No. 22-4082

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

IAN C. AND A.C.,

Plaintiffs/Appellants,

v.

UNITEDHEALTHCARE INSURANCE COMPANY,

Defendants/Appellees.

On appeal from the United States District Court for the
District of Utah, Central Division, Case No. 2:19-cv-00474
The Honorable Howard C. Nielson, Jr.

BRIEF OF APPELLANTS

ORAL ARGUMENT REQUESTED

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STATEMENT OF PRIOR OR RELATED APPEALS

There are no prior or related appeals.

GLOSSARY

ADHD:	Attention Deficit Hyperactivity Disorder
BLUEFIRE:	BlueFire Wilderness Therapy
CATALYST:	Catalyst Residential Treatment Center
ERISA:	Employee Retirement Income Security Act of 1974

INTRODUCTION

After his ADHD, persistent depressive disorder, generalized anxiety disorder, oppositional defiant disorder, severe substance use disorders (including abuse of alcohol, marijuana, cocaine, codeine, hallucinogenic mushrooms, LSD, and Xanax), and potential histrionic and narcissistic personality disorders resulted in A.C. forming a toxic pattern of dependency, lies, and manipulation with both his parents and his treating clinicians, A.C.'s long-time psychiatrist recommended that he be placed in two back-to-back treatment facilities: first, an outdoor behavioral health facility to help A.C. begin to process his disorders and cope with his substance abuse, then a residential treatment facility to build on any initial successes A.C. managed to gain. Following his time at BlueFire Wilderness ("BlueFire"), an outdoor behavioral health program, a psychiatrist who conducted an extensive psychological evaluation of A.C. also recommended he go on to be treated in a residential treatment facility to address his dually diagnosed mental health and substance use disorders.

After leaving BlueFire, A.C. went on to receive treatment at Catalyst Residential Treatment Center ("Catalyst"). United, the claim administrator for the insurance plan that covered A.C. (the "Plan"), approved coverage for only the first fourteen days of A.C.'s treatment at Catalyst. United denied the remainder of

A.C.'s treatment at Catalyst, stating that A.C.'s care there was no longer medically necessary.

After unsuccessfully appealing to United, Plaintiffs brought suit against United in federal court to recover the benefits due to them under the Plan. Plaintiffs argued that A.C.'s treatment was medically necessary and that United wrongly denied him benefits. The district court, however, granted summary judgment in favor of United. It applied the deferential arbitrary and capricious standard of review, ruling that United did not abuse its discretion when it denied A.C. benefits.

This Court should reverse the district court's granting of summary judgment to United. First, the district court applied the incorrect standard of review. And second, it erroneously ruled that United's denials were sufficiently supported by facts and that United adequately considered A.C. substance use disorders.

JURISDICTIONAL STATEMENT

Plaintiffs raised claims under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001 through 1461, and under the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), which is incorporated into ERISA.[1] The district court had jurisdiction to hear Plaintiffs' claims under 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331. The parties moved by

[1] ERISA has its own internal numbering system that is different from that found in the United States Code. For ease of reference, Plaintiffs will refer to ERISA by the section numbers found in the United States Code.

stipulated motion to dismiss Plaintiffs' MHPAEA claim, and the district court dismissed that claim with prejudice on April 2, 2021. App.Vol.1:043.

The district court issued its Order and Memorandum Decision on the parties' cross motions for summary judgment on Plaintiffs' remaining ERISA claim on August 11, 2022, App.Vol.2:057-076, and entered final judgment disposing of all of Plaintiffs' claims on the same day, App.Vol.2:077. Plaintiffs filed a timely notice of appeal on September 9, 2022. App.Vol.2:078-079. This Court has jurisdiction to review the district court's decisions under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

Issue 1: This Court has previously held that some failures by claim administrators to comply with the procedural requirements of ERISA could be overlooked so long as the defendant "substantially complied" with those requirements. Since then, however, ERISA's procedural regulations have been amended to "to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference."

The district court recognized that these amendments appear to be incompatible with the substantial compliance standard. But the district court nonetheless ruled that it was bound by Tenth Circuit precedent to apply the substantial compliance test.

Should this Court make clear that the substantial compliance test is no longer viable?

Issue 2: The district court granted summary judgment to United on Plaintiffs' ERISA claim, ruling that United did not arbitrarily and capriciously deny A.C. benefits. Did the district court erroneously rule that United denials were sufficiently supported by facts and that United adequately considered A.C. substance use disorders?

STATEMENT OF THE CASE[2]

A.C.'s Struggles with Substance Abuse and Mental Illness

A.C. was born in Houston, Texas, the younger of two children born to his parents, Ian and C.C. App.Vol.3:009, 093. While A.C.'s family got along well growing up, A.C. always perceived he was the "odd one out." App.Vol.3:094. He "bounced off the walls and had trouble in school" and felt that he had difficulty living up to his parents' expectations. *Id*.

When A.C. was seven years old, he was diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD"). App.Vol.3:009. Further testing at age thirteen confirmed his ADHD diagnosis and determined that he also had an Anxiety Disorder. *Id*.

