

# 12-1447cv

IN THE UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

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TIFFANY HALO  
Plaintiff-Appellant, *pro se*

v.

YALE HEALTH PLAN, DIRECTOR OF BENEFITS & RECORDS YALE  
UNIVERSITY,  
Defendant-Appellee.

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On Appeal from the United States District Court  
For the District of Connecticut  
Case No. 3:10-CV-1949 VLB

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BRIEF OF THE ACTING SECRETARY OF LABOR, SETH D. HARRIS,  
AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT

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## STATEMENT OF THE ISSUES

1. Whether Yale Health Plan's violations of procedural protections in the Secretary of Labor's claims regulation entitled plaintiff to de novo review of her claim for medical benefits by the district court.
2. Whether the district court erred in holding that plaintiff failed to exhaust the claims process with regard to some of her claims for benefits.

## STATEMENT OF INTEREST

The Secretary of Labor administers and enforces Title I of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.* This case concerns the application of the Secretary's regulation governing claims procedures for group health plans, which were issued pursuant to express rulemaking authority in ERISA section 503, 29 U.S.C. § 1133. The Secretary has a strong interest in the proper construction of the regulation's procedural requirements, and the consequences of widespread failures to comply with those regulatory requirements.

## STATEMENT OF THE CASE

1. Plaintiff Tiffany Halo was a graduate student in the Yale University PhD Chemistry program, and, as a Yale employee, a participant in the YHP, which the parties agree is governed by ERISA. The plan provides that, "[i]n general outpatient care received out of the YHP network of health care clinicians and facilities is not covered . . . . The two exceptions to this are outpatient care received

for an emergency or urgent condition. . . and care that has been arranged in advance . . . and approved by the Care Coordination Department." Ex. A at p. 61. The plan provides that "[e]mergency care and pre-authorized follow-up care for emergency conditions" is "covered at 100% regardless of location." The plan defines an "emergency condition . . . as a major acute medical problem or major acute trauma that requires immediate medical attention, or a condition that could lead to serious harm if treatment is not received or delayed." The plan provides the same coverage for out of network care for an urgent condition when a participant is "out of area." The plan defines an "urgent condition" for these purposes "as the sudden and unexpected onset of an acute medical problem or trauma that requires immediate medical attention." The plan allows YHP to deny coverage "if, in the judgment of YHP, the illness or injury does not meet the plan definition of an emergency or urgent condition," further explaining that "[c]overage will be denied for conditions that could have been treated at YUHS but were not." *Id.* at 62-63.

In late May 2008, Halo developed a vision problem and was seen at the YHP Urgent Care center, and subsequently referred to Yale New Haven Hospital. She had surgery to re-attach her retina on June 1, 2008 and, after a referral to an in-network specialist for a second opinion, had another operation on June 13, 2008 because the first one was unsuccessful. Halo v. Yale Health Plan, 2012 WL 774960, at \*1 (D. Conn. March 8, 2012). Several days later, Halo obtained further

treatment in-network after awakening with severe pain. Id. YHP apparently treated the medical care she received up to this point as emergency services under the YHP plan, covering all claims at 100%, with no required copayments.

On June 16, 2008, Halo requested, and YHP approved, a referral to an out-of-network, out-of-area eye specialist in New York, Dr. D'Amico. Ex. C. The parties dispute the scope of the approved referral, but when Dr. D'Amico saw Halo on June 17, he determined that immediate treatment was necessary to address three substantial issues: (1) allergy to the sutures, which he removed; (2) indications of infection; (3) elevated eye pressure, requiring aspiration. 2012 WL 774960, at \*2-3. Dr. D'Amico began treating Halo for these conditions, and saw her for follow-up appointments on June 18, June 20, and June 26. Ex. B at pp. 21-35.

Halo alleged that between June 17 and July 30, she and her mother made many calls to YHP's Care Coordination Department, in accordance with the plan's terms, to coordinate her future care. Ex. A at pp. 30-31, 62- 63. She claimed neither she nor her mother received any response. On June 26, Dr. D'Amico's office sent a claim to YHP for services and procedures performed on June 17 and 18, 2008. Ex. D. On July 30, YHP issued an Explanation of Benefits (EOB) in which it agreed to pay only for the second opinion by Dr. D'Amico, but not the bulk of the bill attributable to other services performed. The EOB stated only that

the services were not authorized and gave a phone number to call for questions.

