No. 23-586

In the Supreme Court of the United States

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

v.

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

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

Brief of the ERISA Industry Committee and Chamber of Commerce of the United States of America as *Amici Curiae* in Support of Petitioners

ANDREW LIAZOS
McDermott Will & Emery LLP
200 Clarendon St., Fl. 88
Boston, MA 02116-5021
(617) 535-3800
aliazos@mwe.com

MICHAEL B. KIMBERLY
Counsel of Record
CHARLES SEIDELL
McDermott Will & Emery LLP
500 North Capitol Street NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Amici Curiae
Additional counsel on inside cover

Tara S. Morrissey
Jordan L. Von Bokern
U.S. Chamber Litigation Center
200 Clarendon St., Fl. 88
1615 H Street, NW
Washington, DC 20062

Counsel for the U.S. Chamber of Commerce

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INTRODUCTION AND INTERESTS OF *AMICI CURIAE**

The petition in this case presents two questions of broad public importance that are specific to the processing requirements under ERISA for denials of health benefits. As the petition explains (at 22-28), underlying the two questions presented is an even more fundamental issue concerning the Administrative Procedure Act: May a court, at the invitation of an agency in an *amicus* brief, effectively amend regulations by judicial fiat, providing the agency with an end-run around the APA's notice-and-comment rulemaking procedures?

The answer to that question is an obvious *no*. But the Tenth Circuit below disagreed, decreeing a new regulatory requirement for health-benefit denials that the Department of Labor, in dual 2015 and 2016 rulemakings, expressly considered and chose to adopt *only* for disability-benefit denials and *not* for health-benefit denials.

If not corrected by this Court, the decision below will stand as an invitation to agencies to file *amicus* briefs in the courts of appeals, advocating for substantial changes to their regulations without the bother (or transparency) of APA rulemaking. In today's day and age, when so much lawmaking is undertaken by unaccountable federal bureaucrats, that is a deeply troubling prospect.

The ERISA Industry Committee (ERIC) is a national nonprofit organization that exclusively represents large employers throughout the United States in their capacity

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* Pursuant to Rule 37.6, *amici* state that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amici*, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Rule 37.2, counsel for *amici* gave notice of *amici*'s intent to file this brief 10 days in advance of the filing.

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 Chamber of Commerce of the United States of America is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus* briefs in cases, like this one, that raise issues of concern to the nation's business community.

The questions at issue here directly implicate the interests of ERIC's and the Chamber's members. Many of those members are large employers who sponsor health-benefit plans that will see costs rise as a direct result of the decision below. Others are members of the regulated public more generally, who have a strong interest in ensuring that they have a voice in notice-and-comment rulemaking. ERIC and the Chamber are both frequent participants in rulemakings generally and before the Department of Labor, particularly. It is a core part of their missions to ensure that DOL complies with its notice-and-comment obligations and issues regulations that are practically workable and grounded in law.

STATEMENT

A. Legal and rulemaking background

1. The Employee Retirement Income Security Act of 1974 (ERISA) provides minimum standards for voluntarily established benefit plans in private industry. 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*, 554 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.

The Department of Labor has promulgated regulations to implement ERISA's "full and fair review" standard. Those regulations establish a variety of substantive and procedural requirements that apply when a plan administrator denies a claim. For example, 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 benefits of any kind results in an adverse determination "based on a 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 imposes the same plus additional requirements for an adverse determination concerning disability benefits. In that distinct context, 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 explanation is not required for notifications of denials of health benefits. *Id.* § 2560.503-1(g)(1)(vii) (specifying that this requirement applies only "[i]n the case of an adverse benefit determination with respect to disability benefits").

2. These different requirements for health-benefit and disability-benefit determinations grew out of the Affordable Care Act of 2010. See 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. *Ibid.* 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." *Ibid.* (citing 80 Fed. Reg. 72,192).