[2] Appellants cite to Appellants' Appendix by volume and page number, for example, App.Vol.2:267. *See* 10th Cir. R. App. P. 28.1(A)(1).

In middle school, A.C. was bullied. App.Vol.3:094. Despite his "Superior"-tested intelligence, he struggled with executive functioning. App.Vol.3:009, 094. He was unorganized and scattered. App.Vol.3:094. A.C.'s mother "acted as a crutch" for A.C., sorting through his assignments and showing him what he "needed to do." App.Vol.3:094. But A.C. began to resent her, starting an "unhealthy cycle of behavior" in which A.C. became increasingly reliant on his parents, but also increasingly antagonistic towards them. App.Vol.3:009. A.C. "depended on them to keep him in line," but he "resented them for what he saw as efforts to control him." *Id*. A.C. avoided his responsibilities, then used lying as a "first response" to avoid consequences. *Id*. By the time A.C. was in his freshman year of high school, things got worse. App.Vol.3:094. He was drinking alcohol "a lot[.]" *Id.* The following year, he added marijuana and Xanax to his habitual substance abuse roster, and he began to feel depressed and like he "didn't fit in." *Id.*

W. Walker Peacock, a clinical psychologist, started working with A.C. and his family. App.Vol.3:009. His sessions with A.C., however, were not "as productive" because A.C. was avoidant, dishonest, and merely parroted what Dr. Peacock wanted to hear. App.Vol.3:010.

By fall of A.C.'s junior year in high school, the family "was in crisis." *Id*. A.C. refused to comply with his parents' requests and he stopped taking his

medications for ADHD, anxiety, and depression; choosing to regularly use alcohol, marijuana, and cocaine instead. App.Vol.3:010, 096. A.C. experimented with other drugs as well, including Xanax, LSD, hydrocodone, codeine, and mushrooms. App.Vol.3:096. A.C. skipped school and regularly snuck out of home to meet with friends. App.Vol.3:010. By the end of November, A.C. was failing all of his classes except for one. *Id.*

A.C. also began struggling with his sexuality and religious beliefs. App.Vol.3:092. A.C. described himself as "'addicted to sex'" and said he had "multiple male and female sexual partners." App.Vol.3:096.

Despite scheduled weekly appointments with Dr. Peacock, A.C. rarely attended. App.Vol.3:010. He began showing signs of clinical depression and was hospitalized for suicidal ideation in December of his junior year. *Id.*

To Dr. Peacock, it had become clear that "the outpatient treatment plan was not working…." *Id.* A.C. "was simply not participating and his mood, behavior, and performance were declining quickly." *Id.* He recommended that A.C.'s parents admit him to an inpatient wilderness program, followed by inpatient residential treatment. *Id.* He based this recommendation on three reasons. First, Dr. Peacock was "seriously concerned with [A.C.'s] safety" because "[A.C.]'s pattern of behavior was growing more and more dangerous…." *Id.* Second, "[A.C.] and his parents were so intrenched in their family dynamics" that they were "incapable of

doing their own work…." *Id.* And third, "[A.C.] had become so dependent on his parents that he had no confidence in his own abilities to function" and he "needed to be in a place where nobody would save him and he would have to rely on his own skills." *Id.*

A.C.'s parents consequently admitted A.C. to BlueFire Wilderness Therapy ("BlueFire"), an outdoor behavioral health program, in April of his junior year of high school. App.Vol.6:139. While there, Jeremy A. Chiles, Ph.D., a licensed psychologist, performed a psychological evaluation and assessment of A.C. App.Vol.3:091-108. Dr. Chiles found that A.C. "lack[ed] a clear sense of identity," App.Vol.3:105, and was "self-centered and self-absorbed," with a limited ability to "experience compassion or empathy for others," App.Vol.3:101. Although A.C. presented himself as "someone who is conforming and willing to follow rules and expectations," on the inside, A.C. "rarely [thought] about the possible consequences of his behaviors" and had "a pattern [ ] of stirring people and situations up to the point of creating chaos and conflict." *Id.* Dr. Chiles found that A.C. was "charming and likable," but that he used these skills to "manipulat[e] others … to see him as a victim." App.Vol.3:097.

After completing the evaluation and assessment, Dr. Chiles diagnosed A.C. with:

- Generalized Anxiety Disorder, moderate;
- Persistent Depressive Disorder, moderate;

- Features of Histrionic and Narcissistic Personality Disorders, not meeting full criteria for a diagnosis;
- Oppositional Defiant Disorder, moderate to severe;
- Cannabis Use Disorder, moderate to severe;
- Alcohol Use Disorder, moderate to severe; and
- Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation.

A.C. received treatment at BlueFire for two and a half months. App.Vol.6:139.[3] Although he made "slow but steady progress" there, A.C. continued "to evidence a lack of identity and attitudes and behaviors that place[d] him at risk." App.Vol.3:106. Dr. Chiles consequently "strongly recommended" that A.C. continue with residential treatment following his discharge from BlueFire. *Id.* Dr. Chiles explained that A.C. needed "a residential therapeutic setting where he will be able to work with a therapist capable of treating students with unhealthy personality characteristics, substance use, and depression and anxiety." *Id*. He further specifically recommended that A.C. participate in a "substance use specific treatment program within the residential therapeutic setting he is placed." App.Vol.3:107.