Ex. E.

On August 5, Halo saw Dr. D'Amico, reporting further vision problems. Dr. D'Amico diagnosed another retinal detachment and retinal break, a traumatic cataract, and macular puckering of the retina. He scheduled her for surgery the next week. Ex. B at pp. 36-39. On August 7, 2008, Halo appealed the initial denial of the claims for the June 17 and June 18 services, and notified YHP that Halo was scheduled for the surgery on August 13. Ex. F.

Notes of an August 11, 2008 telephone call between YHP's ophthalmologist Dr. Forster and Halo indicate that Dr. Forster recommended that Halo have the surgery with an in-network surgeon in New Haven, and advised Halo that she needed to stay in network. These notes also indicate that Halo said she intended to proceed with the surgery with Dr. D'Amico in New York "in spite of the YHP denial of coverage." Ex. H. There is no indication in the record that Dr. Forster considered whether the surgery might be covered as emergency or urgent care. Indeed, the record indicates that Dr. Forster did not have the medical records from Dr. D'Amico's August 5 diagnosis (which was not faxed to YHP until October 21, 2008), or information about Halo's ability to travel safely with her eye condition. Ex. B at pp. 36-39. Dr. D'Amico performed the surgery on August 13.

On August 15, 2008, YHP issued a decision on the Halos' initial appeal of the benefits denial for June 17-18. The decision stated that the initial denial was correct, but concluded that because Halo and her doctor may not have understood the approval's limited scope, YHP would negotiate with Dr. D'Amico's office to pay for usual and customary charges for the June 17-18 services. Although the decision stated that "[c]overage for non-emergency out of network care is not part of your health care benefit with Yale Health Plan," it did not address whether the services could nevertheless have been covered under the plan as emergency or urgent care. In addition, the decision stated that YHP had communicated to Halo clearly and explicitly that "further visits and follow-up surgery with Dr. D'Amico would be denied" because of the availability of network specialists that could provide the care; there was no discussion about whether such further visits or surgery might qualify for coverage as emergency or urgent care. Ex. J.

On September 8, 2008, Halo appealed both the initial appellate decision regarding the June 17-18 services, and the denial of coverage for the August 13 operation. The appeals described the nature of Halo's medical problems during the period from late May onward, the surgeries she had, the fact that Dr. D'Amico was concerned about further complications because of the length of time her retina was detached, and the fact that she went to New York with YHP approval to consult a specialist, not with the intent to seek further out-of-network treatment. Ex. K. She

only sought such treatment when, as it turned out, her "medical emergency put her health and life in danger." Id.

On September 18, 2008, YHP's Claims Committee sent a letter stating that the Committee had decided to approve payment for the two office visits in June, and "to uphold the denial of payment for surgery on August 13, 2008." Ex. L. The decision offered no reasons for the denial, no reference to applicable plan provisions, no reference to medical records, no indication the Committee had considered whether the surgery might be covered as emergency/urgent care (indeed, the record indicates the Committee did not have any medical records from Dr. D'Amico relating to the August 5 diagnosis or the August 13 surgery), and did not inform Halo of her appeal rights. There is also no indication that Halo was ever contacted, as the plan provides she would be, "if further information is needed to assist in the determination." Ex. A at p. 41.

Meanwhile, on September 10, 2008, Halo went again to see Dr. D'Amico, reporting "an increasingly large black spot" in her field of vision. Dr. D'Amico concluded that she needed another retinal detachment surgery, which he performed on September 17, 2008. Ex. B at pp. 47-52. On September 25, Dr. D'Amico's office sent a claim to YHP for the September 17 surgery. Ex. P.

On September 29, 2008, Halo's father asked the YHP Claims Committee to revisit its denial of coverage for the August 13 surgery. Ex. M. On November 6,

2008, the Claims Committee replied stating "that the Claims Committee voted unanimously to uphold the denial of payment for these services." Ex. N. Again, there was no explanation of the reasons for the denial, the applicable plan provisions, or of Halo's right to bring suit. In addition, the Committee gave no indication that it considered whether the services might qualify as covered emergency or urgent care, or describe any consultation with any appropriate medical professional about whether they so qualified. On November 7, 2008, YHP issued an EOB denying Halo's claims for visits with Dr. D'Amico on June 20 and June 26, and for the September 17 surgery, with the description "Service Not Authorized."