About one year later, DOL undertook a new rulemaking to ensure that its rules governing disability claims procedures did not fall behind those in the health-benefit context. *Id.* at 92,317. Its goal was to "avoid creating differ-

ences in the text of parallel provisions" applicable to the two kinds of benefits determinations "absent a reason that addresses a specific issue for disability claims" that is not also an issue for health claims. 81 Fed. Reg. at 92,319. Thus, using "the amendments to the claims regulation for group health plans" as a starting point (*id.* at 92,317), DOL "carefully selected" certain "basic improvements in procedural protections and consumer safeguards" under the ACA for incorporation into the disability-benefit context (*id.* at 92,318).

But the updated rule "include[d] several adjustments * * * to account for the different features and characteristics of disability benefit claims." *Ibid.* The regulations applicable to disability benefits omit, for example, the requirement that plans make review by an independent review organization (IRO) available, as guaranteed in the health-benefit context. 45 C.F.R. § 147.136(d). DOL also "accommodated differences between health and disability claims by allowing more time for decisions on disability claims." 81 Fed. Reg. at 92,321 n.12 (citing 29 C.F.R. § 2560.503-1(f)(2)-(3)).

This case implicates another of DOL's context-sensitive adjustments. As just noted, 29 C.F.R. § 2560.503-1(g)(1)(vii) requires a third-party administrator denying a claim for disability benefits to provide "an explanation of the basis for disagreeing with" the opinion of the claimant's treating physician. There is no similar requirement stated in 29 C.F.R. § 2560.503-1(g)(1), concerning denials of health benefits. Thus, an administrator denying a claim for health benefits need not expressly state the reasons for disagreeing with the opinions of the claimant's treating physicians or therapists.

Commenters offered several reasons why this difference was warranted. Unlike disability claims, they noted, most health-benefit claims involve limited treatment over a short time concerning isolated issues. See 81 Fed. Reg. at 92,318. A treating physician in the health-benefit context is therefore less likely to have a deep understanding of the patient's overall condition and long-term treatment needs, limiting the relative value of his or her opinion. *Ibid.* "Health claims decisions [thus] typically look only at whether the product or service sought to be covered is appropriate" based on coded inputs, not qualitative judgments. NFL Player Disability & Neurocognitive Benefit Plan, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits 5 (Jan. 19, 2016), perma.cc/8BM5-6GX7.

Moreover, health-benefits determinations typically occur against the backdrop of an immediate medical need. *Ibid.* These determinations therefore must be resolved quickly, so claimants and their doctors can know what will be covered. "The vast majority of medical claims" are thus "determined electronically with little or no human involvement * * * almost instantaneously." Unum Group, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits, at 2 (Jan. 19, 2016), perma.cc/DSN2-9MU6.

In the disability-benefits context, the opposite is true. First, the treating physician is more likely to be close to the patient and have unique insights into her condition and abilities, warranting additional attention to the physician's assessment of the patient's circumstances and prognosis. *See generally* 81 Fed. Reg. at 92,318. To put it another way, "[d]isability claims decisions require a sensitive, often much more complex holistic analysis of the

claimant's physical and mental condition," which treating doctors are well positioned to address. NFL Plan Comment, *supra*, at 5.

In addition, disability benefits are lower volume and "more like pension benefits than health benefits" in that they "are intended to replace income" over the long term. *Ibid.* Given the less urgent, lower volume nature of disability-benefit determinations, the process can be more collaborative and deliberative, with more voices directly involved. That stands in contrast with health-benefit determinations, which "are typically susceptible to automated processing" and as to which requiring fully articulated findings would be unrealistically burdensome. *Ibid.*

B. Factual and procedural background

This case concerns the denial of health benefits—not disability benefits—by United Behavioral Health as third-party administrator for a health-benefits plan. The plaintiffs in this case 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 K.'s treating physician.

UBH's denial of benefits was affirmed at every stage of internal review. The plaintiffs here then commenced suit in federal district court under ERISA.

The district court entered summary judgment for the plaintiffs. Pet. App. 36a. In doing so, it faulted UBH chiefly for failing to provide its "full reasoning" to respondents in its denial letters, including failure to give a sufficient explanation of the basis for disagreeing with the views of Amy's treating physician. Pet. App. 63a. DOL did not file a statement of interest or take any other position in the litigation before the district court.

