AARP Foundation®

May 5, 2017

Lyle W. Cayce
United States Court of Appeals for the Fifth Circuit
Office of the Clerk
F. Edward Hebert Building
600 S. Maestri Place
New Orleans, LA 70130-3408

Re: *Ariana M. v. Humana Health Plan of Texas*
2017 U.S. App. LEXIS 7072 (No. 16-20174) (5th Cir. Apr. 21, 2017)
AARP and AARP Foundation as Amici Curiae
in Support of Petition for Rehearing En Banc

Dear Mr. Cayce:

Certificate of Interested Persons

The undersigned counsel of record certifies that the following persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case: Ariana M. (Plaintiff); James C. Plummer, Amar Raval, Plummer & Kuykendall, Lisa S. Kantor, Peter S. Sessions, Kantor and Kantor, LLP (Plaintiff's Counsel); Humana Health Plan of Texas, Inc., Eyesys Vision Inc. Plan (Defendants); Ellen Burkholder Cochran, Rachael Padgett, Carlos Soltero, McGinnis, Lochridge and Kilgore, LLP (Defendants' Counsel); AARP and AARP Foundation (Amici Curiae); and Mary Ellen Signorille, William Alvarado Rivera (Counsel for Amici Curiae). These representations are made so that the judges of this Court may evaluate possible disqualification or recusal.

Dated: May 5, 2017 /s/Mary Ellen Signorille

Statement of Interest

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. Over three million of AARP's 38 million members reside within the Fifth Circuit's jurisdiction, with over 2.3 million members in Texas alone. AARP Foundation — AARP's charitable affiliate — works to ensure that low-income older adults have nutritious food, affordable housing, a steady income, and strong and sustaining bonds. Supported by vigorous legal advocacy, including through participation as

amicus curiae in state and federal courts, AARP Foundation creates and advances effective solutions that help struggling older adults transform their lives.

Nearly half of AARP's members are employed full or part-time, with many working for employers that provide benefit plans covered by the Employee Retirement Income Security Act (ERISA). Participants and beneficiaries in private employee benefit plans rely on ERISA to protect their rights. The right to seek judicial review of benefit denials under ERISA-governed plans is a crucial protection that the statute provides for. *See* 29 U.S.C. § 1132(a)(1)(B). However, ERISA does not expressly provide for the appropriate standard of review in benefit disputes.

AARP and AARP Foundation have a substantial interest in the standard of review for benefit denials because it impacts the availability and adequacy of employee benefits that countless members and older individuals receive or may be eligible to receive. The level of discretion reserved to a plan administrator and the standard of review of a benefit denial correlates with the ability of AARP members and other working persons to successfully appeal a denial of benefits and to have benefit claims fully and fairly reviewed. One of the Foundation's main areas of concern is to ensure that people over 50 have an adequate income and receive the employee benefits to which they are entitled. In the health insurance context, a denial of benefits could literally mean the difference between life and death if lifesaving treatment is denied. In the disability insurance context, it could result in economic devastation for the claimant.

Argument

At issue is this Circuit's decision in *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991), which held that courts must give deference to the factual determinations of a plan administrator of a plan covered by the Employee Retirement Income Security Act (ERISA), regardless of what the plan document says. The panel decision noted that *Pierre* is contrary to the seven circuits that have also decided this issue. The panel suggested that the Fifth Circuit should reexamine this precedent. We wholeheartedly support this reexamination and urge this Circuit to overrule its decision in *Pierre*.

No provision of ERISA explicitly states what the appropriate standard of review for a court's review of a benefit claims denial. *See* 29 U.S.C. § 1133; *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002), the Supreme Court

reiterated its holding in *Firestone* that discretion is a matter of contract and plan design and stated that "[d]eferential review . . . is not a settled given."

The split between this Circuit and the other circuits that have addressed this issue results from different readings of the scope of *Firestone*'s holdings. Early in its opinion, the Supreme Court noted that "the discussion which follows is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations." *Firestone*, 489 U.S. at 108. However, the Court's later holding is not so expressly limited: "we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id*. at 115. We assume that the language that the Supreme Court uses when it announces its holding is carefully crafted, and any reading of *Firestone* that limits the de novo standard to issues of plan interpretation would fail to accord any meaning to the apparently deliberate use of the phrase "eligibility for benefits" as an issue distinct from "construing the terms of the plan." *See, e.g.*, *Petrilli v. Drechsel*, 910 F.2d 1441, 1446 (7th Cir. 1990) (quoting *Firestone*, 489 U.S. at 115). One court pointed out that "the Supreme Court's limitation of its holding was intended only to distinguish actions pursuant to § 1132(a)(1)(B) from actions brought under other sections of ERISA." *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991). Indeed, the next sentence specifically stated that the Supreme Court expressed "no view as to the appropriate standard of review for actions under" ERISA's other civil enforcement provisions. *Id*. Quite simply, the Court's rationale focuses upon whether the written plan conferred discretion on the administrator, not on the type of decision — factual or interpretative — that the administrator is making. [1]