Following Dr. Peacock and Dr. Chiles's recommendations, after A.C.'s treatment at BlueFire, A.C.'s parents placed A.C. at Catalyst Residential Treatment

[3] United did not pay benefits for A.C.'s treatment at BlueFire, but Plaintiffs did not seek to recover payment for A.C.'s care at BlueFire in this case. *See* App.Vol.1:014, ¶ 6; App.Vol.1:100, ¶ 40.

Center ("Catalyst"), a residential treatment facility. App.Vol.3:004. Shortly after admission, Catalyst diagnosed A.C. with:

- Generalized Anxiety Disorder;
- Unspecified Depressive Disorder;
- Cannabis Use Disorder, Severe;
- Parent-Child Relational Problem; and
- Alcohol Use Disorder, Severe.

App.Vol.4:043. A.C. received treatment at Catalyst until he successfully discharged approximately eleven months later. App.Vol.6:139.

United's Denial of Benefits for A.C.'s Treatment at Catalyst and Plaintiffs' Appeals

United, the insurer and claims administrator for the Plan which provided healthcare coverage for Ian and A.C., initially approved the first two weeks of A.C.'s treatment at Catalyst. App.Vol.3:023. But after that, United determined, A.C.'s care was no longer medically necessary, and it denied coverage for his remaining treatment there. App.Vol.3:023-024. In a letter to Plaintiffs, United explained that, in their estimation, A.C. had "made progress" and that "his condition no longer [met] guidelines for coverage of treatment in this setting." App.Vol.3:023. A.C., United declared, "could safely and effectively continue care in the Mental Health/Dual Diagnosis Intensive Outpatient Program setting." App.Vol.3:024.

Plaintiffs appealed United's denial. App.Vol.3:004-017. They argued that A.C.'s treatment at Catalyst continued to be medically necessary, especially

because A.C. had barely begun his treatment there and in that brief period, he had not had enough time to recover from his addictions. App.Vol.3:007. Plaintiffs included in their appeal a letter from Dr. Peacock, Dr. Chiles's psychological evaluation of A.C., and A.C.'s medical records from BlueFire and Catalyst. *See generally* App.Vol.3:003-297, App.Vol.4:3-080.

But United upheld its denial. App.Vol.7:042-043. It again declared that after the first two weeks, A.C.'s "condition no longer met Guidelines for further coverage of treatment in this setting." *Id*. Having exhausted their internal appeal obligations, Plaintiffs filed suit against United.

The District Court's Decision

Plaintiffs brought two claims for relief: first, a claim for recovery of their benefits under ERISA; and second, a claim that United violated its fiduciary duties under MHPAEA. App.Vol.1:013-026. The parties later moved by stipulation to dismiss the MHPAEA claim, and the district court dismissed it. App.Vol.1:043. Both parties then moved for summary judgment on Plaintiffs' remaining ERISA claim. App.Vol.1:044-244. The district court granted summary judgment in favor of United. App.Vol.2:057-077.

The district court first ruled that the arbitrary and capricious standard of review, not *de novo*, applied. App.Vol.2:064-067. The district court observed that *de novo* review is appropriate—even where the Plan vested discretionary authority

in the administrator to determine eligibility for benefits or construe the terms of the plan—if "the case involves 'serious procedural irregularities.'" App.Vol.2:064 (quoting *Martinez v. Plumbers & Pipefitters Natl'l Pension Plan*, 795 F.3d 1211, 1215 (10th Cir. 2015). But where the claim administrator has "substantially complied" with ERISA's procedural regulations, the district court stated, the arbitrary and capricious standard of review applies. App.Vol.2:066 (citing *Gilberston v. Allied Signal, Inc.*, 328 F.3d 625, 634-635 (10th Cir. 2003), and *Kellogg v. Metro. Life Ins. Co.*, 549 F.3d 818, 826 (10th Cir. 2008)).

Although the district court found "some force" in Plaintiffs' assertion that the "substantial compliance" standard could not be reconciled with ERISA's regulations' 2002 and 2011 amendments, it ruled that it was nonetheless bound by Tenth Circuit precedent that "continued to apply the 'substantial compliance' standard" after these amendments. App.Vol.2:067 (citing *Holmes v. Colorado Coal. For Homeless Long Term Disability Plan*, 762 F.3d 1195, 1211 (10th Cir. 2014) and *Jaremko v. ERISA Admin. Comm.*, 525 F. App'x 692, 694 (10th Cir. 2013)). The district court consequently considered whether United substantially complied with ERISA's procedural requirements and determined that it did. App.Vol.2:067-071.

Applying the arbitrary and capricious standard of review, the district court examined United's decision to deny A.C. benefits. App.Vol.2:072-075. It ruled that United did not arbitrarily or capriciously deny A.C.'s benefits. *Id*.

