No.

In the Supreme Court of the United States

HUMBLE SURGICAL HOSPITAL, LLC, PETITIONER

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY AND CIGNA HEALTH AND LIFE INSURANCE COMPANY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case implicates two important and recurring problems in ERISA litigation. In the decision below, the Fifth Circuit diverged from decisions of this Court and multiple courts of appeals on the standard for reviewing an ERISA administrator's interpretation of plan language. The Fifth Circuit also deepened a widely acknowledged conflict regarding the statutory penalties for failing to furnish plan documents to ERISA participants. Each distinct question has now squarely divided the lower courts, and this case presents an optimal vehicle for resolving them.

The questions presented are:

1. Whether, in reviewing an administrator's interpretation of plan language, it is automatically "dispositive" that at least two other courts previously upheld a "similar" interpretation (as the Fifth Circuit held below, to the express exclusion of any other "factors"), or whether a reviewing court must consider all the traditional factors required in *Firestone*'s "combination-of-factors" analysis (as required by multiple courts of appeals and this Court).

2. Whether an entity not explicitly named as the plan "administrator"—but otherwise assuming the administrator's statutory duties to furnish plan documents—may be subject to ERISA penalties for failing to respond to a proper document request under 29 U.S.C. 1132(c)(1).

PARTIES TO THE PROCEEDING BELOW AND RULE 29.6 STATEMENT

Petitioner is Humble Surgical Hospital, LLC, the appellee below and defendant in the district court.

Respondents are Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, the appellants below and plaintiffs in the district court.[1]

Humble Surgical Hospital, LLC, has no parent corporation, and no publicly held company owns 10% or more of its stock.

[1] Cigna Health and Life Insurance Company is a wholly owned subsidiary of Connecticut General Life Insurance Company. They are referred to collectively as "respondent" in this petition.

TABLE OF CONTENTS

Page

Table of contents—continued:

TABLE OF AUTHORITIES

Cases:

Page

Cases—continued:

Page

Cases—continued:

Page

Cases—continued:

Statutes:

Miscellaneous:

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PETITION FOR A WRIT OF CERTIORARI

Humble Surgical Hospital, LLC, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-15a) is reported at 878 F.3d 478. The opinion of the district court (App., *infra*, 16a-82a) is unreported but available at 2016 WL 3077405.

JURISDICTION

The judgment of the court of appeals was entered on December 19, 2017. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, are reproduced in the appendix to this petition (App., *infra*, 85a-90a).

INTRODUCTION

This petition presents two distinct circuit conflicts about how to interpret ERISA in routine cases.

The case involves a dispute between an out-of-network healthcare provider (petitioner) and an ERISA administrator (respondent). Petitioner rendered services to respondent's beneficiaries for years. Although there was never any dispute about the medical necessity or quality of these services, respondent interpreted "exclusionary" language in its plans to justify denying petitioner coverage for over $11 million in claims.

After a nine-day bench trial, the district court rejected respondent's plan interpretation. It found its interpretation was legally incorrect, adopted in "extraordinary" bad faith, motivated by clear conflicts of interest, and applied inconsistently to different providers. It accordingly awarded petitioner substantial damages, and also awarded petitioner ERISA penalties for respondent's failure to furnish essential plan documents on petitioner's request.

On appeal, the Fifth Circuit reversed. It found it "dispositive" that at least two earlier cases—a 1991 Seventh Circuit decision (which the Fifth Circuit misread) and a district-court decision (which was later *reversed*)—had previously endorsed a "similar" plan interpretation. According to the Fifth Circuit, when "at least two other courts" have supported the administrator's reading, its interpretation is automatically entitled to deference, without considering *any* of the traditional factors that this

Court (and other circuits) say "must" be included in the analysis. It further held that respondent could not be liable under ERISA for failing to furnish plan documents, because only an entity *named* as the "administrator" has duties to provide documents, and respondent's status as the "*de facto* plan administrator" was not enough.

Each holding implicates a square conflict among the lower courts.

First, in reviewing an administrator's plan interpretation, this Court has stated unequivocally that reviewing courts *must* consider all the factors in *Firestone*'s "combination-of-factors" analysis, including whether the plan operated under a conflict of interest or bad faith. Other circuits have understood this Court to mean what it said. These circuits properly examine all the factors before deferring to the plan's interpretation. And these circuits do this, as required, even where past cases support the plan's reading.

In the Fifth Circuit alone, however, it is now "dispositive" that at least two other courts, at some point in time, accepted a "similar" interpretation to the administrator's. In so holding, the court expressly refused to consider any of the traditional factors that this Court said "must" be analyzed. It thus did not consider the district court's findings that the interpretation was legally incorrect, adopted in bad faith, infected by conflicts, and applied unevenly to the plan's providers—factors essential to confirming that the administrator exercised *proper* discretion in construing the plan. Under the Fifth Circuit's rule, administrators can choose to narrow coverage so long as at least two past decisions endorse a "similar" approach—even if the administrator, acting in good faith and without conflicts, would have adopted the *opposite* interpretation.

This conflict is clear and intolerable. It has obvious significance for both participants and plans, and it distorts

the appropriate standard for reviewing plan interpretations, a question demanding uniform treatment nationwide. This Court's review is urgently needed.

Second, there is a straightforward and intractable circuit conflict over the "*de facto* plan administrator" doctrine. ERISA entitles participants and beneficiaries to receive certain plan documents upon request. To enforce that right, ERISA provides for statutory penalties against "any administrator" who fails to furnish those documents. 29 U.S.C. 1132(c)(1). As relevant here, the term "administrator" is defined as "(i) the person specifically so designated by the terms of the instrument under which the plan is operated," or "(ii) if an administrator is not so designated, the plan sponsor." 29 U.S.C. 1002(16)(A).

In this case, the district court found that respondent was not specifically *named* as the "administrator," but that it otherwise was specifically delegated the duties of the administrator, acted as the administrator, controlled the plan documents, and instructed participants and beneficiaries (including petitioner) that *any requests for plan documents should be directed to itself*.

The Fifth Circuit, deepening an acknowledged circuit conflict, nevertheless held that respondent could not be liable for ERISA penalties. The court held that only entities explicitly *labeled* the plan "administrator" could be liable for ignoring proper requests under Section 1132(c)(1). It accordingly rejected the rule in other circuits (the First and Eleventh) asking whether an entity, whatever its nominal label, actually controlled the process and acted as the administrator. In those circuits, if an entity undertakes the administrator's tasks, that entity cannot duck its statutory obligations by dodging the title "administrator" in the plan. There is no "magic words" re-

quirement. If an entity assumed the administrator's statutory duties to furnish plan documents, the entity can be liable for failing to discharge that responsibility.

