UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

JANE DOE,	)	
Appellant	)	
	)	
V.	)	
	)	No. 17-2078
HARVARD PILGRIM HEALTH CARE, INC.,	)	
AND THE HARVARD PILGRIM PPO PLAN	)	
MASSACHUSETTS, GROUP POLICY	)	
NUMBER 0588660000,	)	
Appellees	)	

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

Pursuant to Rule 29 of the Federal Rules of Appellate Procedure and the Court's discretionary authority, United Policy Holders and Health Law Advocates, Inc., respectfully submit this motion for leave to file the accompanying brief *amicus curiae* in support of plaintiffs-appellants in the case of *Jane Doe v. Harvard Pilgrim Health Care, Inc., and The Harvard Pilgrim PPO Plan Massachusetts, Group Policy Number 0588660000*, No. 17-2078.

Amici has contacted the parties to this dispute to obtain permission to file this brief. As of the time of filing this brief, *amici* have had no response from Defendants-Appellees in connection with *amici's* request for consent to file.

INTEREST OF THE *AMICUS CURIAE*

A. UNITED POLICYHOLDERS.

United Policyholders ("UP") is a non-profit 501(c) (3) organization founded in 1991 that is a respected voice and a trusted information resource for insurance consumers in all 50 states. UP promotes fair claim and sales practices and integrity in the insurance marketplace. Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

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UP's work is divided into three program areas: Roadmap to Recovery™ (disaster recovery and claim help), Roadmap to Preparedness (insurance and financial literacy and disaster preparedness), and Advocacy and Action (advancing pro-consumer laws and public policy).

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communities use UP's information and tools to secure prompt and fair insurance claim settlements. UP's Roadmap to Recovery program has proven so useful in resolving disputes that county governments in New Jersey, Colorado and California partner with UP to offer the program to their residents as they struggle to recover from hurricanes, flooding and wildfires.

UP analyzes trends, issues and problems related to claims and the insurance marketplace. Commercial and individual insureds, claim professionals and lawyers share information with UP about coverage and claim disputes every day. UP informs the public and the courts and assist regulators and legislators in effectively overseeing business and personal insurance matters. UP's Executive Director has been appointed for six consecutive years as an official consumer representative to the National Association of Insurance Commissioners where she worked with the former Massachusetts Insurance Commissioner Joseph G. Murphy.

UP strives to assist courts throughout the United States in resolving insurance disputes by filing "friend of the court" briefs in important matters such as this one. UP's amicus briefs have been cited in published decisions by the U.S. Supreme Court and numerous state and federal appellate courts. *See e.g. Humana, Inc. v. Forsyth*, 525 U.S. 299, 314 (1999) and other briefs cited at www.uphelp.org/resources/amicus-briefs.

Previously UP appeared as amicus curiae three times in the First Circuit Court of Appeals (*Mount Vernon Fire Insurance Company v. VisionAid, Inc.*, 825 F.3d 67 (1st Cir. 2016); *Boston Gas Co. v. Century Indem. Co.*, 529 F.3d 8 (1st Cir. 2008); *Denmark v. Liberty Life Assur. Co. Of Boston*, 481 F.3d 16 (1st Cir. 2007). UP has appeared seven times before the Massachusetts Supreme Judicial Court (*Mount Vernon Fire Insurance Company v. Visionaid, Inc.*, 477 Mass. 343 (Mass. 2017); *Auto Flat Car Crushers, Inc. v. Hanover Ins. Co.*, 469 Mass. 813 (Mass.2014); *Boston Gas Co. v. Century Indem. Co.*, 454 Mass. 337 (2009); *Allmerica Fin. Corp. v. Certain Underwriters at Lloyd's, London*, 449 Mass. 621 (2007); *John Hancock Mut. Life Ins. Co. v. Banerji*, 447 Mass. 875 (2006); W. Alliance Ins. Co. v. Gill, 426 Mass. 115 (1997); *Clark Equip. Co. v. Massachusetts Insurers Insolvency Fund*, 423 Mass. 165 (1996)).

Besides serving Massachusetts consumers through advocacy work, UP helps people along the shoreline and the Cape struggling with increasing costs and decreasing options related to their property insurance.

