No. 24-61

In the Supreme Court of the United States

MICHAEL CLOUD,
PETITIONER,

v.

THE BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN,
RESPONDENT.

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

BRIEF FOR UNITED POLICYHOLDERS AS *AMICUS CURIAE IN SUPPORT OF PETITIONER*

ELIZABETH HOPKINS
Counsel of Record
KANTOR & KANTOR, LLP
9301 Corbin Ave.
Suite 1400
Northridge, CA 91324
(818) 886-2525
ehopkins@kantorlaw.net

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, DC 20002

QUESTION PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA") permits participants and beneficiaries of employee benefit plans to sue to obtain benefits under their plan, to enforce rights under the terms of the plan and to clarify their right to future benefits under the plan. 29 U.S.C. § 1132(a)(1)(B). Because the statute does not set forth the standard that courts reviewing benefit denials are to apply, this Court in *Firestone Tire & Rubber Co. v. Bruch*, drew from trust law principles to fill this gap, holding 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." 489 U.S. 101, 115 (1989).

Lower courts, however, have struggled with this two-tier standard, particularly where plan fiduciaries who have been granted discretionary authority have committed significant procedural violations of ERISA's claim-processing requirements in deciding claims. And Circuit Courts have adopted conflicting approaches in reviewing benefits denials that result from an insufficient or unfair review process. This disarray in the courts has increasingly led to strikingly unjust results for plan participants and beneficiaries seeking critically-important disability and health benefits, as exemplified by this case.

The question addressed by United Policyholders as *amicus curiae* is whether a court reviewing a denial of ERISA benefits must decide the claim as a *de novo* matter when the plan fiduciaries have committed significant procedural violations in denying the benefits.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

FEDERAL CASES

FEDERAL STATUTES

FEDERAL REGULATIONS

OTHER AUTHORITIES

INTEREST OF THE AMICUS CURIAE[1]

United Policyholders is a non-profit 501(c)(3) organization whose mission is to be a trustworthy and useful information resource and an effective, well-informed advocate in all 50 states for consumers of all types of insurance. Founded in 1991, United Policyholders helps level the playing field between insurers and insureds.

Among other things, United Policyholders: (1) provides tools and resources for solving insurance problems after an accident, loss, illness, or other adverse event; (2) promotes disaster preparedness and insurance literacy through outreach and education in partnership with civic, faith-based, business, and other nonprofit associations; and (3) advances pro-consumer laws and public policy related to insurance matters.

In furtherance of its mission, United Policyholders cautiously chooses cases and regularly appears as an amicus curiae in courts across the country in order to provide policyholders' perspectives on insurance cases likely to have widespread impact. United Policyholders has been doing this for decades. Since 1991, it has filed hundreds of amicus curiae briefs in state and federal courts across the country. A list of those submissions can be found here: https://uphelp.org/advocacy/amicus-library. United Policyholders' briefs have been cited favorably in the opinions

---

[1] The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no party or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus curiae, its members, or its counsel made a monetary contribution to its preparation or submission.

of state high courts and by the U.S. Supreme Court. *Humana Inc. v. Forsyth*, 525 U.S. 299, 314 (1999).

This case involves a claim for disability benefits by Petitioner Michael Cloud, a former NFL football player suffering from severe neurological impairment, under the Bert Bell/Pete Rozell NFL Player Retirement Plan (the "Plan" or the "NFL Plan"). The Plan is a collectively-bargained, ERISA-governed disability plan administered by a joint board of union and management appointees (the "Board" or the "Retirement Board") expressly named as the fiduciary empowered, among other things, to decide benefit appeals. Pet. App. 2a-3a, 6a-7a. After being denied the highest level of benefits on his reopened claim, Cloud filed suit in federal district court in Texas. *Id*. at 10a-11a. Following extensive discovery and a six-day bench trial, the district court entered judgment in Cloud's favor. *Id*. at 20a-129a.