The district court first rejected Plaintiffs' argument that United abused its discretion by failing to address A.C.'s substance abuse when it evaluated A.C.'s claims. App.Vol.2:072-073. Because United's internal guidelines required it to consider whether "'[c]o-occurring behavioral health and medical conditions can be safely managed,'" App.Vol.2:068 (quoting App.Vol.9:034), the district court concluded that United must have considered A.C.'s substance abuse. App.Vol.2:072. And the district court further determined that "United had substantial evidence that A.C.'s substance abuse did not require residential treatment" for three reasons. App.Vol.2:072-073. First, the district court cited an internal note of United's that stated A.C.'s substance abuse issues were "secondary" to his mental health issues. App.Vol.2:072 (citing App.Vol.7:193). Second, the district court cited another internal note of United's that stated A.C. had not used substances for eleven weeks—the time he had been at BlueFire and Catalyst. App.Vol.2:072 (citing App.Vol.7:247). And third, the district court pointed to an internal note summarizing its reviewer's conversation with a representative with Catalyst, whom the district court represented as saying that the "focus of A.C.'s treatment was working on his 'skill generalization' and coping

skills." App.Vol.2:072-073 (quoting App.Vol.7:237). The district court further stated that A.C.'s master treatment plan from Catalyst supported the conclusion that Catalyst did not "focus" on treating A.C.'s substance abuse because the master treatment plan listed A.C.'s severe cannabis use and severe alcohol use disorders below his anxiety and depressive disorders. App.Vol.2:073.[4]

Plaintiffs timely appealed.

SUMMARY OF THE ARGUMENT

Point I. A district court reviews a denial of ERISA benefits under a *de novo* standard of review unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. If the plan grants the administrator discretionary authority, courts apply a deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious. But even if a plan vests discretionary authority in an administrator, it forfeits the deferential arbitrary and capricious standard of review if it fails to comply with ERISA's procedural requirements. However, this Circuit had long held that some failures to comply with the procedural requirements of ERISA

[4] The district court also rejected Plaintiffs' arguments that A.C.'s treatment at Catalyst was medically necessary, that United abused its discretion by not engaging with A.C.'s treating professionals' opinions and not articulating how it applied the terms of the Plan and internal guidelines to A.C.'s medical history. *See* App.Vol.2:074-075. Because the district court's decision cannot stand, Plaintiffs do not also address these rulings on appeal.

could be overlooked so long as the administrator "substantially complied" with those requirements.

In 2002 and 2011, however, the Department of Labor revised ERISA's procedural regulations "to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." Based on those amendments, this Court has repeatedly noted that the 2002 regulations call the into question and has expressed significant doubt that the lenient "substantial compliance" standard is still applicable.

The Court should now hold that the substantial compliance standard no longer applies. It is wholly inconsistent with the language of the 2002 and 2011 amendments to ERISA's procedural regulations. The Court should reverse the district court's ruling applying the substantial compliance standard and remand with instructions that the district court review Plaintiffs' ERISA claim under the correct standard of review.

Point II. The district court granted summary judgment for United, reviewing its denials of benefits under the arbitrary and capricious standard. But the district court further erred when it determined that under the arbitrary and capricious standard United did not abuse its discretion.

In conducting arbitrary and capricious review, courts must take into account whatever in the record fairly detracts from its weight and may not fail to address an independent ground for benefits specifically raised by the claimant. Here, United's denials were not sufficiently supported by facts and United did not take into account independent ground for benefits. Specifically, the district court erroneously determined that United addressed A.C.'s substance use disorders. United relies on internal notes as evidence that it considered his substance use, but it may not rely on justifications that may be in the record, but that were never *articulated* to Plaintiffs. In addition, United's notes are bald statements without underlying evidence to support them. The district court consequently erroneously granted summary judgment in favor of United and the Court should reverse.

ARGUMENT

I. THIS COURT SHOULD CLARIFY THAT THE SUBSTANTIAL COMPLIANCE STANDARD NO LONGER APPLIES

The district court ruled that although there was "some force" in Plaintiffs' assertion that the "substantial compliance" standard could not be reconciled with ERISA's regulations' 2002 and 2011 amendments, it was nonetheless bound by Tenth Circuit precedent that "continued to apply the 'substantial compliance' standard" after these amendments. App.Vol.2:067 (citing *Holmes v. Colorado Coal. For Homeless Long Term Disability Plan*, 762 F.3d 1195, 1211 (10th Cir. 2014); *Jaremko v. ERISA Admin. Comm.*, 525 F. App'x 692, 694 (10th Cir. 2013)

(unpublished)). This Court should clarify now that the substantial compliance standard is no longer good law when evaluating whether an ERISA plan has complied with ERISA's claims procedure regulations.