This question has exceptional legal and practical importance. Participants cannot challenge improper denials of coverage without access to the controlling documents. This issue has now reached virtually every court of appeals, and there is no point to further percolation: the circuit conflict has been recognized for over a decade, and this is an ideal vehicle for resolving the confusion. The petition should be granted.

STATEMENT

A. Statutory Background

Congress enacted ERISA "'to promote the interests of employees and their beneficiaries in employee benefit plans,'" and "'to protect contractually defined benefits.'" *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989). While employers have no obligation to establish plans, ERISA seeks "to ensure" that employees "receive [earned] benefits" when plans are established. *Conkright* v. *Frommert*, 559 U.S. 506, 516 (2010). To that end, ERISA imposes a variety of obligations on plan administrators and fiduciaries (*e.g.*, 29 U.S.C. 1001(b)), while "provid[ing] 'a panoply of remedial devices' for participants and beneficiaries" to enforce those obligations. *Firestone*, 489 U.S. at 108.

Every ERISA plan is "maintained pursuant to a written instrument," which must identify one or more fiduciaries to administer the plan. 29 U.S.C. 1102(a)(1). In many instances, "the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 108 (2008). Regardless, the fiduciary

always must "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. 1104(a)(1).

Two core elements of ERISA's scheme are pertinent here.

1. ERISA authorizes judicial review to recover improperly denied benefits and to establish beneficiaries' rights. 29 U.S.C. 1132(a)(1)(B); see *Glenn*, 554 U.S. at 115.[2] Section 1132(a) entitles a plan participant to sue "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." 29 U.S.C. 1132(a)(1)(B). This right may be transferred to healthcare providers, who can "obtain standing to sue derivatively to enforce an ERISA plan beneficiary's claim." *Harris Methodist Fort Worth* v. *Sales Support Servs. Inc. Employee Health Care Plan*, 426 F.3d 330, 333-334 (5th Cir. 2005); see, *e.g.*, *N. Jersey Brain & Spine Ctr.* v. *Aetna, Inc.*, 801 F.3d 369, 373 (3d Cir. 2015) (same for "[e]very United States Court of Appeals to have considered this question"). Section 1132(a)'s enforcement scheme "is one of the essential tools for accomplishing the stated purposes of ERISA." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987).

Because ERISA's text does not dictate *how* to review benefit denials, this Court borrowed principles of trust law to fill the gaps. Under this framework, when a plan grants its administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," a court evaluates any benefit denial under an abuse-

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[2] A plan also must establish a claims procedure regarding benefit denials. This procedure must "provide adequate notice" of the denial to the participant or beneficiary, "set[] forth the specific reasons for such denial," and allow "a full and fair review." 29 U.S.C. 1133. The full-and-fair-review requirement "underscores the particular importance of accurate claims processing." *Glenn*, 554 U.S. at 115.

of-discretion standard. *Firestone*, 489 U.S. at 115. At the same time, the Court has declined to issue "a detailed set of instructions" for abuse-of-discretion review, *Glenn*, 554 U.S. at 119, and has disclaimed the use of "'rigid and inflexible requirement[s],'" *Conkright*, 559 U.S. at 522. That caution arises from the varied nature of benefits decisions—they "arise in too many contexts" and "concern too many circumstances" to develop "a one-size-fits-all procedural system that is likely to promote fair and accurate review." *Glenn*, 554 U.S. at 116, 119.

Accordingly, rather than employing a wooden test, courts must consider "many" factors under a "combination-of-factors method of review." *Glenn*, 554 U.S. at 116, 118. This means accounting for "several different, often case-specific, factors, reaching a result by weighing all together." *Id.* at 117.

The Court has also identified one factor that reviewing courts must consider if it exists: an administrator's conflict of interest. *Glenn*, 554 U.S. at 116-118. An administrator, for example, is conflicted when it "both evaluates claims for benefits and pays benefits claims." *Id.* at 112. That is so even when the administrator is an insurance company. *Id.* at 114. When a conflict is present, "a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion." *Id.* at 108. Although the conflict may "prove less important" in a particular case, the reduced weight results from "inherent or case-specific" circumstances, not a categorical rule. *Id.* at 117-118.

2. ERISA also entitles plan participants and beneficiaries to receive certain plan documents upon "written request." 29 U.S.C. 1024(b)(4). Congress provided this right "so that the individual participant knows exactly where he stands with respect to the plan—what benefits he may be entitled to, what circumstances may preclude

him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted." H.R. Rep. 93-533, 93d Cong., 1st Sess. 220 (1973). Congress wanted participants and beneficiaries to have "enough information to enforce their own rights as well as the obligations owned by the fiduciary to the plan in general." *Ibid.*

To enforce these informational rights, Congress authorized penalties under a private right of action: courts have discretion to award up to $100 daily against "[a]ny administrator * * * who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary." 29 U.S.C. 1132(c)(1)(B); see 29 U.S.C. 1132(a)(1)(A) (authorizing civil action "for the relief provided for in subsection (c)").

B. Facts And Procedural History

1. Respondent is an insurance company and fiduciary that "oversees" ERISA plans. App., *infra*, 2a, 19a-20a. The plans delegate respondent broad responsibilities to administer these plans. Those responsibilities include providing plan documents to participants and beneficiaries (*id.* at 77a), and making final benefit determinations (*id.* at 33a). Respondent both "evaluates claims for benefits" and "pays benefits and reimburses itself[] based on what it 'saved' the plan sponsors" by denying claims. *Id.* at 34a.[3]

[3] Respondent distinguishes between in-network healthcare providers and out-of-network providers. *Id.* at 20a-21a. Members with "open access" plans—paying additional premiums—have coverage for out-of-network treatment.

Petitioner is a hospital out of respondent's network. App., *infra*, 2a. It provided services to "hundreds" of respondent's members over a multiyear period. *Ibid.* Petitioner required its patients to sign contracts assigning petitioner their rights and interests under their plans. *Id.* at 2a, 21a-22a.[4] Petitioner's patients also executed financial guarantees obligating them to "pay * * * for all services and products administered to the patient," including those not covered by the plan. App., *infra*, 2a, 23a. This guarantee ensures that patients satisfy their plan's payment obligations and that the provider receives full payment for its services.

After treating respondent's members, petitioner submitted claims for reimbursement. Respondent initially paid petitioner's claims "without dispute." App., *infra*, 2a. But it soon began funneling petitioner's claims to its Special Investigations Unit after receiving allegedly "large-dollar" claims. *Id.* at 24a. Respondent then initiated an investigation and accused petitioner of "'fee-forgiving'—*i.e.*, waiving patients' co-insurance or deductible fees"—and "inflating its prices to increase reimbursement fees." *Id.* at 3a. In response, petitioner explained its "policy" "to hold its patients responsible for the full payment of their respective out-of-network responsibilities and obligations," and provided collection notes on specific patients that respondent had flagged. *Ibid.* Despite this response, respondent remained unsatisfied, and left petitioner's claims, mostly "unpaid," "to languish" in respondent's special claims-processing unit. *Id.* at 28a.