Although the litigation revealed what the Fifth Circuit described as "the NFL Plan's disturbing lack of safeguards to ensure fair and meaningful review of disability claims by former players who suffered incapacitating on-the-field injuries, including severe head trauma," *id*. at 3a, the Circuit Court nevertheless reversed the district court's entry of judgment in favor of Cloud, and remanded for entry in favor of the Plan. *Id*. at 19a. Focusing on the fact that the Plan document "gives the Board absolute discretion to construe the terms of the Plan," the Fifth Circuit upheld the Board's denial on the ground that its interpretation of the "changed circumstances" that would enable Cloud to reopen his previously denied claim for benefits "was a reasonable and fair reading of the phrase." *Id.* at 17a. Thus, the Fifth Circuit concluded that "[w]hile we share the district court's unease with a daunting system that seems stacked against disabled ex-NFLers, we cannot say the Board abused its discretion in denying reclassification due to Cloud's failure to show changed circumstances." *Ibid*.

Although the Plan at issue in this case is not funded by insurance or administered by an insurance company, in the ERISA context, the statute, regulations and rules developed in the courts generally apply to all employee benefit plans, whether or not benefits under these plans are covered by and paid under an insurance policy. This is true with respect to the deference courts reviewing benefit denials afford the fiduciaries that decide benefit claims. Therefore, as a matter of public policy, United Policyholders has a strong interest in ensuring that courts do not defer to plan fiduciaries of insured and self-funded plans alike who, like the Board in this case, have failed to live up to their responsibilities under ERISA to decide benefit claims under a full and fair procedure.

SUMMARY OF ARGUMENT

1. In its three decisions addressing the standard of review that courts should apply in reviewing ERISA benefit denials, this Court has never addressed the standard applicable where a discretionary fiduciary has decided a claim under a procedure that does not comply with ERISA's claims processing and fiduciary requirements. Consequently, courts of appeals have adopted conflicting approaches. On the one hand, several circuits require *de novo* review at least in some circumstances where discretionary decisionmakers have failed to abide by ERISA standards in deciding claims. On the other, at least two circuits mandate deferential, arbitrary and capricious or abuse of discretion review in all circumstances, even those involving significant or egregious violations of ERISA's claims processing requirements.

2. This disarray in the Circuits has led to unjust decisions, as well as to confusion and delay in the lower courts. The decision from the Fifth Circuit in this case is a stark example of the former. Despite the district court's detailed

documentation of not simply failures to abide by regulatory requirements, but a whole system designed to thwart and deny high-level benefits to NFL players suffering from severe head trauma, as well as the Fifth Circuit's candid acknowledgement that Mr. Cloud is likely entitled to the benefits he sought, the appellate court applied the lenient arbitrary and capricious standard to uphold the denial. And other cases where district courts feel compelled to remand to claims administrators that they have already determined engaged in substantially violative practices are examples of the latter.

3. Nothing in this Court's prior decisions precludes application of *de novo* review of a benefit denial where a claims fiduciary has engaged in substantial claims processing violations. To the contrary, the factors that this Court has identified as relevant to deciding the appropriate standard – what the trust law provides and what is most consistent with ERISA's text and purposes – all point to *de novo* review where a fiduciary has denied a claim employing an unfair claims procedure in violation of ERISA's requirements. Because deciding a benefit claim is a fiduciary activity, a fiduciary that denies a claim under a procedure that does not comply with ERISA's claims processing requirements, violates ERISA. The violation is substantial and indeed egregious when, as here, the fiduciary has employed "a daunting system that seems stacked against disabled ex-NFLers." Pet. App. 17a. Under the trust law, a court is empowered to "interpose" in such situations and need not and should not defer to even a fiduciary who has been granted discretionary authority. So too, ERISA's focus on ensuring that plan participants get the benefits they are owed, and its requirement that they are provided with a fair process for doing so, also point to *de novo* review where a benefit claim has been denied in the absence of a fair procedure.

ARGUMENT

I. Overview

This Court has addressed the appropriate standard of review for courts reviewing benefit denials in three principal cases. First, in the *Firestone* decision, this Court rejected arbitrary and capricious review as the background standard in ERISA benefit claims, despite the fact that many courts at that time, drawing from the Labor Management Relations Act, had adopted that standard. *See* 489 U.S. at 109. Given ERISA's remedial purposes focused on promoting "'the interests and employees and their beneficiaries in employee benefit plans'" and protecting "'contractually defined benefits,'" *id*. at 113 (quoting *Shaw v. Delta Airlines, Inc.,* 463 U.S. 85, 90 (1983), and *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 148 (1985)), the Court declined to adopt "a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 114. Instead, the Court held that, "[c]onsistent with established principles of trust law," the denial of a benefit claim "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.