This Court reviews a district court's summary judgment decision *de novo*, using the same standard that applied in district court. *See LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 795-96 (10th Cir. 2010). A district court reviews a denial of ERISA benefits "under a *de novo* standard of review unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan in question vests discretionary authority in the administrator, courts apply a "'deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious.'" *LaAsmar*, 605 F.3d at 796 (quoting *Weber v. GE Group Life Assurance Co.*, 541 F.3d 1002, 1010 (10th Cir. 2008)).

But even if a plan vests discretionary authority in an administrator, a defendant forfeits access to the deferential "arbitrary and capricious" or "abuse of discretion" standard of review if it fails to comply with ERISA's procedural requirements. *See*, *e.g.*, *Rasenack v. AIG Life Ins. Co.*, 585 F.3d 1311, 1316-17

(10th Cir. 2009) (reviewing an ERISA claim *de novo* because the defendant insurance company violated the procedural requirements of ERISA).

ERISA provides that "[i]n accordance with regulations of the [Department of Labor], every employee benefit plan" is required to (1) "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant" and (2) "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133.

Making use of this statutory authority, in 2002 the Department of Labor revised ERISA's procedural regulations (the "2002 regulations") to "set[ ] forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries." 29 C.F.R. § 2560.503-1(a). In pertinent part the 2002 regulations require that, at minimum, a plan administrator initially denying a claim for benefits must provide the claimant with information including: (1) "[t]he specific reason or reasons for the adverse determination;" (2) "[r]eference to the specific plan provisions on which the determination is based;" (3) "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or

information is necessary;" and (4) for denials based on lack of medical necessity, "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances." *Id*. § 2560.503-1(g)(i),(ii),(iii) and (v).

When a claimant appeals an adverse benefit decision, the Plan must provide a "full and fair review" through a process that must, at minimum: (1) "takes into account all comments, documents, records, and other information submitted by the claimant related to the claim[;]" (2) provides "reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits[;]" and (3) in deciding an appeal based on medical necessity, demonstrates that the claim administrator "consult[ed] with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 CFR § 2560.503-1(h)(2)(iii)-(iv), *Id*. § 2560.503-1(h)(3)(iii). These procedures require that the appeals process represents "a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Gilbertson v. Allied Signal*, 328 F.3d 625, 635 (10th Cir. 2003) (citation omitted).

The regulation's preamble explained that the 2002 change was made "to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." ERISA Rules and

Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70246, 70255 (Nov. 21, 2000).

In 2011, as part of the passage of the Patient Protection and Affordable Care Act, further changes were made to the regulations as they apply to health benefit claims such as in this case. They now state that if an administrator "fails to *strictly adhere* to all the requirements," "the claim or appeal is deemed denied on review *without the exercise of discretion by an appropriate fiduciary*" unless the procedural violations are "de minimis," occurred "for good cause or due to matters beyond the control of the plan or issuer," and do not cause prejudice or harm to the claimant. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)*(1)-(2)* (emphasis added). This language demonstrates the Department of Labor's intention that, for all but *de minimis* harmless procedural violations, any deviation from the procedural requirements of ERISA forfeits a defendant's right to the deferential abuse of discretion standard of review and instead triggers *de novo* review.

Under the now obsolete pre-2002 version of the ERISA regulations, this Court has previously held that some failures to comply with the procedural requirements of ERISA could be overlooked so long as the defendant "substantially complied" with those requirements. *Gilbertson*, 328 F.3d at 634. Under that circumstance, *Gilbertson* held that a defendant insurance company would not forfeit its right to the abuse of discretion standard of review. *See id*. at

634-635. However, this Court has repeatedly noted that the 2002 regulations call this precedent into question and has expressed significant doubt that the lenient "substantial compliance" standard is still applicable to allow insurance companies to salvage procedurally defective claims processes and preserve deferential review. *See e.g., Rasenack*, 585 F.3d at 1316 (noting that "[t]he 2002 amendments have … called into question the continuing validity of the substantial compliance test"), *Kellogg v. Metro Life Ins. Co.*, 549 F.3d 818, 828 (10th Cir. 2008) (noting that the substantial compliance rule "was issued in light of the then-controlling 1998 federal regulations implementing ERISA" and that the 2002 regulations "have called into question the continuing validity of the substantial compliance rule"); *see also Finley v. Hewlett-Packard Co. Empl. Benefits Org. Income Prot. Plan*, 379 F.3d 1168, 1175 n.6 (10th Cir. 2004) (specifically reserving the question of whether the substantial compliance test articulated in *Gilbertson* is still applicable following the adoption of the 2002 regulations).

In addition, at least one district court in the Tenth Circuit has determined "that the substantial compliance doctrine is not applicable under the [2002] regulations," *Reeves v. UNUM Life Ins. Co.*, 376 F. Supp. 2d 1285, 1293 (W.D. Okla. 2005), and that "a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference," *id*. a t 1294 (citation and internal quotation marks omitted).

Further, the Second Circuit Court of Appeals has rejected *Gilbertson*'s "substantial compliance" doctrine outright, determining it to be "flatly inconsistent" with the language in the 2002 version of the claims procedure regulations. *Halo v. Yale Health Plan*, 819 F.3d 42, 56 (2nd Cir. 2016). In reaching this conclusion, the Second Circuit noted that when revising the regulations in 2002, the Department of Labor specifically rejected requests from commenters to the proposed changes in the claims procedure regulations who sought to preserve the substantial compliance concept outlined in *Gilbertson* and other cases. *Id.* at 57.