B. HEALTH LAW ADVOCATES.

Health Law Advocates ("HLA") operates as a public interest law firm founded in 1996 committed to ensuring universal access to quality health care in Massachusetts, particularly for those who are most vulnerable or at risk in society. HLA selects cases, provides pro bono legal representation, identifies pro-bono attorneys in private practice and works in collaboration with other organizations to secure access to quality health care for low income individuals, families and groups. Many of HLA's clients are children, elderly or people coping with disabilities. Since its inception in 1996, HLA has helped thousands of Massachusetts residents obtain needed health or disability services or coverage.

Many of HLA's clients are participants in private employer-sponsored employee benefit plans and the plan beneficiaries rely on the Employee Retirement Income Security Act (ERISA) to protect their rights. 29 U.S.C. §1001 *et seq*. Because the quality of their lives depends vitally upon the security of their health and disability benefits, HLA's clients have a vital concern with ERISA protections and the public policy promise of ERISA's consistent and "full and fair review" claims process. The issues in this appeal will directly affect the ability of HLA's clients to have benefit claims fully and fairly reviewed as required by ERISA.

ISSUES ADDRESSED BY THE *AMICI*

This *amicus* brief addresses the ERISA fiduciary's duty under the ERISA statute and Secretary of Labor regulations to afford full and fair review when a fiduciary denies a benefit claim This duty requires a fiduciary to help secure "readily available material evidence of which it was put on notice," which is necessary for the fiduciary to review in order to comply with 29 U.S.C. § 1133(b). *Harrison v. Wells Fargo Bank*, N.A., 773 F.3d 15, 20 (4th Cir.2014). This is in accord with the collaborative process expected by fiduciaries in this Circuit. *Glista v. Unum Life Ins. Co. of America*, 378 F.3d 113, 129 (1st Cir. 2004).

CONCLUSION

For these reasons, United Policy Holders and HLA respectfully requests that the Court grant both leave to file the accompanying brief *amicus curiae* in support of Plaintiffs-Appellants to facilitate a full consideration by the court. If such leave is granted, *amicus* requests that the brief *amicus curiae* be considered filed as of the it was forwarded to the Court in accordance with Rule 25(a)(2)(B)(I) F.R.A.P.

Date: April 16, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 16, 2018, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF system. I certify that all counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system, except

/s/ Jonathan M. Feigenbaum
Jonathan M. Feigenbaum

No. 17-2078

**IN THE UNITED STATES
COURT OF APPEALS
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JANE DOE,

Plaintiff-Appellant,

vs.

HARVARD PILGRIM HEALTH CARE, INC. AND THE HARVARD PILGRIM PPO PLAN MASSACHUSETTS, GROUP POLICY NUMBER 0588660000,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
CIVIL ACTION NO. 15-CV-10672 DJC
HONORABLE DENISE J. CASPER

**BRIEF OF UNITED POLICYHOLDERS AND HEALTH LAW ADVOCATES, INC.
AS AMICUS CURIAE IN SUPPORT OF REVERSAL IN FAVOR OF PLAINTIFF-APPELLANT JANE DOE**

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I. STATEMENTS OF INTEREST OF AMICI.[1]

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[1] Pursuant to Fed. R. App. P. 26.1, United Policyholders and Health Law Advocates, Inc. states that each is a non-profit 501(c)(3) organization and has no parents, subsidiaries, or affiliates. Pursuant to Fed. R. App. P. 29(a)(4)(E), both United Policyholders and Health Law Advocates states that no party's counsel authored this brief in whole or in part, and that no party or party's counsel, and no person other than the amicus or its counsel, contributed money that was intended to fund preparing or submitting this brief.

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[2] *Mount Vernon Fire Insurance Company v. VisionAid, Inc.*, 825 F.3d 67 (1st Cir. 2016); *Boston Gas Co. v. Century Indem. Co*., 529 F.3d 8 (1st Cir. 2008); *Denmark v. Liberty Life Assur. Co. Of Boston*, 481 F.3d 16 (1st Cir. 2007).

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II. SUMMARY OF ARGUMENT

An ERISA fiduciary must act solely and exclusively for the benefit of the participants and beneficiaries and for the exclusive purpose of providing plan benefits and defraying reasonable plan expenses. 29 U.S.C. § 1104(a). So holds a long line of cases beginning with *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989).