The Court had a second occasion to address the standard of review in *Metropolitan Life Insurance Co. v. Glenn*, this time focusing on how to determine whether a fiduciary decisionmaker is operating under a conflict of interest and, if so, how to account for that conflict. 554 U.S. 105, 111 (2008). With regard to the former question, the Court held that an entity that both funds plan benefits and decides claims is operating under a conflict of interest in the relevant sense. *Id*. at 112-115. As to the latter question, the Court declined to adopt a rule that would change the standard of review of the "discretionary decisionmaking of

a conflicted" fiduciary "from deferential to *de novo* review." *Id*. at 115. Instead, the Court reiterated and "elucidate[d] what this Court set forth in *Firestone*, namely, that a conflict should 'be weighed as a factor in determining whether there is an abuse of discretion.'" *Ibid*. (quoting *Firestone*, 489 U.S. at 115, additional citation and punctuation omitted).

Two years later, this Court addressed "whether a single honest mistake in plan interpretation justifies stripping the administrator of that deference for subsequent related interpretations of the plan." *Conkright v. Frommert*, 559 U.S. 506, 509 (2010). The Court held that "it does not." *Ibid*. In reaching this conclusion, the Court relied on "the considerations on which our holdings in *Firestone* and *Glenn* were based – namely, the terms of the plan, principles of trust law, and the purposes of ERISA." *Id*. at 513.

These three decisions leave open the issue raised by Petitioner in this case: how to account for significant procedural violations committed by a discretionary decisionmaker. As discussed below, this issue has led to significant conflicts in the Circuits and to unsatisfactory results that have frustrated courts and litigants alike. United Policyholders therefore believes that it is appropriate for this Court to grant Cloud's Petition for Writ of Certiorari to clear up the confusion and that, indeed, his case presents an ideal vehicle for doing so.

II. The Court Should Grant Certiorari to Resolve A Circuit Split Over Deference to be Accorded by Courts to Fiduciaries Who Have Denied Benefit Claims Without Engaging in a Full and Fair Claims Process

Federal Circuit courts have been far from uniform in applying *Firestone* review principles in cases where fiduciary decisionmakers who have been granted discretion

have violated ERISA procedural requirements in deciding benefit claims.

The Second, Eighth, Ninth and Tenth Circuits stand on one side of the divide, applying *de novo* review to denials that result from either non-*de minimis* or flagrant violations, respectively, of ERISA claims processing requirements. But they are not uniform in their application of *de novo* review.

For instance, in *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), the Second Circuit addressed the applicable standard of review that courts should apply when plan fiduciaries fail to comply with the Department of Labor's claims regulations in denying claims for medical benefits. It disagreed with the district court that so long as the claims administrator substantially complies with the regulations, the administrator's denial of benefits is to be reviewed under a deferential arbitrary and capricious standard. *Id*. at 56. Instead, deferring to the Department of Labor's interpretation of the amended version of the claims regulations it adopted in 2000, *id*. at 54 (citing *Auer v. Robbins*, 519 U.S. 452, 461 (1997); *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989)), the Second Circuit held 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 regulation in the processing of a particular claim was inadvertent *and* harmless." 819 F.3d at 57-58.

Taking a somewhat less strict approach, the Eighth Circuit has substituted *de novo* for deferential review when the plan administrator has committed severe procedural

violations in denying a claim for benefits. *Trs. of Electricians' Salary Deferral Plan v. Wright,* 688 F.3d 922, 927 (8th Cir. 2012).

In a similar vein, the Ninth Circuit differentiates cases involving less substantial procedural violations by discretionary fiduciaries, which do not require departure from deferential review, from cases where "the violations are so flagrant as to alter the substantive relationship between the employer and employee." *Gatti v. Reliance Standard Life Ins. Co.,* 415 F.3d 978, 984-85 (9th Cir. 2005) (citing *Blau v. Del Monte Corp.,* 748 F.2d 1348 (9th Cir. 1984), *abrogation on other grounds recognized by Dytrt v. Mountain State Tel. & Tel. Co.,* 921 F.2d 889, 894 n. 4 (9th Cir. 1990), as an example of the latter). The Ninth Circuit has reasoned that "[w]hen an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well," *de novo* review is appropriate under *Firestone* because "a plan administrator's decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th Cir. 2006) (en banc) (citing *Firestone*, 489 U.S. at 111). This is because, as the Ninth Circuit sees it, "decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority." *Abatie*, 458 F.2d at 971-72.