Ex. Q. No other explanation of the reasons for the denial or the applicable plan provisions was given, and nothing was said about the right to appeal. Instead, this EOB directed Halo to call a listed phone number if she had questions. There is no indication in the record that YHP considered the possibility that the services might be covered as emergency/urgent care.

2. On December 13, 2008, Halo sued for benefits. She argued, among other things, that YHP "fail[ed] to comply with procedures and stringent time tables for processing benefit claims" under the regulations and the plan terms and, for that reason, the court should review her claim for benefits de novo. Pl[']s Opp. Mem., at 1-2. The court, however, granted YHP's motion for judgment on the

administrative record, which it treated as a motion for summary judgment. 2012 WL 774960, at \*1, \*7.

The court determined that the denials were entitled to arbitrary and capricious review because the relevant plan language conferred discretionary authority on YHP to interpret the plan and determine whether an illness or injury met the plan's definition of an emergency or urgent condition. 2012 WL 774960, at \*9. The court held that it need not address whether YHP violated requirements under the claims regulations (or apparently Halo's claim that she was entitled to de novo review on that basis) because Halo already obtained the only remedy available for a plan's failure to comply with the regulatory requirements, namely, the ability to sue in federal court. Id. at \*12-13. In addition, the court held (notwithstanding its first ruling) that it could not entertain certain of Halo's claims because she failed to exhaust her administrative remedies under the plan. Id. at \*13.

Moreover, relying on language in the August 15, 2008 denial that "coverage for non-emergency out of network care is not part of your health care benefit with Yale Health Plan," the court held that YHP met the regulatory requirement that it provide sufficient notice of its reason for denying coverage, and "by implication," gave Halo "a description of how she could perfect or cure her claim and thereby enabled her to have a fair chance to present her case on appeal." 2012 WL 774960,

at \*14-15. The court found that Halo "failed to address those determinative issues on appeal and therefore failed to carry her burden to establish that she was entitled to the benefit pursuant to the terms of the plan" because she did not present YHP with medical records supporting her contention that her treatments were for an emergency or urgent condition under the terms of the plan. Id. at \*15-16. The court therefore concluded that the denials were supported by substantial evidence, and were not arbitrary or capricious even if YHP was operating under a conflict of interest. Id. at \*16.

#### SUMMARY OF ARGUMENT

The record in this case indicates that YHP's fiduciaries repeatedly violated the procedural requirements of the claims regulations (as well as the plan's own procedural requirements), resulting in a fundamentally flawed decisionmaking process. The nature and degree of procedural irregularities, including the repeated violations of the timing, notification, content, and manner of decision making requirements of 29 C.F.R. § 2560.503-1, more than suffice to establish that YHP did not substantially comply with the regulations' requirements. Nor did the decisions address whether Halo's claims were for emergency or urgent care. Halo is therefore entitled to de novo judicial review of her claims by the district court.

In addition, because YHP's decision denying certain of plaintiff's claims failed to comply in nearly all material aspects with the claims regulations, she

should be deemed to have exhausted the plan's claims process and was entitled to bring her claim for benefits in district court.

## ARGUMENT

### I. THE YALE HEALTH PLAN REPEATEDLY VIOLATED THE CLAIMS REGULATIONS

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 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 full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. Pursuant to section 503's directive, the Secretary has twice promulgated regulations governing the claims process, designed to "set[] forth the minimum requirements for employee benefit plan procedures pertaining to claims for benefits." 29 C.F.R. § 2560.503-1(a). Although it is well established that ERISA favors exhaustion of administrative remedies before commencing suit for benefits in federal court, Alfarone v. Bernie Wolff Constr., 788 F.2d 76, 79 (2d Cir. 1986), under the current regulations, which were promulgated in 2000 and govern this case, a claimant is "deemed to have exhausted the administrative remedies under the plan" and the participant may bring suit under section 502(a) of

ERISA and "pursue any available remedies" under that section if a plan fails "to establish or follow claims procedures consistent with the requirements" of the regulation. 29 C.F.R. § 2560.503-1(l). Moreover, in the regulation's preamble, the Secretary stated that this "deemed exhaustion" provision was intended "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." 65 Fed. Reg. 70246, 70255 (Nov. 21, 2000).<sup>1</sup>