Harvard Pilgrim Health Care and the Harvard PPO Plan of Massachusetts ("HPHC" collectively), as the plan fiduciary charged with making the benefit determination regarding Doe, had an obligation to seek readily-available medical evidence from Doe's mental healthcare providers concerning the full panoply of psychological challenges she faced. In failing to help gather medical records for which HPHC would have had no difficulty securing, HPHC violated Section 503 of ERISA. Section 503 mandates ERISA plans, "[i]n accordance with regulations of the Secretary" to "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." 29 U.S.C. § 1133(b). This statutory requirement applies to all claims for benefits under ERISA plans. *Id*.

This unremarkable proposition requiring a fiduciary to assist a participant in obtaining relevant medical records was last and best articulated by the Fourth

Circuit in *Harrison v. Wells Fargo Bank, N.A.*, 773 F.3d 15 (4th Cir.2014). The court held in administering a disability claim governed under ERISA, the fiduciary had an obligation to get "readily available material evidence of which it was put on notice," and in failing to obtain those records violated the basic tenet of full and fair review. *Id*. at 20. The court remarked that a fiduciary may not turn a blind-eye to necessary and easily obtainable records as ERISA envisions a cooperative process. *Id*. at 21.

Although the First Circuit has not tackled this issue in a health insurance claim, the Court is urged to follow the Fourth Circuit, which turned to Tenth Circuit case law which relied on older decisions from the Seventh, Eighth and Ninth Circuits. *See Gaither v. Aetna Life Assur. Co*., 394 F.3d 792 (10th Cir. 2004) (a fiduciary must protect plan against bogus claims and a parallel duty to assure that eligible participants receive benefits they earned by assisting in the claim adjudication process). In addition, the non-adversarial relationship between the fiduciary and the participant prior to litigation mandates that the fiduciary assist in the claim evaluation development procedure to reach a just decision based on available evidence. *Glista v. Unum Life Ins. Co. of America*, 378 F.3d 113, 129 (1st Cir. 2004). This is in accord with both *Harrison* and *Gaither*.

III. ARGUMENT: A FIDUCIARY'S DECISION DENYING BENEFITS THAT FAILS TO PROVIDE FULL AND FAIR REVIEW OF ALL RELEVANT FACTS AND CIRCUMSTANCES IS LEGALLY WRONG AS A MATTER OF LAW ON *DE NOVO* DETERMINATION.

A. HPHC Materially Violated ERISA By Failing To Secure Copies Of Readily Available And Necessary Medical Records.

The First Circuit has not decided head-on whether an ERISA fiduciary must help gather readily-available additional information in deciding a claim for health plan benefits. But finding an affirmative duty imposed on an ERISA fiduciary is not a stretch of current law or the position of the Secretary of Labor. In examining the Secretary of Labor regulations, more than a decade ago this Court noted that a purpose of the claim regulations is to "provide a nonadversarial dispute resolution process" and to resolve benefit disputes foregoing litigation. *Glista v. Unum Life Ins. Co. of America*, 378 F.3d 113, 129 (1st Cir. 2004).

Simply, ERISA requires a fiduciary to investigate and to seek and to obtain readily-available information necessary to decide a benefit claim. The posture of HPHC in avoiding this proposition is perplexing given that during litigation it stipulated to considering certain medical records HPHC neglected to collect pre-suit. (Dkt. No. 18 and No. 20). After deciding that the medical evidence undermined its litigation position, in summary judgment briefing, HPHC urged the trial court to

avoid examining the medical records as HPHC then claimed the review was only part of a settlement discussion. (AA253).

HPHC's assertion runs against fundamental notions that parties may stipulate to facts and are not free to unwind their stipulations made to the court. Parties may not, at-will, extricate themselves from factual stipulations represented as agreed facts to the court. *See TI Federal Credit Union v. DelBonis*, 72 F.3d 921, 928 (1st Cir. 1995) (factual stipulations may only be avoided under burdens to contract defenses such as mutual mistake of both parties). Based on this edict, the District Court should have held HPHC to honor its stipulation of facts and considered the evidence when deciding the case *de novo*.