In yet another variation, the Tenth Circuit applies *de novo* review of a claims denial where there has not been substantial compliance with the timing or other requirements of the Department of Labor's claims processing regulations. *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 636-37 (10th Cir. 2003) (remanding to the district court for *de novo* review of claim for disability benefits where admin-

istrator failed to substantially comply with the claims regulations through a "meaningful dialogue" with claimant). More recently, the Tenth Circuit has rejected a claimant's argument for strict adherence to the claims regulation requirements, indicating that abuse of discretion review of a denial by a discretionary fiduciary is the proper standard even when such a fiduciary does not substantially comply with ERISA claims regulations, although this is likely dicta given that the court viewed plaintiff's argument as "fruitless" because the court also concluded that the denial was an abuse of discretion. *Ian C. v. UnitedHealthcare Ins. Co.*, 87 F.4th 1207, 1218 (10th Cir. 2023).

On the other side of the divide, the Fifth and Seventh Circuits apply deferential review even when a denial of benefits results from a non-compliant claims process. For instance, in the Fifth Circuit, when the administrator fails to substantially comply with ERISA's procedural requirements, remand to the administrator is considered the appropriate remedy rather than substantive remedies or judgment in the claimant's favor. *LaFleur v. Louisiana Health Serv. & Indem. Co.*, 563 F.3d 148, 157-58 (5th Cir. 2009). Furthermore, as exemplified by the decision of the Fifth Circuit in this case, even wholesale and "disturbing" non-compliance does not result in a change in the standard of review from deferential to *de novo*. Pet. App. 3a. *But see Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 694 F.3d 557, 567 (5th Cir. 2012) (noting that although the Fifth Circuit "has rejected arguments to alter the standard of review based on procedural irregularities in ERISA benefit determinations, such as delays in making a determination . . . a flagrant violation or utter disregard of the Plan [] might require a heightened standard of review").

So too, the Seventh Circuit has declined to apply *de novo* review, instead holding that arbitrary and capricious review applies even where there are procedural errors,

which are simply factors to be considered in determining if the plan administrator's interpretation was reasonable. *Weitzenkamp v. Unum Life Ins. Co. of Am.*, 661 F.3d 323, 329 n. 3 (7th Cir. 2011).

All of this doctrinal disarray in the Circuits concerning application of *Firestone* principles where claims administrators have failed to abide by procedural requirements in deciding benefit claims has led to even greater confusion and frustration in the district courts. And this confusion is not without consequence. To the contrary, it has often led to questionable results in district courts reviewing benefit denials, as discussed next.

III. Application of *Firestone* Deference in Cases Involving Substantial Procedural Irregularities Leads to Unfair and Even Absurd Results and Abusive Practices

Almost from the beginning, there have been well-founded critiques of arbitrary and capricious review under *Firestone*, particularly where fiduciaries fail to decide claims under a fair process. *E.g.*, John H. Langbein, *Trust Law As Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA* (hereinafter *"The Unum/Provident Scandal"*), 101 Nw. U. L. Rev. 1315 (2007). Indeed, as Professor Langbein points out, lawsuits and state investigations into highly questionable disability claims practices by Unum/Provident Corporation in the early 2000s uncovered an internal memorandum at Unum from a decade earlier that extolled the advantages of ERISA for insurance companies denying benefit claims, citing, among other things, that "claims administrators may receive a deferential standard of review." *The Unum/Provident Scandal* 101 Nw. U. L. Rev. at 1321. A review standard that rewards insurers and other plan fiduciaries with deferential review of their denials in all circumstances may be likely to encourage violative claims processing practices,

particularly where the fiduciaries operate under a direct or indirect financial conflict of interest. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 (2002) (referring to deferential review of benefit denials as "highly prized by benefit plans").

This case paints a revealing but bleak picture of the problems that may ensue if courts simply defer to denials from discretionary decisionmakers even when there have been wholesale and systemic process failures in claims processing. As detailed by the district court, the Board failed in numerous respects to provide a full and fair review of the denial of Cloud's claim for reclassification to the highest level of disability benefits. Pet. App. 88a.