The regulations set forth numerous requirements regarding timing of claims determinations, the form and content of initial denials and appeals, the manner of appellate review, access to relevant documents, and other matters. These detailed procedures are meant to give participants notice of the reasons for adverse determinations so that they have the opportunity to address those determinations and present evidence and arguments on appeal, to have documents relevant to the determination, and to ensure a fair and objective consideration of medical evidence

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<sup>1</sup> Although the Department of Labor has stated in FAQs about the claims regulations that inadvertent deviations from procedures otherwise established in "full conformity with the regulation" will not trigger the deemed exhausted provision where "the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, through the internal appeal process or otherwise," [http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html), as described below, YHP's violations of the regulation's procedural requirements were not inadvertent and harmless deviations that Halo had an effective opportunity to remedy.

on the appeal. The regulations set strict time limits for decisions on initial determinations and appeals, which are significantly shortened when the care is for an urgent condition, and mandate notice to the participant of her rights to appeal and bring legal action. In this case, the record indicates that YHP's fiduciaries repeatedly violated these procedural requirements (as well as the plan's own procedural requirements), resulting in a fundamentally flawed decisionmaking process.

Halo alleges that after YHP approved her referral for out-of-network care, she and her mother made many calls to YHP's Care Coordination Department from June 17 through July 30, in accordance with the plan's terms, to coordinate her care, and received no response for approximately 50 days. Initial determinations on pre-service claims (generally claims where coverage depends upon prior approval) must be decided within a reasonable period of time, but not later than 15 days after receipt of the claim. 29 C.F.R. § 2560.503-1(f)(2)(iii)(A). However, for urgent care claims, a plan administrator must notify the claimant of the plan's determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether or to what extent the benefits

are covered or payable.<sup>2</sup> 29 C.F.R. § 2560.503-1(f)(2)(i). In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. Id. YHP did none of those things in response to the Halos' calls for confirmation of benefits coverage.

YHP's July 30 denial of Halo's June 17-18 claim, which she says was submitted on June 26, violated both the regulatory time requirements and the plan's coordination provisions. Although that denial was reversed at the administrative appeal level, and thus is not an issue in this appeal, it is nonetheless relevant in showing that YHP consistently ignored the time and notice requirements applicable at the initial claims-determination level. Generally, post-service claims must be decided within 30 days, but urgent care claims must be decided within 72 hours. 29 C.F.R. § 2560.503-1(f)(2)(i), (iii)(B). If D'Amico submitted her claim on

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<sup>2</sup> Under the regulations a "claim involving urgent care" includes "any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations . . . [c]ould seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function." Id. § 2560.503-1(m)(1)(i)(A). That question "is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine." Id. § 2560.503-1(m)(1)(ii). Urgent care also includes care that, without the shorter time limits, "[i]n the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim." Id. § 2560.503-1(m)(1)(i)(B).

June 26, YHP's July 30 notification violated the 30-day requirement for even non-urgent post-service claims, and far exceeded the deadline for urgent care claims.

More important, the only explanation for the denial was "SERVICE NOT AUTHORIZED." Under the regulations, notification of an adverse benefit determination must provide: (i) the specific reason(s) for the determination; (ii) reference to the specific plan provision upon which the determination is based; (iii) 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 (iv) a description of the plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) following an adverse benefit determination on review. 29 C.F.R. § 2560.503-1(g)(1).<sup>3</sup> The July 30 EOB met none of those requirements. It does not reference any plan provision upon which the determination is based. It does not address whether the June 17-18 services were emergency or urgent care. It does not describe additional material or information necessary to perfect the claim, such as medical support for a claim of an

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<sup>3</sup> A plan's claims procedures must also provide that a claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and information relevant to the claimant's claim for benefits. 29 C.F.R. § 2560.503-1(h)(2)(iii). YHP did not meet this requirement according to Halo, who claims that, after she requested the claims file, YHP charged her for copying, and then sent her only a copy of the plan itself. Appellants' Br. at 29 and Ex. 2.

emergency/urgent condition. Finally, it does not describe the plan's review procedures or applicable time periods, or mention the right to sue following adverse appeals.