UBH appealed to the Tenth Circuit. After UBH had filed its principal brief, DOL submitted an *amicus* brief supporting affirmance. Analogizing to the disability-claims context, DOL's brief purported to "interpret" the regulations applicable to health-benefit denials as imposing the same requirements as the regulations applicable to disability-benefit denials. DOL *Amicus* Br. 12-23. In doing so, DOL did not acknowledge that these distinct requirements were adopted by notice-and-comment rulemaking for disability-benefit claims only, and not for health-benefit claims.

The Tenth Circuit adopted DOL's position. Pet. App. 18a-28a. The court "recognize[d] the textual difference in the ERISA disability and ERISA medical regulations" but "disagree[d]" that the express inclusion in one and exclusion in the other had any impact on UBH's regulatory duties. Pet. App. 20a. It therefore rejected UBH's argument that health-benefit plan administrators are not required to explain their disagreement with medical professionals' opinions in their denial letters to satisfy ERISA's procedural requirements. Pet. App. 28a.

ARGUMENT

The Tenth Circuit's revision of properly promulgated regulations by judicial decree, at the invitation of an agency that aimed to sidestep the APA, is a matter of enormous practical consequence warranting the Court's immediate attention and correction.

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 regulatory change, it must publish a proposed rule in the Federal Register, allowing the public to comment, and respond to those comments. See generally 5 U.S.C. § 553(b).

That is, of course, not what DOL did below. The requirements for claims administrators are governed by detailed, written regulations that were promulgated through the APA's inclusive notice-and-comment rulemaking process. In its brief before the Tenth Circuit, DOL adopted, for the first time, a revisionist interpretation of those regulations, significantly altering claims administrators' obligations in health-benefits denial cases. And it induced the Tenth Circuit to adopt its new regulatory standard through litigation rather than rulemaking.

That is precisely what the APA prohibits. DOL may not announce a new regulatory requirement in an *amicus* brief, and the Tenth Circuit was not at liberty to adopt it. To allow agencies to backdoor regulatory changes like this would vitiate the procedural protections at the heart of the modern administrative state. And in skirting the APA's procedural requirements, DOL was deprived of the benefit of well-informed views of stakeholders, which would have highlighted the key differences between the disability and health-benefit contexts. The Court should grant UBH's petition and reject DOL's and the Tenth Circuit's revision of the regulations at issue here.

A. The lower court improperly approved substantive changes to DOL's regulations

The department having adopted considered distinctions between the rules for health-benefit denials and disability benefit denials in a duly promulgated regulation following notice and comment, the Tenth Circuit was not at liberty to implement changes to the scheme by judicial fiat, even at DOL's invitation in its *amicus* brief.

The regulations at issue here do not interpret statutory language. They are policy-based, gap-filling rules. They thus reflect DOL's exercise of executive policymaking judgment to implement ERISA, and substantive changes to them must be promulgated, if at all, through new notice-and-comment rulemaking. This Court's immediate review is necessary to confirm these critically important points.

1. DOL's litigating position amends, rather than interprets, its regulations

In its *amicus* brief before the Tenth Circuit, DOL urged the court to adopt a new, extra-regulatory requirement that UBH must "demonstrate" that it actually reviewed and rejected 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 *Amicus* Br. at 15-16. In offering this new view, DOL attempted to eliminate—by judicial order rather than APA rulemaking—the different standards for denials in the disability-benefits and health-benefit contexts. DOL's position is not an interpretation of the regulations, but a revision of them.

The relevant 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, the health-benefit provision contains an identical requirement to the disability-benefit provision, 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). But the disability-specific subsection *also* requires that a disability-benefit denial include "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 provision applicable to health-benefit claim denials omits this language.

Even if there were not already clear evidence from the 2016 rulemaking that the respective inclusion and exclusion of this requirement was considered and intentional, the standard rules of construction confirm it. After all, it is fundamental with respect to regulations, just like statutes, 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.

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.*, 580 U.S. 288, 302 (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). Meanwhile, DOL has shown that it knows how to impose a requirement to respond to the opinions of treating physicians when it wishes to. It did not do so here, and neither DOL in an *amicus* brief, nor the Tenth Circuit in a judicial opinion, was free to override that considered omission.