Under *Halo*, not every failure to comply with ERISA's claims procedure regulations results in *de novo* review. Minor deviations are tolerable so long as the ERISA plan shows it has procedural integrity and the errors that occur are harmless and inadvertent:

> [W]e hold that when denying a claim for benefits, a plan's failure to comply with the Department of Labor's claims-procedure regulation, 29 C.F.R. §2560.503-1, will result in that claim being reviewed *de novo* in federal court, *unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulations in the processing of a particular claim was inadvertent and harmless*. Moreover, the plan "bears the burden of proof on this issue since the party claiming deferential review should prove the predicate that justifies it."

Id. at 57-58 (emphasis added, citations omitted)

Similar to §2590.715-2719, the Second Circuit approach does not impose strict liability on insurers and plan administrators for failing to meticulously follow ERISA's procedural regulations. Rather, its analysis requires that claimants identify some aspect of the claims procedure regulations that have been violated. Only then does the burden of proving both inadvertence and lack of harm shift to the plan or claim administrator. This careful balancing of legitimate interests emphasizes the importance of ERISA regulations and increases the likelihood that plan participants and beneficiaries will receive a fair and full review of their claims. Other courts have followed the Second Circuit and adopted the *Halo* rationale. *See, e.g.*, *Otero v. Unum Life Ins. Co. of Am.*, 226 F.Supp.3d 1242, 1265 (N.D. Ala. 2017) (referencing the Second Circuit's "thorough, well-reasoned" analysis of the issue) and *Johnston v. Aetna Life Ins. Co.*, 2018 U.S. Dist. LEXIS 34622, *35 (S.D. Fla. 2018) (commenting on the "detailed analysis of the regulation's ambiguity, timing, and history"). This Court should too.

As this Court has noted, the Circuit's pre-2002 precedence does not comport with ERISA's new regulations. *See Rasenack*, 585 F.3d at 1316 (noting that "[t]he 2002 amendments have … called into question the continuing validity of the substantial compliance test"); *Kellogg*, 549 F.3d at 828 (noting that the substantial compliance rule "was issued in light of the then-controlling 1998 federal regulations implementing ERISA" and that the 2002 regulations "have called into

question the continuing validity of the substantial compliance rule"). And despite the district court's hesitation to agree, it was not bound to rule otherwise. This Court has not "continued to apply the 'substantial compliance' standard" after the 2002 amendments. App.Vol.2:067 (citing *Holmes*, 762 F.3d at 1211; *Jaremko*, 525 F. App'x at 694. Indeed, *Holmes* did not address whether the substantial compliance standard was still controlling, but examined whether Ms. Holmes was required to exhaust her administrative remedies under the regulation's "deemed-exhausted provision." 762 F.3d 1195, 1211-1214 (10th Cir. 2014). And although *Jaremko* stated in passing that "[d]e novo review may be appropriate if the determination process was not in substantial compliance with ERISA regulations," *Jaremko* likewise did not address the viability of the substantial compliance standard, and in any event, it applied the *de novo* standard. 525 Fed. App'x. at 694. In addition, *Jaremko* is an unpublished decision that "is not binding precedent." 10th Cir. App. R. 32.1 (providing that "[u]npublished decisions are not precedential"). It therefore is neither binding nor persuasive here.

Now is time for this Court to explicitly state that changes in ERISA's claims procedure regulatory framework in both 2002 and 2011 have negated the substantial compliance standard and adopt the *Halo* analysis that aligns with the language of 29 C.F.R. §2590.715-2719. The Court should thus reverse the district court's ruling that the substantial compliance standard is binding precedent and

remand with instructions for the district court to consider Plaintiffs' ERISA claim under the correct standard of review.

II. THE DISTRICT COURT ERRONEOUSLY DETERMINED THAT UNITED DID NOT ARBITRARILY AND CAPRICIOUSLY DENY PLAINTIFFS' BENEFITS

The district court granted summary judgment for United, reviewing its denials of benefits under the arbitrary and capricious standard. App.Vol.2:071-075. As shown, the district court incorrectly applied the substantial compliance standard to determine that the deferential arbitrary and capricious standard of review applied. But the district court further erred when it determined that under the arbitrary and capricious standard United did not abuse its discretion.

Under the arbitrary and capricious standard, a plan administrator's denial will be upheld "so long as it is predicated on a reasoned basis." *Adamson v. Unum Life Ins. Co. of N. Am.*, 455 F.3d 1209, 1212 (10th Cir. 2006); *see also Abnathya v. Hoffman LaRoche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) (explaining that district court may overturn denial that is "'without reason, unsupported by the evidence or erroneous as a matter of law'") (citation omitted). While the claim administrator's "decision need not be the only logical one nor even the best one," it must be "sufficiently supported by facts within his knowledge." *Finley v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan*, 379 F.3d 1168, 1176 (10th Cir. 2004) (quoting *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999)).