Similarly, Dr. Forster's August 11 telephone call advised plaintiff "as to the YHP need to have her stay in network where equivalent [sic] care could be given," but did not address whether the condition requiring surgery might qualify as an emergency or urgent condition. YHP's subsequent August 15 letter stated that YHP had previously communicated clearly to her that coverage for "further visits and surgery with Dr. D'Amico would be denied," and that in-network specialist were available. The August 11 and August 15 determinations did not describe the reason(s) for denying coverage for the operation, the applicable plan provisions, or additional material or information needed to perfect her claim, such as evidence that the surgery was for an emergency or urgent condition. In fact, YHP did not have any of the medical records from Dr. D'Amico's diagnosis on August 5 concerning Tiffany's retinal detachment and cataract or records from the operation when it made these determinations, and there is no evidence in the record that YHP considered whether the surgery might qualify as covered emergency or urgent care.<sup>4</sup> Instead, YHP merely expressed its desire to have Halo stay in network, and

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<sup>4</sup> The district court found, incorrectly, that the fact that the letter mentioned that the plan did not cover non-emergency out-of-network care provided Halo

its intent to deny coverage for further medical care without consideration of the emergency or urgent nature of such care. With respect to appellate rights, the August 15 letter stated: "You are entitled to further review of your appeal with the Claims Review Committee as described in your member handbook," and to contact Ms. Eisler for information and assistance.<sup>5</sup>

Similarly, YHP's September 18 response to Halo's appeal of the denials of full coverage for the June 17-18 services and the August 13 operation notified Halo, without explaining its reasons, that YHP would cover in full the June 17-18 services, but upheld the denial for the August 13 surgery. Again, if this was a decision regarding an urgent condition under the regulation, the notification was a week late under the regulation.

Most important, this denial violated the substantive requirements for a full and fair appellate review, as well as the plan's own procedures, in several ways. First, the Secretary's regulation provides that in deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health

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sufficient notice that her claim for the August 13 surgery was denied for that reason. This statement was entirely conclusory and provided no explanation of why the denied, out-of-network services were not for emergency or urgent care.

<sup>5</sup> If the June 17-18 services and the August 13 surgery satisfied the regulatory definition of "urgent care," both the August 11 and 15 decisions were late since they violated the 72-hour time requirement for determinations and appellate decisions for urgent care.

care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and was not involved in the original denial, and identify any experts whose advice was obtained. 29 C.F.R. § 2560.503-1(h)(3)(iii), (iv). There is no indication that any expert was consulted regarding whether the August 13 surgery was for an emergency or urgent condition as those terms are defined in the plan, and none were identified. Indeed, the record indicates that YHP did not even have Dr. D'Amico's medical records reflecting his August 5 diagnosis or the surgery. In addition, the plans own appellate procedures provide: "[y]ou will be contacted if further information is needed to assist in the determination," but YHP never told Halo that she needed to supply additional information. In fact, there is no evidence that YHP exercised the discretionary judgment conferred upon it to determine whether the surgery was for an emergency or urgent condition.

As with the initial denial, the claims regulation requires that the appeal determination provide: (1) the specific reason(s) for an adverse determination; (2) reference to the specific plan provisions on which it is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to the claimant's claim for benefits; and (4) a statement of the claimant's right to bring an action under section 502(a). 29 C.F.R. § 2560.503-1(j)(1)-(4). The September 18

decision, which simply notified Halo that YHP was upholding its denial of coverage for the August 13 surgery, did none of those things.

On September 29, Halo requested that the Claims Committee "revisit" the denial of coverage for the August 13 surgery. On November 6, 2008 the Committee responded that it had unanimously upheld the decision to deny coverage. Again, no reasons were given. Although YHP had received Dr. D'Amico's medical records on October 21, there is no indication anyone involved with or consulted in connection with the November 6 decision reviewed those records or determined that the condition requiring surgery did not satisfy the requirements for a covered emergency or urgent condition.

On September 25, 2008, D'Amico's office submitted a claim to YHP for the September 17, 2008 surgery, which was stamped received by YHP on October 3, 2008. On November 7, 2008, YHP issued an EOB denying the claim for the September 17 surgery, stating only "Service Not Authorized."<sup>6</sup> No other reasons for denial were given, and none of the other requirements for an adverse determination under the regulation were satisfied. This notification also did not

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<sup>6</sup> The EOB also denied coverage for services rendered on June 20 and June 26 based on the same "Service Not Authorized." The record before the district court does not indicate when the claim for the June 20 and June 26 services were submitted to YHP, but it is likely that it was submitted earlier than the claim for the September 17 surgery.

meet the time deadline for a post-service claim, regardless of whether it was for urgent or non-urgent care.