Second, DOL's interpretation would render paragraph (vii)(A)(i) superfluous. If, as DOL asserted, 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 disfavored. *NAHB* v. *Defenders of Wildlife*, 551 U.S. 644, 669 (2007).

2. DOL's amicus *brief is not entitled to deference*

Because it is not reasonably characterized as an interpretation of the regulation, so much as an amendment of it, DOL's *amicus* brief is not entitled to deference.

Indeed, DOL never offered a persuasive account for its position before the Tenth Circuit. It asserted below that "while subsection (g) separates regulations for dis-

ability and group health claims, many relevant provisions * * * apply to" all employee benefit plans. DOL *Amicus* Br. 18. For evidence, it cited 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). But that reasoning backfires—again, it shows only that the Secretary knew how to draft regulations applicable to all benefits determinations and did so when that was her intention. Yet here, she adopted a requirement expressly limited to disability-benefit denials, indicating an intent that the requirement *not* apply to health-benefit denials.

Against this background, no court owes any deference to the positions in DOL's *amicus* brief. "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. *Ibid.* (quoting *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984)). 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." *Ibid.*

Even if it were otherwise, courts "should decline to defer to a merely 'convenient litigating position.'" *Kisor*, 139 S. Ct. at 2417 (quoting *Christopher* v. *SmithKline*

Beecham Corp., 567 U.S. 142, 155 (2012)). This Court has announced a "general rule * * * not to give deference to agency interpretations advanced for the first time in legal briefs." *Id.* at 2417 n.6. That is especially so here, given that "a court may not defer to a new interpretation, whether or not introduced in litigation, that creates 'unfair surprise' to regulated parties." *Id.* at 2417-2418. Applying these factors in the past, this Court has refused to credit agency interpretations that upset regulated parties' settled expectations. *Ibid.* The same was warranted below: 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 which changes the clear requirements of a statutory scheme, thereby disrupting the settled expectations of regulated entities—is owed no deference and should be rejected.

B. Allowing the decision below to stand would strike a dangerous blow to the APA

Proper enforcement of agencies' rulemaking obligations is a matter of surpassing practical importance that warrants an immediate grant of certiorari.

1. Notice-and-comment rulemaking fosters transparency and public accountability

"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 essential 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 submission 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, paramount among them, transparency. At the onset of the Cold War, 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 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.*, 441 U.S. at 316. 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 *Christensen* v. *Harris County*, 529 U.S. 576 (2000), for example, this 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 Tenth Circuit was wrong to countenance DOL's evasion of the APA's carefully crafted requirements below.

2. The outcome below denies an opportunity for participation in a major regulatory change

a. DOL's effort to circumvent the APA with a late-stage *amicus* brief was inconsistent with the statute's core values. Most significantly, by announcing a substantive alteration of longstanding regulations in an *amicus* brief, DOL effectively excluded the public from participating in the policymaking process. These procedures are not "arbitrary hoops through with federal agencies must jump without reason"—instead, they "improve[] the quality of agency rulemaking" by providing the agency with "diverse public comment." *Sprint Corp.* v. *FCC*, 315 F.3d 369, 373 (D.C. Cir. 2003).

Taking and responding to public comment would have produced a better policy in this case. As they had done in 2016, interested parties would have emphasized the important differences between disability and health-benefit claims. See *supra*, pages 5-7.

At bottom, health and disability benefits serve fundamentally different purposes—whereas one reimburses for one-off medical expenses, the other replaces income for the long term. Decisions in one context need to be made relatively quickly, making detailed reviews of and responses to treating-physician opinions impractical. Decisions in the other context are less urgent and implicate a more comprehensive review. And unlike health-benefit claims, which are decided automatically based on coding rules, disability claims involve more holistic assessments as to which the opinions of doctors with longstanding and detailed understanding of the patient may be entitled to greater weight. 81 Fed. Reg. at 92,318.