In conducting arbitrary and capricious review, courts "must take into account whatever in the record fairly detracts from its weight." *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002) (internal citations, quotation marks, and alterations omitted). This means an administrator may not fail to address 'another independent ground for [benefits] presented in the record and specifically raised in [the claimant's] administrative appeal." *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 806 (10th Cir. 2004). Thus, while deferential, the arbitrary and capricious standard "is not without meaning." *McMillan v. AT&T Umbrella Ben. Plan No. 1*, 746 Fed. App'x. 697, 705 (10th Cir. 2018) (unpublished).

Here, the district court did not hold United to this standard. United's denials were not "sufficiently supported by facts within … [the Plan administrator's] knowledge." *Finley*, 379 F.3d at 1176. And United did not "take into account whatever in the record fairly detracts from its weight." *Caldwell*, 287 F.3d at 1282.

A. The District Court Erroneously Ruled that United Adequately Considered A.C.'S Substance Abuse Disorders.

The district court erroneously determined that United addressed A.C.'s substance use disorders when United evaluated and denied A.C.'s claims. App.Vol.2:072-073. The district court relied on two justifications for its ruling. First, it concluded that because United's internal guidelines required it to consider whether "'[c]o-occurring behavioral health and medical conditions can be safely managed,'" App.Vol.2:068 (quoting App.Vol.9:034), United must have considered

A.C.'s substance abuse. App.Vol.2:072. And second, citing to only three notations in United's internal notes and its own interpretation of the order of diagnoses listed on A.C.'s master treatment plan, the district court determined that A.C.'s substance abuse disorders were "secondary" to his mental health issues and did not require residential treatment.

"[I]nternal documents cannot satisfy ERISA's requirement that the specific reasons for [a] denial be articulated to the claimant." *Glista v. UNUM Life Ins. Co. of Am.*, 378 F.3d 113, 130 (1st Cir. 2004). This is because, as this Court has also noted, "[a] plan administrator is required by statute to provide a claimant with the specific reasons for a claim denial," including "the specific reason or reasons for the adverse determination" and "reference to the specific plan provisions on which the determination is based" within its letters denying a plaintiff's claims. *Spradley v. Owens-Illinois Hourly Employees Welfare Benefit Plan*, 686 F.3d 1135, 1140 (10th Cir. 2012) (brackets, citation, and internal quotation marks omitted).

Accordingly, federal courts may consider "only those rationales that were *specifically articulated* in the administrative record as the basis for denying a claim" when reviewing a cause of action asserted under ERISA. *Id*. (emphasis added, citation and internal quotation marks omitted). The Court should not permit United to paper over the deficiencies in its denial letters by relying on reasoning that may be in the record, but that was never *articulated* to Plaintiffs. *See id*. at

1141 (citing to *Glista*, 378 F.3d at 128, and holding that where denial letters "never even suggest[ ]" a denial rationale to Plaintiffs, a defendant claims administrator may not rely on that rationale in litigation).

But in any event, United's justifications do not hold water. First, merely because United has a guideline that says it should consider co-occurring behavioral health conditions does not mean that it did consider them, especially where there is no evidence in the prelitigation record that it did so.

Further, United's bald statements in its internal notes are not evidence. There are no underlying bases for the statements. For example, the district court relied on United's internal note that stated A.C.'s substance abuse issues were "secondary" to his mental health issues. App.Vol.2:072-073. But the district court did not cite to A.C.'s medical records or his master treatment plan for providing that statement. And Plaintiffs are unaware of anywhere in A.C.'s medical records that make such a designation.

The district court's pointing to A.C.'s master treatment plan from Catalyst does not "support[]" the district court's conclusion that A.C.'s substance use treatment was "secondary." Simply because the master treatment plan listed A.C.'s severe cannabis use disorder and severe alcohol use disorder below his anxiety and depressive disorders is not proof that A.C.'s substance abuse treatment was "secondary." App.Vol.2:073. They are not labeled as "secondary." In fact, they are

listed as "severe." And the notation that a Catalyst representative declared that A.C.'s treatment "was working on his 'skill generalization' and coping skills" did not mean that A.C.'s substance use treatment was not important. App.Vol.2:072-073 (quoting App.Vol.7:237). As the Catalyst representative explained, A.C.'s substance use and mental health issues were intertwined and he required treatment for both of them. App.Vol.7:237.