## II. THE YALE HEALTH PLAN'S REPEATED VIOLATIONS OF THE CLAIMS REGULATION ENTITLES HALO TO DE NOVO JUDICIAL REVIEW OF HER CLAIMS

The Supreme Court has explained that, in determining the standard of review applicable to a denial of plan benefits, courts are to be "guided by principles of trust law," under which a de novo standard applies "unless the plan provides to the contrary." Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111-13 (1989)) (internal quotations omitted). Where the plan gives the administrator or other fiduciary discretion to determine eligibility, as the court found that this plan did, an abuse-of-discretion standard applies. 554 U.S. at 111 (citing Firestone, 489 U.S. at 115). The Supreme Court has never had occasion to decide what standard applies where a decision is untimely or otherwise fails to meet or substantially meet the requirements of either the current claims regulations or its predecessor. However, several courts, including the Second Circuit, have addressed the applicable standard of review where there are violations of the regulations during the claims review process. Moreover, the preamble to the current regulations states that a claim decision made without the procedural safeguards mandated by the regulations is not entitled to judicial deference. 65 Fed. Reg. 70246, 70255

(Nov. 21, 2000). The Secretary's reasonable interpretation of her regulations in this regard is entitled to controlling deference under Auer v. Robbins, 519 U.S. 452, 461 (1997).

In Jebian v. Hewlett-Packard Co. Emp. Benefits Org, 349 F.3d 1098, 1103 (2003), the Ninth Circuit held that where, under the prior regulations (and applicable plan language) "a claim is 'deemed . . . denied' on review after the expiration of a given time period, there is no opportunity for the exercise of discretion and the denial is usually to be reviewed *de novo*," despite a grant of discretion, unless there was a good faith attempt to comply with the deadlines. The court relied on trust law to reason that untimely decisions are "made outside the boundaries of conferred discretion" and are therefore "not exercises of discretion." Id. at 1104.

The government filed an amicus brief on invitation from the Supreme Court opposing certiorari and arguing that "[w]hen an ERISA administrator having discretion under [a grant of discretion] fails to issue a decision... at all or fails to comply substantially with the mandatory deadlines and the claim is therefore 'deemed denied,' the administrator has failed to act within the scope of discretion conferred by the plan. That is so because the administrator's discretion is necessarily limited by the governing regulations as well as by the terms of the plan itself, which in this case incorporated the regulations' deadlines and 'deemed

denied' language." Jebian, Brief for the United States as Amicus Curiae, 2005 WL 1277853, at \*13 (May 27, 2005). The brief also noted that "the new regulations dispense with the exhaustion requirement and allow a claimant to proceed directly to federal court in the event of a broader range of procedural violations," and that, "if a claimant invokes [the deemed exhausted] provision and the court agrees that the plan failed to follow a reasonable claims procedure, the court might then conclude that the default rule of *de novo* consideration is triggered as a corollary." Id. at \*17. The Supreme Court denied the writ of certiorari. 545 U.S. 1139 (2005). In Nichols v. Prudential Ins. Co., 406 F.3d 98, 109 (2d Cir. 2005), the Second Circuit reached a result consistent with the government's views in Jebian. Examining timing issues under the prior regulations, the court reasoned that when a plaintiff's benefit claim was "deemed denied" because the plan had not decided her claim within the applicable time limits there was no "exercise of discretion" to which to give "deferential review." In that situation, the court held despite a conferral of discretion, Prudential's decision denying benefits would be reviewed *de novo*. Id. The court noted decisions from the Ninth and Tenth Circuit holding that deferential review might still be appropriate if the administrator substantially complied with deadlines, but determined that it need "not reach the question of whether to adopt this form of the substantial compliance doctrine" because Prudential "failed to comply in any reasonable respect with the regulatory

deadlines." Id. (citing Jebian, 349 F.3d at 1107; Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 634-35 (10th Cir. 2003)).

The following year, in Demirovic v. Bldg. Serv. 32 B-J Pension Fund, 467 F.3d 208 (2006), the Second Circuit considered a case where, despite a late initial determination, the claimant had chosen to appeal that decision internally rather than bringing suit, and the plan issued a timely decision on her appeal. The court distinguished Nichols, stating:

Here, by contrast, rather than go directly to court when the Fund failed to issue a timely initial determination, Demirovic chose to appeal. She then waited for and received a timely decision on her appeal. This eventual decision constitutes a final decision and exercise of the Fund's discretion, to which we must defer. Accordingly, we will apply arbitrary and capricious review to the Fund's determination.