The regulated public could have brought other important observations to DOL's attention. For example, a

2012 study indicated that disability claims accounted for 64.5% of all ERISA benefits litigation, compared to 14.3% for health-benefit claims—despite that "fewer private employees participate in disability plans than in other types of plans." Sean M. Anderson, *ERISA Benefits Litigation: An Empirical Picture*, 28 A.B.A. J. Lab. & Emp. L. 1, 7 & Fig. 2 (2012). Given the holistic nature of disability claim processing, arguments in disability cases are more likely to focus on asserted conflicts of interest or to ask for *de novo* consideration of the plan's decision. *Id.* at 11. Imposing more demanding procedural requirements at the outset in disability cases therefore may be justified by a preference to keep disputes from maturing into court cases—and to make judicial review easier when they do.

Comments also would have alerted DOL to the administrative burdens that extending the disclosure requirements for disability-benefits determinations into the health-benefit context would impose on claim administrators. The Court has recognized Congress's desire in the ERISA context to afford 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). Commenters to the 2016 disability rule expressed these precise concerns. See, *e.g.*, ABC, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits, at 1-2 (Jan. 19, 2016) perma.cc/VJB9-EHE2; NBGH, Comment on 2016 Claims Procedure Regulation Amendment for Plans Providing Disability Benefits at 2-3 (Jan. 19, 2016), perma.cc/NLD9-4VQY.

DOL was obligated to hear these and other parties' concerns and to determine whether the additional administrative burdens are justified before changing its rules as it did in this case.

For their part, neither ERIC nor the Chamber takes a position on the wisdom of DOL's proposed rule change. The point for now is a simpler one: The only legitimate process for an agency to propose rules and collect public comments is through APA notice-and-comment rulemaking. When DOL attempts to circumvent notice-and-comment rulemaking as it has done in this case, trade groups and other interested parties lack the opportunity to develop and convey their positions under the procedural framework and protections afforded by the APA—the precise problem with DOL's approach below.

b. Rather than hew to an appropriately narrow judicial role, the Tenth Circuit accepted DOL's invitation to rewrite the department's ERISA regulations in a judicial opinion. It "recognize[d] the textual difference in the ERISA disability and ERISA medical regulations," but trampled the important linguistic distinction. Pet. App. 20a. In doing so, it repeated DOL's basic interpretive errors. The lower court claimed, for example, that the disability-benefit regulation "was merely making explicit requirements for claims review that were already required" (Pet. App. 21a), ignoring DOL's own explanation in 2016 that the rule "revises" the disability regulations as "a process enhancement" that alters the "procedural steps for claimants to get an explanation of the reasons the plan disagrees with the views of its own consulting experts." 81 Fed. Reg. at 92,321.

At its core, the court of appeals reasoned that its new judicially imposed requirement flows from an ERISA

fiduciary's standing obligation to "provide a full and fair review of the evidence presented." Pet. App. 23a. But this Court has already held that "ERISA does not support judicial imposition of a treating physician rule." *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 834 n.4 (2003). And, as discussed above, DOL has not seen fit to adopt the Tenth Circuit's requirement through the APA's proper rulemaking procedures.

While "Congress 'expect[ed]' courts would develop 'a federal common law of rights and obligations under ERISA-regulated plans," (*Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)), "the scope of permissible judicial innovation is narrower in areas where other federal actors are engaged" (*Black & Decker*, 538 U.S. at 831). The Tenth Circuit's choice to act where Congress and DOL have not—at least not through the appropriate lawmaking channels—runs counter to both its limited role in crafting ERISA requirements and its obligation to ensure that DOL follows proper steps when doing so. It is tremendously important to the regulated public that the Court grant review in this case and say so.

CONCLUSION

The Court should grant the petition.

Respectfully submitted.

TARA S. MORRISSEY
JORDAN L. VON BOKERN
U.S. Chamber Litigation Ctr.
200 Clarendon St., Fl. 88
1615 H Street, NW
Washington, DC 20062

Counsel for the Chamber of Commerce of the United States of America

MICHAEL B. KIMBERLY
Counsel of Record
CHARLES SEIDELL
McDermott Will & Emery LLP
500 North Capitol Street NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

ANDREW LIAZOS
McDermott Will & Emery LLP
200 Clarendon St., Fl. 88
Boston, MA 02116-5021

Counsel for Amici Curiae