Respondent also decided its new course: it would treat petitioner's claims under a "proportionate share" analysis, where it would "either not pay [petitioner] at all, or

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[4] Such assignments are commonplace and assist both providers and patients. See *N. Jersey*, 801 F.3d at 373.

pay a portion of the claim(s) based on the percentage-share that the member/patient had paid at the time the healthcare service was provided." App., *infra*, 29a. Respondent justified this analysis on the plans' "exclusionary" language: "Payment for the following is specifically excluded from this plan: * * * charges which you [the member] are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan." *Id.* at 6a-7a.

2. Eventually, respondent sued petitioner for over $5 million in alleged overpayments, and petitioner counterclaimed under ERISA for unpaid benefits. App., *infra*, 4a.[5]

There was no dispute that petitioner's services were "medically necessary" and performed competently. App., *infra*, 31a. Petitioner thus alleged that respondent breached its fiduciary duties and abused its discretion in refusing to pay the full amount on 595 claims over a four-year period. App., *infra*, 31a; 29 U.S.C. 1132(a)(1)(B). Petitioner also sought penalties under 29 U.S.C. 1132(c)(1)(B) for respondent's failure to supply requested plan documents, which petitioner needed to "determine the parameters associated with the members/patients' benefits," "defend[] against [respondent's] claims for overpayment," and support "its own claims for underpayment." App., *infra*, 72a.

3. After a nine-day bench trial, the district court granted petitioner's motion for judgment, dismissed respondent's claims, and awarded petitioner damages for unpaid benefits, ERISA penalties, and ERISA attorney's fees. App., *infra*, 18a-19a, 80a-81a.

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[5] Neither respondent's claims nor petitioner's state-law counterclaims are at issue.

a. For petitioner's counterclaims, the court first addressed whether respondent abused its discretion in underpaying petitioner. The court examined this Court's abuse-of-discretion standard, App., *infra*, 33a, and determined that respondent had a conflict of interest: it "evaluates claims for benefits, pays benefits and reimburses itself, based on what it 'saved' the plan sponsors." *Id.* at 34a-35a. The court explained that, under *Glenn* and *Firestone*, that conflict must be "considered * * * as a factor" but only one "'among many that a reviewing judge must take into account.'" *Ibid.* (quoting *Glenn*, 554 U.S. at 116).

Employing that framework, the court held respondent "abused its discretion": it "obstinately" denied petitioner's claims under a baseless proportionate-share analysis. App., *infra*, at 59a. In so holding, the court rejected respondent's assertion that the plan's language "excluded" the claims. *Id.* at 58a.

The court's extended analysis showed that respondent's interpretation was legally incorrect. App., *infra*, 60a-61a. The court explained the plan's language does not "excuse" respondent "from making payments where the services are covered by the plan and are properly billed." *Id.* at 61a-62a. Instead, the court found, "the average plan participant would expect [respondent] to pay its full share in accordance with the terms of the various plans, irrespective of what a plan participant paid or was capable of paying." *Id.* at 62a. Indeed, respondent's own investigators "testified by deposition that the 'proportionate share' analysis was not part of any plan." *Id.* at 63a n.18.

The court also found additional factors and misconduct confirming an abuse of discretion. As the court explained, the evidence did not support respondent's allegations of fee-forgiving or inflating. App., *infra*, 64a. Petitioner priced its services via a Chargemaster database, which was used by multiple Texas hospitals. *Id.* at 55a, 64a. And

respondent's own investigators did "not dispute [petitioner's] attempts to collect co-pays from members/patients," ultimately admitting petitioner's conduct did not constitute fee-forgiving. *Id.* at 65a.

Moreover, the court determined, respondent interpreted the same "exclusionary" language differently when evaluating in-network claims. Respondent reimbursed these providers, unlike petitioner, without proof of patients' full out-of-pocket payments. App., *infra*, 67a. That disparate treatment undercut the genuineness of respondent's interpretation and suggested its reading was arbitrary. *Ibid.*

Next, the court revisited respondent's conflict of interest: respondent reaped "a double heaping from the plan sponsors' pockets—first, in receiving a fee for claim processing services—and second, in receiving fees based on 'savings,' regardless of how garnered." App., *infra*, 68a. It declared respondent's "method for processing [petitioner's] claims" both "disingenuous and arbitrary"; found it "focused" on "accomplishing a predetermined purpose—denying [petitioner's] claims"; noted respondent "denied [petitioner] a meaningful opportunity to appeal any claim denials and/or underpayments"; and concluded that, shortly after petitioner's first submissions, respondent "did not seriously consider the amounts of [petitioner's] claims even though the services" were properly billed. *Id.* at 65a, 67a-68a. Respondent thus "earned handsome returns as a result of its aberrant and arbitrary claims processing methodology." *Id.* at 65a, 67a-68a.

The court emphasized that respondent's "arbitrary manner" was "relentless." App., *infra*, 62a-63a. Respondent "forfeited its objectivity," and its "unprecedented claims processing methodology and incessant related acts were extraordinary acts of bad faith." *Id.* at 68a, 78a; see

id. at 81a (respondent "exhibited a conflict of interest and its presumptuous conduct lacked good faith").

Based on its collective findings and balancing of factors, the court held that respondent abused its discretion in denying petitioner's reimbursement claims and violated its fiduciary duties under ERISA. App., *infra*, 66a, 68a. The court awarded petitioner over $11.3 million as compensation for these counterclaims. *Id.* at 72a, 81a.

b. The district court next determined that respondent violated 29 U.S.C. 1024(b)(4) by failing to provide covered plan documents on request, and was liable for penalties under Section 1132(c)(1)(B). App., *infra*, 72a-79a. Respondent argued it was not subject to those provisions because it was not the explicit "administrator" responsible for providing documents under those sections. *Id.* at 73a-74a (citing 29 U.S.C. 1002(16)).

The court disagreed. It explained that respondent "stepped beyond its role as third-party claims administrator." App., *infra*, 76a. It found that respondent's "conduct and admissions" made it the "*de facto* plan administrator" under "an ERISA-estoppel theory." *Id.* at 74a; see *id.* at 77a (finding support in *Law* v. *Ernst & Young*, 956 F.2d 364 (1st Cir. 1992), and *Rosen* v. *TRW, Inc.*, 979 F.2d 191 (11th Cir. 1992)).