Besides the ERISA statute, the Secretary of Labor claim regulations contain an anti-abuse rule. An ERISA plan's claims process will be reasonable only if it is "not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims." 29 C.F.R. § 2560.503-1(b)(1)(iii) (2016). This anti-abuse part of the regulation applies to all benefit plans. *See id*. 29 C.F.R. § 2560.503-1(b) (imposing the requirements on "[e]very employee benefit plan"). Avoiding medical information that is readily-available is illustrative of abuse by a fiduciary. Creating a procedural barrier by solely saddling a mentally ill individual the responsibility for securing all medical records is abusive. Based on the actions of HPHC when

examined under the Secretary of Labor claim regulations, this Court should follow the lead of Fourth Circuit, which held that a claims administrator cannot ignore readily-available information that could confirm a participant's entitlement to benefits under an ERISA plan. *Harrison v. Wells Fargo Bank, N.A.*, 773 F.3d 15 (4th Cir.2014).

In explicit language, the Fourth Circuit held in administering a disability claim governed under ERISA that the fiduciary had an obligation to secure copies of "readily available material evidence of which it was put on notice," and in failing to gather those records violated the basic tenet of full and fair review arising under ERISA. *Id*. at 20. The Fourth Circuit noted that a fiduciary could not shirk this duty by engaging in willful blindness by avoiding information that could support the participant's claim for benefits as this violated the duty of loyalty arising under ERISA. *Id*. at 21. In *Glista*, this Court held it was legally indefensible to withhold information pre-suit on which the fiduciary intended to deny a benefit claim but release the grounds later in litigation. The First Circuit held this undermined the required dialogue between the fiduciary and the participant expected under ERISA. *Glista*, 378 F.3d at 129.

In *Harrison*, the plan participant underwent surgery to remove her thyroid. *Harrison*, 773 F.3d at 18. She applied for and was approved to receive short-term

disability benefits, but the benefits were terminated after only three weeks based on a "typical" recovery period. *Id*. Harrison's medical situation was not "typical" and she had to undergo a second surgery. *Id*. While recovering, her husband died suddenly which triggered a recurrence of post-traumatic stress disorder relating to the death of family members in a house fire. *Id*.

After the first denial, Harrison appealed *pro-se* to the insurance company which administered this self-funded plan welfare-benefit plan. *Id*. at 19. The insurance company denied the claim. *Id*. The plan offered a second level of appeal to the employer which Harrison pursued *pro-se*. *Id*. The employer, an ERISA fiduciary, retained two file reviewers, which included a psychiatrist. *Id*. The psychiatric consultant spoke to Harrison's primary care doctor, however, he failed to contact Harrison's psychiatrist. *Id*. The employer determined that Harrison's functional capacity was not limited due to her psychiatric condition and denied her claim for benefits at the second level appeal. *Id*.

The Fourth Circuit held that the employer ERISA fiduciary failed to fulfill its obligation to conduct a full and fair review required by the statute. The court faulted the fiduciary for choosing "to remain willfully blind to readily available information that may well have confirmed Harrison's theory of disability." *Id*. at 20. In reaching this result, the Fourth Circuit looked to other Circuits.

In *Gaither,* the evidence disclosed that Gaither took a significant quantity of narcotics to control bone pain caused by multiple myeloma. *Gaither,* 394 F.3d at 794-95. Gaither filed a claim for disability benefits after he "was suspended from employment because his employer determined that his medical condition – his use of narcotic painkillers – made him unable to perform his job." *Id.* at 794. Gaither's employer mandated a narcotic free workplace, and Gaither could not give-up all of his prescription medicines due to pain conditions. While administering the disability claim the ERISA insurance fiduciary refused to pay Gaither disability benefits because his medical condition did not render him unable to perform his job." *Id.* When the insurance fiduciary defended on grounds that it had no obligation to learn why Gaither lost his job, the Tenth Circuit rejected that argument and reversed. The court wrote in part

> We assert the narrow principle that fiduciaries cannot shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory.

Id. at 807.

The court pointed to similar reasoning in other Circuits. *See Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463–64 (9th Cir.1997) (finding that the fiduciary did not request confirmatory evidence "easily obtainable" from the

plaintiff's dentists); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 476 (7th Cir.1998) (finding benefits denial was an abuse of discretion given that the claims processor had to "under a duty to make a reasonable inquiry" about the employee's skills); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir.1998) (finding that when a beneficiary was diagnosed with scleroderma fiduciary could not deny benefits based on a work termination date when it should have consulted with an appropriate medical expert). Of significance, the Tenth Circuit rejected the insurance company's contention that the court could not impose a sweeping burden on it to scour everywhere for supporting documentation. The court looked to *Vega v. Nat'l Life Ins. Servs., Inc.*, in so holding that it would not impose a broad requirement saddling the fiduciary but noting that the Fifth Circuit had not demanded such a result. See *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 298 (5th Cir.1999) (en banc) (refusing to impose a rule—even on conflicted administrators—that would place "the burden solely on the administrator to generate evidence relevant to deciding the claim, which may or may not be available to it, or which may be more readily available to the claimant").