The district court found that "the Board did not review its own stated bases for rejecting Plaintiffs claim," and that its denial letters failed to comport with the claims regulations because these letters did not reference or discuss some of the Board's reasons for denial. *Id*. at 88a, 91a. The court also found that the Board did not review all of the documents in the claims record and instead "relied on 'advisors' to review Plaintiff's file, including the facts of his case, medical records, and other specifics," including a law firm paralegal. *Id.* at 92a-93a. The court then faulted the Board for improperly affording deference to a denial decision from the Committee charged with making initial benefits determinations in direct violation of the claims regulations. *Id.* at 88a. The court additionally found that the Board failed to consult with an appropriate medical professional as required by the regulations and recommended by one of the Plan's own neutral doctors, who informed the Board that "neuropsychological testing was 'essential' to evaluate Plaintiffs traumatic brain injury." *Id*. at 96a-97a.

These process failures led, in the district court's view, to an incorrect denial of benefits. Pet. App. 124a-25a.

Moreover, the district court found that "[t]he Board's review process, its interpretation and application of the Plan language, and overall factual context all suggest an intent to deny Plaintiff's reclassification appeal regardless of the evidence." *Id*. at 124a. And this was not an isolated instance, in the district court's view, but was "part of a larger strategy" to improperly deny benefits, as evidenced by the fact that "out of the thousands of former players who filed applications for benefits, only 30 players currently receive Active Football benefits." *Id.* at 125a.

The Fifth Circuit did not disagree with the district court's factual findings. To the contrary, the appellate court "commend[ed] the district court for its thorough findings," acknowledged that "the NFL Plan's review board may well have denied Cloud a full and fair review," and concluded that "Cloud is probably entitled to the highest level of disability pay," Pet. App. 3a. Despite all this, the appellate court deferred to the Board's interpretation of "changed circumstances," and on that basis concluded that Cloud was not entitled to reclassification of his level of benefits. *See id*. at 17a ("we cannot say the Board abused its discretion in denying reclassification due to Cloud's failure to show changed circumstances"). In other words, application of a deferential standard of review led the Fifth Circuit to deny benefits to a disabled participant who is "probably entitled" to them and whose claim was denied under "a daunting system that seems stacked against disabled ex-NFLers." *Ibid*.

Other cases likewise shed light on the difficulties that courts face and the unsatisfying results that often follow when courts apply deferential review to decisions reached under flawed processes. For instance, in a case in which a father sought to overturn a denial of benefits for residential psychiatric treatment for his young son, the district court granted summary judgment to the family, criticizing

the administrator for not engaging with the family and issuing denials that were conclusory, inaccurate, and shifting in their rationales. *H.R. v. United Healthcare Ins. Co.*, No. 2:21-cv-00386, 2024 WL 3106468, at *19 (D. Utah Jun. 24, 2024). Nevertheless, despite the court's sharp critique of the process failures, the district court felt compelled under Tenth Circuit precedent to remand to the administrator for further consideration of the claim. *Id*. at *20 ("When the court concludes a plan administrator's denial of benefits was arbitrary and capricious, it 'may either remand the case to the plan administrator for a renewed evaluation of the claimant's case or [it] may order an award of benefits.'") (citation omitted).

Another judge in Utah overturned as arbitrary and capricious a denial of mental health benefits for a family who sought coverage of hundreds of thousands of dollars in unreimbursed psychiatric care for their daughter, noting that the claims fiduciary for the plan largely ignored the voluminous medical record, which included 1,700 pages of exhibits, and provided only vague and conclusory explanations, without reference to, and often in conflict with, the medical records. *Anne A. v United Healthcare Ins. Co.*, No. 2:20-CV-00814, 2024 WL 1307168, *4, *7-*8 (D. Utah Mar. 26, 2024). Tellingly, the court expressed concern about the somewhat murky guidelines for determining the appropriate remedy where plaintiffs have demonstrated these kinds of ERISA procedural violations. *Id*. at *10. Even though the family's enormous costs had gone unreimbursed for eight years already, *id*. at *1, the district court ultimately concluded that a remand to the administrator was required, albeit with certain guardrails limiting the scope of the renewed review by the administrator. *Id.* at *11. *See also K.S. v. Cigna Health & Life Ins. Co.*, No. 1:22-cv-00004, 2024 WL 3358653 (D. Utah Jul. 8, 2024) (reversing and remanding an arbitrary and capricious denial of a

boy's claim for residential treatment during a severe mental health crisis after the insurance company administering the claims ignored the patent's four suicide attempts and prior failed treatment).