As the court explained, the plan sponsors "conferred upon [respondent] the duty to provide plan documents." App., *infra*, 77a. Respondent "instructed members/patients to request plan documents directly from it, NOT the employer or plan sponsor (*id.* at 74a), and petitioner honored those instructions. *Id.* at 75a-76a. Respondent's corporate representative further admitted respondent acted as the plan administrator: he described "[t]he plan administrator" as "the entity that makes the decisions and enforces the plan document," which were respondent's duties. *Id.* at 75a. Finally, the court found, respondent, with

its arbitrary claims-processing, "'hijacked' the plan administrator's role and subverted it for its personal benefit." *Id.* at 78a.

The court awarded $2.29M in penalties, based on a $25-daily penalty for 418 claims over 220 days that respondent "withheld pertinent plan information" and "prejudiced" petitioner. App., *infra*, 79a.

4. In relevant part, the Fifth Circuit reversed. App., *infra*, 1a-15a.

a. The court recognized that respondent's benefits denials were reviewed under the abuse-of-discretion standard. App., *infra*, 4a-6a. It explained that the Fifth Circuit conducts that analysis in three steps: (i) it asks whether the administrator's plan interpretation was "legally correct"; if not, (ii) it asks whether the (incorrect) decision was an abuse of discretion; and (iii) it asks whether substantial evidence supports the benefits denial. *Id.* at 5a-6a. The Fifth Circuit did not otherwise discuss *Firestone* or *Glenn* (except to note that *Glenn* overruled another Fifth Circuit decision on other grounds, *id.* at 5a). Without explanation, it declared "[t]he district court failed to apply the required abuse of discretion analysis." *Id.* at 2a.

In conducting that analysis itself, the court "skip[ped]" the first step and thus declined to decide whether respondent's plan interpretation was legally correct. App., *infra*, 7a. It did, however, note that "the Fifth Circuit has previously suggested (without deciding) that [respondent's] reading might be legally incorrect." *Ibid.* (citing *N. Cypress Med. Ctr. Operating Co., Ltd.* v. *Cigna Healthcare*, 781 F.3d 182, 196 (5th Cir. 2015)).

Instead, the court held that respondent's interpretation "still fell within its broad discretion." App., *infra*, 7a. In making that determination, the court expressly refused to consider whether respondent "'had a conflict of

interest,'" "'lack of good faith,'" applied the plan "'consisten[tly],'" or fell short under any other *Firestone* factor. *Id.* at 7a-8a (declaring "[w]e need not review these factors"). The court instead found a single fact "dispositive": "where an administrator's interpretation is supported by prior case law, it cannot be an abuse of discretion." *Id.* at 8a.

According to the Fifth Circuit, "[a]t least two other courts have effectively or explicitly concluded that the provision at issue here was legally correct." App., *infra*, 8a. "In these circumstances," the court held, "'the fact that two courts have found [respondent's] interpretation of the policy language reasonable itself establishes that the interpretation does not constitute an abuse of discretion.'" *Id.* at 9a. Put simply: "'the fact that [at least] two courts have upheld interpretations similar to that of [respondent] is dispositive of the issue.'" *Ibid.* The court accordingly upheld respondent's interpretation without confronting the extensive findings from the nine-day bench trial that respondent had indeed abused its discretion.

Having held that respondent's "interpretation fell within its discretion," the court next concluded that substantial evidence supported respondent's benefits decision. App., *infra*, 10a-11a (declaring that petitioner "engaged in fee-forgiving"). Aside from asserting that the "district court did not address this question," the court made no effort to engage the district court's extensive findings on the topic. *Id.* at 9a; compare *id.* at 64a-65a (examining witness testimony and other evidence to conclude the record does not "show that [petitioner] engaged in fee-forgiving"). Instead, the court highlighted a handful of patient responses to a survey which the court read to confirm evidence of fee-forgiving. *Ibid.*

Because the court thus reversed on the abuse-of-discretion claim, it also reversed on the fiduciary-breach

claim: "the two claims succeed or fail in tandem as the exclusionary language defense applies equally to both." App., *infra*, 11a.

b. Turning to Section 1132(c) penalties, the court again reversed. App., *infra*, 11a-12a. It noted that respondent was not the *nominal* "plan administrator," and it rejected the district court's reliance on a "'*de facto* plan administrator'" via "'ERISA-estoppel theory.'" *Ibid.* Without elaboration, the court declared "persuasive" decisions from other circuits rejecting the "'*de facto* administrator doctrine.'" *Ibid.*

REASONS FOR GRANTING THE PETITION

I. THE FIFTH CIRCUIT'S DECISION UNDERMINES *FIRESTONE* DEFERENCE AND DISTORTS PROPER JUDICIAL REVIEW IN THIS CRITICAL AREA

Under this Court's settled law, a court must examine the totality of circumstances, including evidence of conflicts of interest and bad faith, to determine whether an administrator's plan interpretation was an abuse of discretion. The Fifth Circuit replaced that analysis with a new rule that, where at least two prior cases uphold a "similar" construction, the interpretation is automatically not an abuse of discretion. Those earlier decisions are "dispositive" of the issue, and the reviewing court can refuse to engage any of the traditional factors that this Court, unequivocally, said *must* be reviewed.

The Fifth Circuit's holding squarely conflicts with the decisions other circuits and this Court. Its departure from settled principles is unsound, and it promises to generate intolerable confusion in an area that demands uniformity. This Court's immediate review is warranted.

A. The Fifth Circuit's Decision Creates A Direct Conflict With Decisions Of This Court And Other Circuits

1. According to the Fifth Circuit, "'the fact that two courts have found [respondent's] interpretation of the policy language reasonable itself establishes that the interpretation does not constitute an abuse of discretion.'" App., *infra*, 9a. Indeed, those prior decisions are "'dispositive of the issue.'" *Ibid.*

That holding squarely conflicts with the decisions of multiple courts of appeals. Those courts do not find prior cases "dispositive," but instead examine *all* relevant factors in reviewing the administrator's interpretation.

a. The decision below is directly at odds with the First Circuit's decision in *Colby* v. *Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58 (1st Cir. 2013). In *Colby*, a plan administrator terminated the plaintiff's long-term disability benefits based on an interpretation excluding the risk of drug relapse as a "current disability." 705 F.3d at 61. In confronting a challenge to that interpretation, the court recognized that "the caselaw is mixed," and "the only court of appeals to have considered this precise issue" supported the administrator's construction. *Id.* at 65, 67. The court nevertheless conducted the traditional inquiry by examining all the factors, and ultimately rejected the administrator's reading. *Id.* at 61-62, 65-67 (examining "'the record as a whole,'" "weigh[ing]" an "inherent conflict of interest" as "a factor," and evaluating "the language of the plan").