Together both *Harrison* and *Gaither* and prior decisions achieve the correct policy result required under ERISA and the Secretary of Labor regulations. While the Secretary of Labor regulations do not expressly require a fiduciary to obtain

necessary medical evidence, such a requirement is implied by the case law of the First Circuit contemplating a collaborative process. *Glista*, 378 F.3d at 129. *See e.g*, *Martin v. Polaroid Corp. Long Term Disability Plan*, 2004 WL 1305661, at *1 (D. Mass. 2004). ("The claims process is…a collaborative effort…of the claimant and the plan administrator, the ultimate goal of which is not to trick a claimant out of benefits that he deserves because of a failure on his part to square every corner…"). The burden imposed on the fiduciary in both *Harrison* and *Gaither* hardly increase the duties of the fiduciary. Both courts reiterated that the primary duty to prove benefit entitlement rests with the participant.

ERISA is, however, an unforgiving area of the law that plays an oversized role in our society as the majority of individuals in the United States receive healthcare coverage through private sector employers. Injecting a minimal level of prudence on ERISA fiduciaries to help gather records is not much to ask.

This case presents the First Circuit with the opportunity to join the Fourth and Tenth Circuit which have recognized the duty of an ERISA fiduciary as claims decider to obtain and to consider readily-available evidence necessary to fairly decide health benefit claims and other welfare-benefit claims arising under ERISA.

B. The District Court's Suggestion That Expanding The Claim Record, To Include Medical Records That Were Readily Available And Necessary To Adjudicate The Claim, Would Thwart Full And Fair Review, Runs Against The Non-Adversarial Nature Of The Claims Process.

As argued *supra* the parties filed a stipulation with the District Court expanding the claim record. HPHC backed-out of the stipulation with the approval of the District Court when the facts did not support its argument. The District Court countenanced HPHC's conduct by ignoring available and necessary medical information that was before HPHC after litigation and in front of the District Court before it issued an opinion.

The District Court wrote

> The Court is also wary of converting what may have been reasonable efforts by both parties to resolve the dispute without continuing litigation into a full-blown administrative review. When the parties sought leave of this Court to conduct a review of Jane's claim, they did so in an effort to resolve their dispute short of a disposition on the merits before this Court. An insurer's decision to conduct a further review with the hopes of out-of-court resolution is not one this Court seeks to discourage by reopening the administrative record to documents postdating the administrative decisions that led to the litigation in the first place.

(Docket 70, p. 22). (citation omitted).

To the contrary, expanding the claim record to include documents available and reviewed by a fiduciary furthers ERISA's goal of encouraging pre-suit resolution of claims to the benefit of both parties. In this instance, HPHC suggested an expanded review, filed a joint stipulation with Doe, and in fact HPHC's medical director analyzed the additional information before denying Doe's benefit claim again. Under the most fundamental notion of full and fair review, the District Court erred in not considering the medical evidence that was available, necessary and reviewed by HPHC before it rendered a final decision.

IV. CONCLUSION

The Court should reverse the District Court decision, and award benefits to Ms. Doe.

Respectfully submitted,
HEALTHL LAW ADVOCATS
UNITED POLICYHOLDERS

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CERTIFICATION OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32 (a)(7)(B)(ii), and First Circuit Rule IOP VI A, I hereby certify that this brief uses monospaced font, 14 point Times New Roman. The brief was prepared using Microsoft Word, and contains 3260 words, less than half of the party's principal brief, including all citations but exclusive of all certificates of counsel, according to that system's word count function.

Date: April 16, 2018

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CERTIFICATE OF SERVICE

I hereby certify that on April 16, 2018, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF system. I certify that all counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system, except

/s/ Jonathan M. Feigenbaum
Jonathan M. Feigenbaum