Id. at 212.

As Nichols notes, there was a split of authority under the old regulations as to whether de novo review applies in the absence of substantial compliance with the regulatory deadlines. Compare Jebian, supra; Gilbertson, supra, with Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir. 1993); Daniel v. Eaton Corp., 839 F.2d 263, 267 (6th Cir. 1988). However, to date, the circuits that have addressed the issue under the new regulation have concluded that de novo review is appropriate in at least some circumstances where regulatory requirements have not been met. See LaAsmar v. Phelps Dodge Corp. Life, 605 F.3d 789, 800 (10th Cir. 2010); Rasenack v. AIG Life Ins. Co., 585 F.3d 1311, 1316 (10th Cir.

2009); cf. Seman v. FMC Corp. Ret. Plan for Hourly Employees, 334 F.3d 728, 733 (8th Cir. 2003) (deferential review is appropriate unless the untimeliness of a decision raises serious doubts about the denial); Finley v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan, 379 F.3d 1168, 1174-75 (10th Cir. 2004) (deference given to initial determination despite failure to render decision on appeal where participant did not present meaningful new evidence on appeal).

Halo's suit presents a somewhat different situation than these cases. Unlike in cases like Jebian or Nichols, Halo filed suit after YHP issued its final denials of her claims for benefits (with several exceptions discussed below). However, the pervasive nature and degree of procedural irregularities, including the repeated violations of the timing, notification, content and manner of decisionmaking requirements of 29 C.F.R. § 2560.503-1, more than suffice to establish that YHP did not substantially comply with the regulation's requirements, and distinguish this case both from the situation in Demirovic, which involved a late initial decision and nothing more, and from the situation described in the Secretary's FAQs, [http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html), where the Secretary indicated that inadvertent and harmless deviations do not necessitate de novo review.

Here, as described above, numerous and fundamental procedural violations permeated the claims procedure and decisionmaking process, adversely affected

Halo's ability to present evidence and arguments for coverage, and prevented a fair review of her claims, including: (1) determinations that failed to give sufficient notice of the reasons for denials or the applicable plan provisions; (2) failure to obtain and consider relevant medical records before rendering decisions; (3) a lack of evidence that YHP considered or decided whether the August 13 and September 17 surgeries were emergency or urgent care; (4) failure to notify Halo of additional information necessary to perfect her claim, or to investigate whether her condition met the plan's requirements for emergency or urgent care; (5) apparent failure to consult with an objective medical expert to determine whether care met the medical definition of emergency or urgent care; (6) failure to notify Halo of her right to obtain relevant documents free of charge, and failure to provide her with relevant documents; (7) numerous initial determinations and appeals determinations that were late under the regulations; and (8) failure to follow plan procedures for coordinating urgent care.

Indeed, the record is devoid of evidence that YHP exercised the discretionary judgment granted it under the plan to determine whether Halo's illness and injuries met the plan definition for emergency or urgent conditions. Courts have routinely refused to defer to determinations where the decisionmaker did not actually exercise the discretion afforded it, and where the administrator engaged in wholesale violations of the procedural requirements of ERISA. Gritzer

v. CBS, Inc., 275 F.3d 291, 296 (3d Cir. 2002); Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 971-72 (9th Cir. 2006) (en banc). Here, there is no evidence that YHP reviewed medical records for the June, August and September surgeries for the purpose of making a judgment about whether the services were for an emergency or urgent care under the regulations or the plan and there is no evidence of any consultation with a medical expert regarding that question in connection with her appeals of the benefit denial for the August 13 surgery. Instead, YHP emphasized only that the plan had not authorized the out-of-network services, that Halo should see available in-house specialists, and that YHP wanted her to stay in network.

Without a record of a reasoned discussion or even notice of the emergency or urgent care issue: (1) the reviewing court cannot know if the administrator actually exercised its discretion on the issue; (2) the court is deprived of the benefit of any analysis by the plan that it can review; and (3) the claimant (here pro se) is not alerted to the issue she should be addressing or the information she should supply so that she can develop the record and make responsive arguments. These pervasive and fundamental violations establish that YHP did not substantially comply with the regulation and that Halo did not receive "adequate notice" of the "specific reasons" for the denial or a "full and fair review" of the denial under section 503 of ERISA. In these circumstances, YHP was not entitled to deferential

review of its benefits denials. See Abatie, 458 F.3d at 971 (although "an administrator's failure to comply with such procedural requirements ordinarily does not alter the standard of review," the court recognized "some situations in which procedural irregularities are so substantial as to alter the standard of review").