Under the Fifth Circuit's disposition, the prior case law—including the only circuit-level authority on the books—would have been "dispositive." App., *infra*, 9a. But the First Circuit instead conducted the familiar analysis (without automatically deferring to the decisions of

prior cases) and reached the opposite result. That holding is irreconcilable with the Fifth Circuit's decision.

b. The decision below also conflicts with the Eighth Circuit's decision in *Darvell* v. *Life Ins. Co. of N. Am.*, 597 F.3d 929 (8th Cir. 2010). In *Darvell*, the parties' dispute turned on the meaning of the phrase "regular occupation" in the plan's definition of "disability." 597 F.3d at 933, 935. Although the court recognized that "[t]he circuits are split" on the issue, it still proceeded to engage in a traditional review of the administrator's decision. That review included examining the administrator's interpretation for "reasonableness," and assigning "some weight" to the administrator's "conflict of interest." *Id.* at 934-935. While the court ultimately sided with the administrator, it did not do so automatically simply because prior cases supported the administrator. See *id.* at 936. Had the typical "abuse of discretion" analysis pointed the other way, the administrator would have lost. *Id.* at 934. This methodology, again, is consistent with the uniform practice in other circuits, but incompatible with the Fifth Circuit's decision.

c. The decision below even conflicts with the Third Circuit's decision in *Hinkle ex rel. Estate of Hinkle* v. *Assurant, Inc.*, 390 F. App'x 105 (3d Cir. 2010), a case the Fifth Circuit incorrectly cited for support. The dispute there centered on the meaning of "accidental" in an ERISA plan. 390 F. App'x at 106, 108. That issue divided the circuits, and the district court (not the appellate court) "held that 'where the courts of appeals are in disagreement on an issue, a decision one way or another cannot be regarded as arbitrary or capricious.'" *Id.* at 108. Although the Fifth Circuit attributed that "holding" to the Third Circuit, App., *infra*, 8a, the language was "[t]he district court['s]," and the Third Circuit cautioned it was not necessarily "true." 390 F. App'x at 108. Indeed, far from automatically deferring to prior authority, the Third Circuit

conducted a typical *Firestone* review, faulted the district court for failing to "acknowledge[] Defendants' conflict of interest in reviewing the decision," and agreed with prior cases only after examining their *underlying* "analysis" for reasonableness. *Id.* at 107-108; see also *id.* at 107 (reaffirming that "[c]onflicts" represent "one factor among many that a reviewing judge *must* take into account'") (emphasis in *Hinkle*; quoting *Glenn*, 554 U.S. at 116).

This analysis directly conflicts with the Fifth Circuit's refusal to consider the traditional "factor[s] among many" whenever "[a]t least two other courts" have accepted the plan's interpretation. App., *infra*, 8a.

d. Like the First, Eighth, and Third Circuits, other courts of appeals have likewise confronted the same scenario and examined the usual "factors" rather than finding past decisions "dispositive." See, *e.g.*, *Osborne* v. *Hartford Life & Accident Ins.*, 465 F.3d 296, 299-300 (6th Cir. 2006); *Ehrensaft* v. *Dimension Works Inc. Long Term Disability Plan*, 33 F. App'x 908, 909-910 (9th Cir. 2002); see also *Gallo* v. *Madera*, 136 F.3d 326, 328-331 & n.11 (2d Cir. 1998).

In short, "[c]ourts reviewing benefits decisions for abuse of discretion cannot avoid the process of evaluating whether an ERISA administrator's interpretation was reasonable, even if other courts have already interpreted similar language." *Creno* v. *Metro. Life Ins.*, No. CV-12-1642, 2014 WL 4053410, at *7, *11 (D. Ariz. Aug. 15, 2014); see also, *e.g.*, *Pettit* v. *UnumProvident Corp.*, 774 F. Supp. 2d 970, 981, 983-984 (S.D. Iowa 2011) (giving conflict of interest "some weight" and conducting full five-factor analysis); *Jones* v. *Allen*, No. 2:11-cv-380, 2013 WL 5728344, at *12 (S.D. Ohio Oct. 22, 2013) (performing review without automatically deferring to past cases); *Clarke* v. *Fed. Ins. Co.*, 823 F. Supp. 2d 1213, 1216-1217, 1219-1221 (W.D. Okla. 2011) (same).

None of these decisions can be squared with the Fifth Circuit's analysis.

e. The Fifth Circuit's position was both unsupportable and (literally) unsupported: the Fifth Circuit did not identify a *single* case that actually supports its holding, misreading each case it cited for this proposition. See App., *infra*, 8a-9a (citing *Hinkle*, *supra*; *McGuffie* v. *Anderson Tully Co.*, No. 3:13-cv-888, 2014 WL 4658971 (S.D. Miss. Sept. 17, 2014); *Fitzgerald* v. *Colonial Life & Ins. Co.*, No. JFM-12-38, 2012 WL 1030261 (D. Md. Mar. 26, 2012)).

Hinkle, as noted above, applied the usual totality analysis; it expressly considered the factors that the Fifth Circuit refused to credit, and it did not find it "dispositive" that prior case law supported the plan's interpretation. 390 F. App'x at 108. *Hinkle* thus stands for the *opposite* proposition: even in the face of supporting cases, it was indeed necessary to consider all the "factors" before deciding whether the administrator abused its discretion.

In *Fitzgerald*, the district court did at one point suggest that "the fact that two courts have upheld interpretations similar to that of [the administrator] is dispositive of the issue." 2012 WL 1030261, at *3. But it earlier held that the administrator's conflict of interest "constitutes *a factor that must be considered*." *Id.* at *2 (emphasis added). Even more telling, after the court hinted the prior cases "arguably" are "dispositive," it continued that it "was not content, however, to rely upon that fact alone": "Were I to do so, I believe *I would be shirking my responsibility to independently review* the reasonableness of [the administrator's] interpretation of the language of the [plan] in this case." *Id.* at 3 (emphasis added). The Fifth Circuit, unlike other courts, alone refused to conduct that "independent[] review."

Finally, *McGuffie* did indeed note that "case law supports the Plan's interpretation," but it also independently

found that interpretation "reasonable," declared it "the most logical and pragmatic interpretation," and examined the issue from "a practical and actuarial perspective." 2014 WL 4658971, at *3-*4. The Fifth Circuit, by contrast, considered solely the bald "fact" that "[a]t least two other courts" had accepted the administrator's interpretation. App., *infra*, 8a.

Not a single court has read *McGuffie* or *Fitzgerald* as the Fifth Circuit did here.

In sum, multiple circuits have confronted situations where prior courts had adopted an administrator's reading, but those circuits (i) still refused to find "*dispositive*" the mere existence of those prior cases; and (ii) still evaluated the issue in light of all the evidence, including all the factors this Court has required in the *Firestone* analysis. The Fifth Circuit's decision is irreconcilable with these decisions.[6]

2. a. The Fifth Circuit's truncated analysis is also at odds with decisions of this Court. According to the Fifth Circuit, when at least two courts support the administrator's interpretation, it becomes *unnecessary* to review any of the "ordinar[y]" factors considered in the usual *Firestone* review. App., *infra*, 8a. The court accordingly refused to consider the lower court's findings of "extraordinary" bad faith, a conflict of interest, "disingenuous and arbitrary" conduct, disparate treatment, or even the fact that respondent misread the plan. *Id.* at 67a, 77a-78a, 81a.