The importance of the proper standard of review for ERISA benefit denials cannot be overstated, inasmuch as this standard is often outcome determinative. Plan administrators are able to insulate their decisions to deny benefits from exacting judicial scrutiny by the use of discretionary clauses. Discretionary clauses require claimants not only to prove that the insurer was wrong, but also that the decision was beyond reason. Indeed, in *Herzberger v. Standard Ins. Co*., 205 F.3d 327, 332-333 (7th Cir. 2000), the court expressed its concern that an employer

[1] Trust law provides no basis for distinguishing between court review of factual determinations and interpretations of claim language. Likewise, courts reviewing the actions of trustees have made no such distinction. *See Ramsey v. Hercules, Inc*., 77 F.3d 199, 203 (7th Cir. 1996).

would "get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat." Notably, deferral to a plan administrator's factual findings without explicit authority in the plan would "afford less protection to employees" than before ERISA's enactment. *Firestone*, 489 U.S. at 114.

By the early 2000s, the National Association of Insurance Commissioners (NAIC) had growing concerns about these clauses. The NAIC believed that discretionary clauses were inconsistent with basic insurance consumer rights.[2] Further, they wanted to assure that the reasonable expectations of the claimant would be protected under an objective, contract-based standard for claims[3] and that the long-standing principle that any ambiguities in an insurance policy must be interpreted in favor of the insured person would be preserved.[4] Thus, the NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act[5] that bans discretionary clauses in health insurance and disability income protection coverage.

In 2009, Texas joined at least sixteen states to prohibit discretionary clauses in insurance policies.[6] These states stress the inequitable results for claimants when these discretionary clauses are applied. To regulate these clauses, these states have relied on their insurance code provisions, which prohibit clauses that are unfair or deceptive, misleading, inconsistent, or ambiguous. Although the insurance industry claimed that benefit claim litigation would increase due to these prohibitions, amici

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[2] 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 2290 (2003).

[3] Prohibition on the Use of Discretionary Clauses Model Act, Technical Amendment and Project History, 2 Proc. of the Nat'l Ass'n of Ins. Comm'rs 10, 17 (2002).

[4] 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 57 (2004).

[5] 1 NAIC Model Laws, Regulations and Guidelines, 42-1 to 42-6 (2002, amended 2004).

[6] These laws have withstood preemption challenges. *See Fontaine v. Metropolitan Life Ins. Co.*, 800 F.3d 883 (7th Cir. 2015); *Standard Ins. Co. v. Morrison*, 584 F.3d 83 (9th Cir. 2009); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009).

are unaware of any publicly available research that validates these claims — even though the first prohibition of such clauses occurred in 2004.[7]

Finally, rehearing of this case and a reversal of *Pierre* will promote national uniformity in how courts treat the standard of review. *See Guardian Life Ins. Co. v. Finch*, 395 F.3d 238, 242 (5th Cir. 2004).

Conclusion

Amici urge this Court to grant Plaintiff-Appellant's petition for rehearing en banc to reconsider its decision in *Pierre* so that this Circuit's jurisprudence is consistent with the Supreme Court's rejection of a default deferential standard of review.

Sincerely,

/s/Mary Ellen Signorille*
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[7] California was the first state to ban discretionary clauses, finding in an opinion letter that they violated state insurance law. Dep't of Ins., Letter Opinion per CIC §12921.9: Discretionary Clauses, Feb. 26, 2004, https://goo.gl/RbRDeV (last visited May 1, 2017).

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 1,428 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced 14-point typeface using Microsoft Word 2010.

Dated: May 5, 2017

/s/Mary Ellen Signorille
Counsel for Amici Curiae

CERTIFICATE OF SERVICE AND FILING

I hereby certify that on May 5, 2017, the foregoing LETTER BRIEF FOR AARP AND AARP FOUNDATION AS AMICI CURIAE SUPPORTING PETITION FOR REHEARING EN BANC was electronically filed with the Clerk of the Court for the United States Court of Appeals of the Fifth Circuit using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: May 5, 2017 /s/Mary Ellen Signorille

Counsel for Amici Curiae