If Halo is given de novo review by the district court, it is quite possible that she will prevail on some or all of her claims for benefits. For instance, she may be able to establish, as she claims, that once she had traveled to her parent's home in New Jersey, and found out from Dr. D'Amico how serious her condition was, she could not safely travel back to New Haven for follow-up treatments, especially after her third and fourth surgeries. Moreover, any deficiencies in the claims record in this regard should not be determinative because, especially given the numerous procedural deficiencies which prevented Halo from addressing the correct issue during the claims processing, she should be able to present this evidence for the first time to the district court. See DeFelice v. Amer. Int'l Life Assur. Co. of New York, 112 F.3d 61, 67 (2d Cir. 1997) (noting that a district court can consider additional evidence on de novo review of an ERISA claims denial if there is good cause for doing so, such as a conflict of interest).

### III. HALO SHOULD BE DEEMED TO HAVE EXHAUSTED HER PLAN REMEDIES

As the Second Circuit noted in Eastman Kodak v. STWB. Inc., 452 F.3d 215, 219 (2nd Cir. 2006), "ERISA requires both that employee benefit plans have reasonable claims procedures in place, and that plan participants avail themselves of these procedures before turning to litigation." The district court held that Halo failed to satisfy this exhaustion requirement with regard to the office visits of June 20, June 26, August 5, and September 10, and the surgery of September 17, 2008, because there was no indication that she internally appealed the denial of these claims. However, the claims regulations' "'deemed exhausted' provision was plainly designed to give claimants faced with inadequate claims procedures a fast track into court." Id. Because the denials were wholly deficient under the regulations and at least some were untimely, Halo was "deemed to have exhausted the administrative remedies under the plan and . . . entitled to pursue any available remedies under section 502(a) of the Act."

29 C.F.R. §2560.503-1(l).

The record shows that a claim for the September 17, 2008 surgery was sent on September 25, 2008 and was stamped received by YHP on October 3, 2008. (Halo contends that D'Amico's claims were sent electronically to YHP on the date they were completed). The EOB denying the claim for the September 17 surgery (as well as the June 20 and June 26 services), which stated only "SERVICE NOT

AUTHORIZED," was "processed" on November 7. Even if it were a claim for non-urgent care, the determination was made outside the 30-day deadline, and was well beyond the 72-hour deadline for urgent care claims. The same is likely true of the June 20 and June 26 claims, although it is not clear from the record when those claims were submitted. More significantly, the denials did not explain their basis with reference to the applicable plan provisions and indeed failed to meet the requirements of the claims regulations in any material respect. Under the plain terms of the regulations, the claim process was therefore "deemed exhausted" and Halo was entitled to file suit in district court without further resort to the claims process.<sup>7</sup>

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<sup>7</sup> Thus, as we have described, the remedies for violations of section 503 of ERISA and the claims regulations are the ability to immediately sue in court under the "deemed exhausted" provision, and the loss of deferential review of any decision made in violation of the regulatory requirements. Neither section 503 nor the regulations provide for monetary penalties, and the penalty in section 502(c) of ERISA, 29 U.S.C. § 1132(c), which Halo cites in her brief, is aimed at violations of the disclosure requirements placed specifically on plan administrators by the statute, not on violations of the claims regulations. Wilcynski v. Lumbermens Mut. Cas. Co., 93 F.3d 397 (7th Cir.1996); Groves v. Modified Ret. Plan, 803 F.2d 109, 111 (3d Cir.1986).

## CONCLUSION

For the foregoing reasons, the Acting Secretary respectfully requests that the Court reverse the decision of the district court.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type volume of Fed. R. App. P. 32(a)(7)(B) because it contains 6,988 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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 it has been prepared in a proportionally spaced typeface using Microsoft Office Word 14 Times New Roman.

Dated: January 31, 2013

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CERTIFICATE OF SERVICE

I hereby certify that on the 31st day of January, 2013, the foregoing Brief of the Acting Secretary of Labor as Amicus Curiae in Support of Plaintiff-Appellant was electronically filed with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system.

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