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[6] According to the Fifth Circuit, it was not adopting "a bright-line rule." App., *infra*, 9a. But while it said the rule might not *always* apply, it also held it is "dispositive" where "at least two other courts have effectively or explicitly concluded that the provision at issue here was legally correct." *Ibid.* The panel did not identify any other relevant factors, and none are apparent. To the extent any exceptions exist, they do not diminish the clear and obvious conflict between the Fifth Circuit's holding and the decisions in other circuits.

As the Fifth Circuit expressly held, "[w]e need not review these factors today." *Id.* at 8a.

But this Court has repeatedly affirmed that *Firestone* requires a "combination-of-factors" analysis. *Glenn*, 554 U.S. at 118. It directs "judges to determine lawfulness by taking account of several different, often case-specific factors," and "reaching a result by weighing all together." *Id.* at 117. There is no license for simply setting aside all the usual indications of arbitrary-and-capricious conduct; when these "factors" are present, "a reviewing judge *must* take [them] into account." *Id.* at 116; see also *Firestone*, 489 U.S. at 115.[7]

Moreover, this Court has cautioned against creating "special procedural or evidentiary rules." *Conkright*, 559 U.S. at 513. As the Court explained, there are no "formulas that will 'falsif[y] the actual process of judging' or serve as 'instrument[s] of futile casuistry.'" *Glenn*, 554 U.S.at 119. The Fifth Circuit cannot "'avoid the process of judgment'" by simply identifying prior decisions, without even asking whether their reasoning was sound or the factual context was the same. This does not show whether the administrator adopted the same interpretation today due to principled reasoning or improperly "to accomplish[] a predetermined purpose" (App., *infra*, 67a). This is especially troubling where a decision, as here, was based on conflicts and bad faith, and the administrator, in a *proper* exercise of discretion, likely would have adopted the opposite construction. See, *e.g.*, *Conkright*, 559 U.S. at 521-522.

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[7] The Fifth Circuit's decision is also at odds with the Chief Justice's concurrence in *Glenn*, which required considering "the conflict of interest on review only where there is evidence that the benefits denial was motivated or affected by the administrator's conflict." 554 U.S. at 120 (Roberts, C.J., concurring). Here, the district court made express findings that the conflict directly affected respondent's action.

Contrary to the Fifth Circuit's approach, other circuits apply the proper standard of review: "the court *must consider* numerous case-specific factors, including the administrator's conflict of interest, and reach a decision as to whether discretion has been abused by weighing and balancing those factors together." *Montour* v. *Hartford Life & Accident Ins.*, 588 F.3d 623, 630 (9th Cir. 2009); see also, *e.g.*, *Dragus* v. *Reliance Standard Life Ins. Co.*, 882 F.3d 667, 673 (7th Cir. 2018); *Marcin* v. *Reliance Standard Life Ins. Co.*, 861 F.3d 254, 263 (D.C. Cir. 2017); *Roganti* v. *Metro. Life Ins. Co.*, 786 F.3d 201, 217-218 (2d Cir. 2015); *Blankenship* v. *Metro. Life Ins. Co.*, 644 F.3d 1350, 1355 (11th Cir. 2011) (per curiam).

And the Fifth Circuit adopted its contrary rule—declaring "dispositive" the existence of any two supporting cases—despite clear findings below on every factor that traditionally *undercuts* deference: the administrator's reading was legally wrong, adopted in bad faith, affected by conflicts, and not applied uniformly to similarly situated participants. The fact that two courts approved a "similar" plan construction in the past says nothing about the legitimacy of the administrator's multifaceted decision here. The Fifth Circuit's contrary position creates a clear and obvious conflict, and it warrants the Court's immediate review.

b. What is more, the Fifth Circuit was even wrong on its own terms. Contrary to the panel's contention, the Seventh Circuit did *not* endorse respondent's reading of the plan language; it said the provider there fit within the plan's exclusion because it expressly waived its patients' liability for any charges. See, *e.g.*, *Kennedy* v. *Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701-702 (7th Cir. 1991) ("the district court concluded that the contract excused Myers from paying"; if the provider "wishes to receive payment

under a plan that requires co-payments, then he must collect those co-payments—*or at least leave the patient legally responsible for them*") (emphasis added); *Ctr. for Restorative Breast Surgery, L.L.C.* v. *Blue Cross Blue Shield of La.*, No. 11-806, 2016 WL 9439243, at *8 (E.D. La. Sept. 19, 2016) (explaining this distinction). Here, by contrast, petitioner required patients to accept full financial responsibility. App., *infra*, 22a-23a. And while a Texas district court did endorse respondent's reading, it was reversed on appeal, and the Fifth Circuit identified "strong reasons" to believe its plan interpretation was wrong. *N. Cypress Med. Ctr. Operating Co., Ltd.* v. *Cigna Healthcare*, 781 F.3d 182, 195 (5th Cir. 2015) ("[t]here are strong arguments that Cigna's plan interpretation is not 'legally correct'").

At bottom, the Fifth Circuit expressly refused to consider findings of bad faith, conflicts, and disparate treatment because a *reversed* district court had accepted the same interpretation and the Seventh Circuit had accepted a distinguishable proposition in a decision the Fifth Circuit blatantly misread. This underscores the dangers of adopting a truncated analysis that fails to incorporate the relevant *Firestone* factors.

B. The Question Presented Is Exceptionally Important And Frequently Recurring

The question presented is of obvious legal and practical importance.

First, this Court often grants review to ensure the application of uniform national standards in the ERISA context. See, *e.g.*, *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 381 (2002); *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). The decision below creates a new exception to the existing framework for reviewing an administrator's plan interpretations. It conflicts with the established means of reviewing administrator decisions, and it departs from the

rules this Court has developed over decades. The Fifth Circuit's new rule deprives regulated stakeholders of needed stability and uniformity in a context that requires both.

Second, the decision below undermines judicial review as a tool to combat fiduciary misconduct. Congress recognized the vitality of judicial review to securing participant rights under ERISA. Those rights mean little if a plan can operate in bad faith and under a conflict of interest, yet excuse itself so long as two prior cases (arguably) endorsed the plan's view under different circumstances.

This Court's prevailing analysis—which is faithfully applied everywhere outside the Fifth Circuit—ensures that administrators receive meaningful latitude while also ensuring that participants get a fair shake. And that means securing the benefit of the administrator's good-faith exercise of discretion. *Glenn*, 554 U.S. at 111. The very factors that the Fifth Circuit refused to apply are essential to rooting out bad decisions tainted by improper considerations. The Fifth Circuit's contrary rule threatens to frustrate and complicate judicial review in a manner incompatible with Congress's intent.

