach balances the competing interests of employers and employees. Satisfying ERISA's dual congressional purposes.

Compliance Tolerance

Applying the 1977 regulation, many circuits adopted the so-called "substantial compliance" doctrine based on not "depriving the administrator of his discretion for a minor procedural irregularity that did not substantively harm the claimant would reflect a hyper-proceduralism that is inconsistent with the flexibility and discretion contemplated by the Plan and ERISA regulations." *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003).

That doctrine is inconsistent with the 2000 regulation for claims-procedures. The Department of Labor considered and rejected the doctrine when it completely replaced the 1977 regulation. When the Department issued its proposed regulation, it specifically noted that subsection (l) was drafted in response to public comments that "plans often fail to follow the minimum standards for procedural fairness set by the current [i.e., 1977] regulation." 63 Fed.Reg. at 48,397. The Department decided to retain the proposed subsection without modification. See, 65 Fed.Reg at

70,256. Only allowing for "inadvertent and harmless" non-compliance. See, Brief for Sec'y of Labor as Amicus Curiae Supporting Pl. at 11 n. 1, *Halo v. Yale Health Plan*, No. 12-1447 (2d Cir. Jan. 28, 2013).

B. The Second Question Presented Arises In Almost Every ERISA Adverse Benefits Case, And The Department Of Labor Has Consistently Emphasized Its Exceptional Importance.

As the numerous decisions cited above reveal, cases involving fiduciary violation of claims-procedures arise regularly.

Except in the Second Circuit, beneficiaries remain unable to obtain the protections that Congress, and the Department of Labor envisioned. The result is that even egregious fiduciary violations can go unpunished in some circuits. Under the Opinion below, bad-faith fiduciaries can openly deny and terminate benefits with impunity, showing blatant contravention of ERISA's fiduciary standards. Until misconduct results in actual consequences, misconduct may only be remedied in the few cases the Secretary decides to pursue. That result directly frustrates Congress's unambiguous intention and relies solely on the Department of Labor to carrying out Congress's enforcement scheme.

The Department of Labor stated in the Sec'y of Labor as Amicus Curiae Supporting Pl., *Halo v. Yale Health Plan* at 19, No. 12-1447 (2d Cir. Jan. 28, 2013):

> "The Supreme Court has never had occasion to decide what standard applies where a decision is untimely or otherwise fails to meet or substantially meet the requirements of either the current claims regulations or its predecessor. However, several courts, including the Second Circuit, have addressed the applicable standard of review where there are violations of the regulations during the claims review process. Moreover, the preamble to the current regulations states that a claim decision made without the procedural safeguards mandated by the regulations is not entitled to judicial deference."

C. The Lower Court's Resolution Of The Second Question Presented Is Incorrect.

This Court's review is also warranted because the decision below was incorrect.

ERISA plan fiduciaries that fail to comply with ERISA statute and regulation should result in consequences. The Eleventh Circuit's standing that O'Leary's argument of fiduciary violations fell outside the statute's zone of interests because the fiduciary had discretionary authority and owed deference by the court is incorrect to say the least.

O'Leary also has Article III standing to pursue his Section 1132(a)(1)(B) claim.

The Article III analysis here mirrors the same as Question 1. The beneficiary's injury is the invasion on his right to a plan free from fiduciary misconduct, an

intangible injury that Congress has made actionable based on centuries of common-law precedent.

D. The Instant Case Is An Ideal Vehicle To Address The Second Question Presented.

The instant case is an optimal vehicle for resolving this important issue. The question was dispositive of O'Leary's assertation of fiduciaries violation of claims-procedures which provided the core basis for the Eleventh Circuit's decision. It was the core basis for rehearing en banc, which was denied. The parties argued the issues on both sides. The Department of Labor has given direction and has commented on this question before and there are no unresolved factual issues that could hamper this Court's ability to resolve this legal issue. This significant question is accordingly ripe for the Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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