Clearly, the current system of deference even to decisions issued under terribly flawed procedures is not working well for either plan participants and beneficiaries or the courts.

IV. Deference to a Benefit Denial is Unwarranted Where the Fiduciaries Deciding the Claim Have Committed Substantial Procedural Violations in Processing the Claim

Nothing in *Firestone* or other decisions from this Court make deferential review necessary or even appropriate when an administrator has failed to provide a fair process and has substantially violated ERISA's claims regulations. Indeed, *Firestone* makes *de novo* and not deferential review the "general or default rule." *Rush Prudential*, 536 U.S. at 385. Furthermore,"[n]ot only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly." *Ibid*.

Nor do trust law principles on which the Court in *Firestone* drew support deferential review of a claims administrator's decision denying benefits under a claims procedure that violates ERISA. To the contrary, it is well-established in the trust law that "a court may properly interpose if it finds that the trustee's conduct, in exercising a discretionary power, fails to satisfy the applicable standard of care, skill, and caution." Restatement (Third) of Trusts, § 87 cmt. c. (2007). Given that courts "should consider a benefit determination to be a fiduciary act (*i.e.,* an act in which the administrator owes a special duty of loyalty to the plan beneficiaries)" *Metropolitan Life*, 554 U.S. at 111

(citing *Firestone* 489 U.S. at 113)(additional citations omitted), a court should be empowered under this venerable trust law principle to "interpose" and conduct a plenary review of a denied claim when a fiduciary administrator fails to meet the requirements of the claims regulations and to provide full and fair review of a claim for benefits. *See Halo*, 819 F.3d at 52 (discussing this point).

Perhaps most importantly, ERISA's text and purposes support reviewing benefit denials as a *de novo* matter when there has been a substantial failure to comply with ERISA's requirements for a full and fair claims process, that meets the minimum standards set forth in claims regulations promulgated by the Department of Labor an express delegation of authority.[2] More generally, "rather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility." *Central States Se. & Sw. Areas*

---

[2] ERISA Section 503 provides:

In accordance with regulations of the Secretary, every employee benefit plan shall –

(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 reason for the 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 an appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. The Secretary has promulgated such regulations, which have been amended several times since ERISA's enactment. *See* 29 C.F.R. § 29 C.F.R. § 2560.503–1.

Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570 (1985). To this end, ERISA imposes "strict standards of trustee conduct, also derived from the common law of trusts—most prominently, a standard of loyalty and a standard of care." *Ibid*. Deciding the benefit claim of a disabled plan participant under the kind of procedures described by both the Fifth Circuit and the district court in this case does not comport with these fiduciary requirements. *See* Pet. App. 11a-12a (describing numerous failures of process by the Board deciding Cloud's claim and quoting the district court concerning "'the troubling but apparent reality that these abuses by the Board are part of a larger strategy engineered to ensure that former NFL players suffering from the devastating effects of severe head trauma are not awarded [maximum] benefits").

ERISA, as this Court has repeatedly emphasized, does not require employers to establish employee benefit plans, but once they have done so, ERISA aims "to ensure that they [] receive the benefits they [have] earned." *Conkright*, 559 U.S. at 1648 (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)). A rule that requires courts to defer to benefit denials reached under an unfair and non-compliant process does not serve this goal.

Nor does deference in such situations serve ERISA's "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Aetna Health Inc. v. Davila,* 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 54 (1987)). This balance requires, at a minimum, a "fair" process for determining plan benefits. In the absence of such a process, the balance is far too lopsided to advance any of ERISA's goals, as this case demonstrates.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

ELIZABETH HOPKINS
Counsel of Record
KANTOR & KANTOR
9301 Corbin Ave.
Suite 1400
Northridge, CA 91324
(818) 886-2525
ehopkins@kantorlaw.net

Counsel for Amicus Curiae

August 19, 2024