Finally, this question arises all the time. Indeed, one of the animating reasons for *Firestone* deference is to avoid different constructions of the same plan language in different jurisdictions. *E.g.*, *Conkright*, 559 U.S. at 517. That concern reflects the obvious reality of benefit disputes: Many employers operate across state lines. And smaller employers tend to contract with large plan administrators with national practices. Those dynamics regularly lead to similar disputes over similar plan language.

A rule *in one circuit* that replaces meaningful review with simple head-counting—did another court embrace this in the past?—frustrates the system while reducing

the accuracy of the process. Further review is warranted to eliminate the conflicts created by the decision below.

C. This Case Is The Perfect Vehicle For Deciding The Question Presented

This case presents an ideal vehicle to resolve the question presented. This case was litigated at a nine-day bench trial. Its extensive findings implicate the usual factors that reviewing courts evaluate during *Firestone*'s "combination-of-factors method of review." *Glenn*, 554 U.S. at 118. And the existence of an actual trial—as opposed to an initial ruling on the pleadings—avoids potential factual disputes that could interfere with a clean ruling on the legal question.

The Fifth Circuit's disposition was outcome-determinative. It held a reviewing court can ignore concrete findings of bad faith, conflicts of interest, and disparate treatment. Those factors would tip the scales had they been considered. This is the ideal backdrop for evaluating a new legal rule that finds it "dispositive" that at least two prior cases decided a "similar" issue.

The correctness of the Fifth Circuit's analysis is a pure question of law, and there are no obstacles to deciding the question presented. The case creates a square conflict, and it cries out for this Court's immediate intervention.

II. THE FIFTH CIRCUIT MISCONSTRUED ERISA'S STATUTORY RIGHT TO OBTAIN CRITICAL PLAN DOCUMENTS

The second question presented also readily satisfies the Court's traditional criteria for review. There is a straightforward and acknowledged conflict among the courts of appeals over the *de facto* administrator doctrine. This important question has now been decided in *ten* courts of appeals; the arguments on each side are known and well-developed. Each side of the split has recognized

the conflict and refused to abandon its own position. Further percolation is pointless, and the conflict has no realistic prospect of dissipating on its own.

And this case is an ideal vehicle for resolving the confusion. The Fifth Circuit rejected ERISA penalties based entirely on its construction of the statute. There is no genuine debate that petitioner would have prevailed had the court adopted the opposite construction. And the factual backdrop is ideal for considering the issue: again, the case was decided at a bench trial, and the district court made extensive findings to round out the issue. The question is outcome-determinative, and there are no obstacles to review.

This issue is critical to ERISA participants and beneficiaries who need ready access to documents to enforce their rights. And it is likewise critical to ERISA administrators, who need to know who is responsible (and potentially liable) for furnishing plan documents on request. As it now stands, the same nationwide entity will have different statutory duties depending on where any given beneficiary happens to live. That situation is untenable, and the Court's review is warranted.

A. The Fifth Circuit's Decision Deepens A Widespread And Intractable Conflict

The Fifth Circuit's decision deepens a preexisting conflict over the *de facto* administrator doctrine. That circuit conflict is both widely acknowledged and indisputable, and it should be resolved by this Court.[8]

1. The decision below directly conflicts with settled law in two courts of appeals.

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[8] Despite rejecting the *de facto* administrator doctrine below, the Fifth Circuit had earlier acknowledged its "intuitive appeal." *Fisher* v. *Metro. Life Ins.*, 895 F.2d 1073, 1077 (5th Cir. 1990).

First, in *Law* v. *Ernst & Young*, 956 F.2d 364 (1st Cir. 1992), the First Circuit held that, for purposes of Section 1132(c), an entity can be held liable as an "administrator" despite not being listed as the nominal "administrator" in plan documents. 956 F.2d at 372-374. The First Circuit agreed with other courts that "a party may be treated as a plan administrator where it is shown *to control the administration of a plan*." *Id.* at 372 (emphasis added). The court identified a "plethora of evidence" indicating the defendant "had assumed and controlled the plan administrator's function of furnishing required information in response to a plan beneficiary's request." *Ibid.* "If, to all appearances, [the entity] acted as the plan administrator in respect to dissemination of information concerning plan benefits, it may properly be treated as such for purposes of the liability provided under § 1132(c)." *Id.* at 373.

The court reasoned that its conclusion was "consistent with the intent of Congress that employees have a remedy when they are denied timely information about their ERISA benefits." 956 F.2d at 373. According to the court, "[t]o hold that an entity not named as administrator in the plan documents may not be held liable under § 1132(c), even though it actually controls the dissemination of plan information, would cut off the remedy Congress intended to create." *Ibid.* As the court explained, "[a] § 1132(c) suit against the company would fail, because the company itself was not named administrator in the plan documents"; yet "a suit against the plan administrator would fail, because employees would have had no reason to request information from the plan administrator if company personnel assumed responsibility for such requests." *Ibid.*; see

Hudson v. *Empire State Carpenters Annuity Fund*, No. 11-12134, 2013 WL 697135, at *2 (D. Mass. Feb. 25, 2013).[9]

Second, in *Rosen* v. *TRW, Inc.*, 979 F.2d 191 (11th Cir. 1992), the Eleventh Circuit adopted the First Circuit's holding in *Law*. See 979 F.2d at 193-194. As the court concluded, "[w]e agree with the reasoning of the First Circuit and we hold that if a company is administrating the plan, then it can be held liable for ERISA violations, regardless of the provisions of the plan documents." *Ibid.*

The court further rejected "[s]ome older cases" declaring a company "not a proper defendant in an ERISA case solely because the plan instrument designates a plan administrator." *Id.* at 193 n.1. The court "disagreed": "If the company is acting as a plan administrator, then it should be held liable for such conduct regardless of a sham designation in the plan document." *Ibid.*

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[9] *Tetreault* v. *Reliance Standard Life Ins. Co.*, 769 F.3d 49 (1st Cir. 2014), is not to the contrary. The defendant there acted as the *claims* administrator, not the *plan* administrator; it was "not tasked in the written instrument with 'manag[ing]' the Program as a whole," and it was "authorized only" to undertake certain tasks. 769 F.3d at 59-60 (also noting that the claims administrator was "entirely separate from the expressly designated 'administrator'"). Indeed, *Tetreault* ultimately reaffirmed *Law*'s core holding: "The Court held that the employer (rather than the retirement committee) was the *de facto* 'administrator' under ERISA not only because the employer responded to the claimant's request, but also because there was other evidence that the employer in fact controlled the retirement committee." 769 F.3d at 60; see also, *e.g.*, *Seacoast Mental Health Ctr.* v. *Sheakley Pension Admin., Inc.*, No. 99-43, 2001 WL 274816, at *2 (D.N.H. Jan. 5, 2001) ("[i]n *Law*, the court reasoned that the entity that controls the dissemination of required information and holds itself out to plan participants as the administrator should be held liable under § 1132(c)").