Finally, the district court's citation to another internal note that stated A.C. had not used substances for eleven weeks—which is the time A.C. had been in treatment at BlueFire and Catalyst—is also not persuasive. App.Vol.2:072 (citing App.Vol.7:247). United's own internal notes detract from the weight of this note, demonstrating that A.C. was struggling with his addictions. For example, United noted that on June 28, 2016 A.C. was "having high cravings for using, talking and thinking about drugs a lot, was using daily…." App.Vol.7:204. And on July 1, 2016, United noted that A.C. "reports craving for substances." App.Vol.7:213. That same day, United determined that A.C.'s symptoms were "not manageable in [a] less restrictive setting" because there was an "[i]nadequate relapse prevention strategy." App.Vol.7:211. Four days later on July 5, United reported that A.C.'s treating professionals at Catalyst were "worried about [A.C.] reverting back to cd use if he doesn't treat his anxiety." App.Vol.7:221. And United again determined that day that A.C.'s symptoms were "not manageable in [a] less restrictive setting"

because there was an "[i]nadequate relapse prevention strategy." App.Vol.7:219. Two days later, United noted that A.C. was again "report[ing] cravings." App.Vol.7:230. One day later on July 8, United noted that A.C. was at risk for relapse—especially because he used substances to manage his anxiety—and that A.C. "was having flashbacks of drinking" and that was "triggering him." App.Vol.7:237. That same day, United determined that A.C.'s substance abuse treatment was not medically necessary. *Id*.

Fiduciaries may not "shut their eyes to readily available information when the evidence in the record suggest that the information might confirm the beneficiary's theory of entitlement.'" *Gaither*, 394 F.3d at 807. But here, United did not "take into account whatever in the record fairly detracts from its weight." *Caldwell*, 287 F.3d at 1282. It was required to look at the whole picture, including whether patients can maintain their progress outside of residential treatment. As one court explained, a reviewer must "evaluate whether improvements in the patient's depression would last if she was removed from residential treatment." *Charles W. v. Regence BlueCross BlueShield of Or.*, 2019 U.S. Dist. LEXIS 167184, *24, 2019 WL 4736932. *See also Wiwel v. IBM Med. & Dental Ben. Plans for Regular Full-Time & Part-Time Employees*, 2017 U.S. Dist. LEXIS 46377, at *13, 2017 WL 1184066 (reversing claim administrator's denial where

reviewer offered no reasons to conclude that removing patient from residential treatment would not return patient's progress to their prior dynamic of decline).

When a reviewer fails to take into account a patient's ability to maintain their progress outside of residential treatment, their denial should be reversed. For if a reviewer "fails entirely to address a conspicuous confounding variable, namely, the influence that [a treatment center], itself, may have brought to bear upon [a patient]'s behavior," the denial is insufficient. *Wiwel*, 2017 U.S. Dist. LEXIS 46377, at *12 ("That is, where the evidence of record demonstrates that before her admission to [residential treatment], [a patient]'s behavior was destructive, and while in residency [], [her]behavior was stable, ... the IPRO opinion does not adequately state reasons to conclude that in the absence of [residential treatment facility]'s care, [her] behavior would have remained stable....").

Like in *Gaither*, United rejected Plaintiffs' claim for benefits "without a substantial basis for doing so, without following up on obvious leads, and apparently without specifically considering the claim at all." 394 F.3d at 806; *see also Raymond M. v. Beacon Health Options, Inc.*, 463 F. Supp. 3d 1250, 1275, (D. Utah 2020) (same). United's denials were not "sufficiently supported by facts within … [its] knowledge." *Finley*, 379 F.3d at 1176. And United did not "take into account whatever in the record fairly detracts from its weight." *Caldwell*, 287 F.3d at 1282. This Court should therefore reverse the district court's decision.

CONCLUSION

For the foregoing reasons, the Court should reverse the district court's summary judgment ruling in favor of United and remand to the district court to reconsider Plaintiffs' ERISA claim under the proper standard of review.

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STATEMENT REGARDING THE NEED FOR ORAL ARGUMENT

Pursuant to 10th Cir. R. 28.2(C)(2), the Appellants provide the following statement regarding their request for oral argument in this case:

Plaintiffs request the opportunity to present oral argument. This case involves the interpretation of ERISA and its regulations, including the standard of review that district courts should apply in determining whether claim administrators have wrongly denied benefits. The Tenth Circuit has not addressed the proper standard of review since regulations implementing ERISA have been amended. This is a matter of significant importance as several million individuals in the Circuit receive employee welfare benefits. This Court's decision will impact all these individuals.

DATED this 11th day of January, 2023.

/s/ *Brian S. King*
Brian S. King

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Certificate of Compliance With Type-Volume Limitation, Typeface Requirements, and Type Style Requirements

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because:

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Dated this 11th day of January, 2023.

/s/ *Brian S. King*
Brian S. King

CERTIFICATE OF DIGITAL SUBMISSION

I hereby certify that with respect to the foregoing:

1. all required privacy redactions have been made per 10th Cir. R. 25.5;

2. if required to file additional hard copies, that the ECF submission is an exact copy of those documents;

3. the digital submissions have been scanned for viruses with the most recent version of a commercial virus scanning program, AVG, which is updated on a daily basis, and according to the program are free of viruses.

/s/ *Brian S. King*

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the Appellants' brief and its attachments have been served to all parties registered to receive court notices via the Court's CM/ECF system.

At such time as the Court accepts the Appellants' filing, bound copies of the brief and attachments will be ordered and delivered to the Court and counsel for the Appellees.

Dated: 1/11/23

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