The Eleventh Circuit has consistently adhered to the view that "[a] plan administrator is either 'the person specifically so designated by the terms of the instrument under which the plan is operated,' or *a company acting as a plan administrator*." *Smiley* v. *Hartford Life & Accident Ins. Co.*, 610 F. App'x 8, 8 (11th Cir. 2015); see also, *e.g.*, *Hunt* v. *Hawthorne Assocs., Inc.*, 119 F.3d 888, 914-915 & n.73 (11th Cir. 1997); *Alexander* v. *Cott Beverages, Inc.*, No. 1:09-cv-2535, 2009 WL 10664661, at *7 (N.D. Ga. Nov. 23, 2009) ("the Eleventh Circuit has long recognized that courts may look *past* the plan documents, and examine the 'factual circumstances surrounding the administration of the plan, even if these factual circumstances contradict the designation in the plan document,' to determine the entity acting as the true plan administrator") (citing *Oliver* v. *Coca-Cola Co.*, 497 F.3d 1181, 1193 (11th Cir. 2007)).[10]

2. As widely recognized, *Law* and *Rosen* are in direct conflict with settled law in multiple circuits. *E.g.*, *Mondry* v. *Am. Family Mut. Ins. Co.*, 557 F.3d 781, 793-794 (7th Cir. 2009); *Hunt*, 119 F.3d at 914 n.73; *Lee* v. *Burkhart*, 991 F.2d 1004, 1010 n.5 (2d Cir. 1993); *McKinsey* v. *Sentry Ins.*, 986 F.2d 401, 404-405 (10th Cir. 1993); *McFarlane* v. *First Unum Life Ins. Co.*, 274 F. Supp. 3d 150, 166 & n.13 (S.D.N.Y. 2017).[11] Unlike the First and Eleventh Circuits,

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[10] Although *Oliver*, in the benefits context, discussed the difference between true "administrative service providers" and employers (497 F.3d at 1195), courts have since confirmed that the "crucial question" for ERISA penalties remains "whether the asserted *de facto* plan administrator exercised 'sufficient decisional control over the claim process' to qualify as a plan administrator." *Alexander*, 2009 WL 10664661, at *7; accord *House* v. *Aetna Life Ins. Co.*, No. 8:15-cv-560, 2015 WL 2250976, at *4 (M.D. Fla. May 13, 2015).

[11] The Fifth Circuit's suggestion that there is no "circuit split" (App., *infra*, 12a) is obviously mistaken.

these courts declare ERISA penalties unavailable against any defendant not explicitly recited, *by name*, as the "administrator" in plan documents. See *Butler* v. *United Healthcare of Tenn., Inc.*, 764 F.3d 563, 569-570 (6th Cir. 2014); *Brown* v. *J.B. Hunt Transport Servs., Inc.*, 586 F.3d 1079, 1088 (8th Cir. 2009); *Mondry*, 557 F.3d at 793-794; *Sgro* v. *Danone Waters of N. Am.*, 532 F.3d 940, 945 (9th Cir. 2008); *Lee*, 991 F.2d at 1010 & n.5; *McKinsey*, 986 F.2d at 404-405; *Coleman* v. *Nationwide Life Ins. Co.*, 969 F.2d 54, 62 (4th Cir. 1992); *Davis* v. *Liberty Mut. Ins. Co.*, 871 F.2d 1134, 1138 (D.C. Cir. 1989).[12]

The conflict is thus square and entrenched. The First and Eleventh Circuits permit liability where an entity acts as the administrator and has control over plan documents. That view has prevailed in those circuits for decades and is faithfully applied by regional district courts. Unlike those two circuits, most courts of appeals have reached the opposite conclusion, holding that ERISA penalties are recoverable exclusively against "administrators" explicitly named in plan documents.

This established conflict has persisted for well over a decade, and there is no legitimate prospect of either side backing down. The conflict is clear and will remain entrenched until this Court decides the issue.

B. The Question Presented Is Exceptionally Important And Frequently Recurring

This case presents a mature conflict on an important question of statutory construction that frequently arises in ERISA disputes.

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[12] The Seventh Circuit "left the door open" to "the possibility that a non-administrator may be equitably estopped to deny that it is the plan administrator." *Mondry*, 557 F.3d at 794-795. This version of the *de facto* administrator doctrine was rejected by a split panel of the Ninth Circuit (*Moran* v. *Aetna Life Ins. Co.*, 872 F.2d 296, 300 (9th Cir. 1989); *id.* at 301-303 (B. Fletcher, J., dissenting)).

Congress understood the importance of guaranteeing ERISA participants full access to plan documents, and it enforced that right with a statutory penalty. *Firestone*, 489 U.S. at 118. ERISA participants cannot enforce their rights if they do not know what they are, let alone how to assert them. Those rights and rules appear in the documents governing the plans, and those documents are necessary to combat wrongful or accidental denials by plan administrators.

The question of *who* is responsible for providing those documents—and who is liable when that duty is violated—is an essential component of the regulatory scheme. Yet the courts of appeals remain hopelessly deadlocked on the question. There might even be a vacuum in which *no one* is legally responsible for furnishing plan documents. *Law*, 956 F.2d at 373. The end result is that the same administrator may face inconsistent obligations in different locations—even while administering the same national plan. This patchwork scheme is incompatible with ERISA's emphasis on a uniform design.

Nor is this problem going away. This significant issue arises with great frequency. One of the first steps in any coverage dispute is obtaining the relevant documents underlying the determination. And in recent years, large insurance companies have increasingly assumed complete responsibility for plan administration without being explicitly named the "administrator" under 29 U.S.C. 1002(16)(A). Unsurprisingly, many plan participants direct requests for documents to those companies. This is why these cases have now been litigated in nearly every court of appeals and recur repeatedly in district court. Participants and administrators alike need a clear answer on the parties' respective responsibilities and rights in this crucial area.

C. This Case Is The Perfect Vehicle For Deciding The Question Presented

This is an optimal vehicle for resolving this significant question. Again, this case involved a nine-day bench trial with extensive fact-findings. Those findings perfectly frame the common fact-pattern: respondent acted as the plan administrator, held itself out as the plan administrator, assumed the statutory responsibility for providing plan documents to members, and instructed those members to request plan documents from respondent. Respondent functioned in every pertinent capacity as the plan administrator—and yet was not explicitly *named* as the "administrator" in plan documents. The question presented is thus outcome-determinative.

This issue has now been exhaustively vetted among the courts of appeals, and there is no benefit to further percolation. Because this case presents an ideal vehicle for resolving this important question, the petition should be granted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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MARCH 2018