Nos. 20-17363, 20-17364, 21-15193, 21-15194

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DAVID WIT, et al.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

GARY ALEXANDER, et al.,
Plaintiffs-Appellees,
v.
UNITED BEHAVIORAL HEALTH,
Defendant-Appellant.

Appeal from the United States District Court for the
Northern District of California
Nos. 3:14-cv-2346, 3:14-cv-5337

BRIEF OF THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF APPELLEES

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STATEMENT OF THE ISSUES

Plaintiffs are participants and beneficiaries in various ERISA-covered health benefit plans administered by United Behavioral Health ("UBH") who sought coverage for treatment of a variety of mental health and substance use conditions. UBH denied coverage based on its own internal medical necessity guidelines. In addition to a fiduciary breach claim, Plaintiffs brought a claim under ERISA section 502(a)(1)(B) asserting that UBH arbitrarily and capriciously denied coverage based on its guidelines, rather than evaluating Plaintiffs' claims based on the generally accepted standards of care required by their plans. The district court found that UBH's guidelines deviated from generally accepted standards of care, and remanded Plaintiffs' claims to UBH for reprocessing under the proper standard.

The Secretary addresses the following questions presented:

1. Whether participants and beneficiaries in ERISA-covered plans suffer an "injury in fact" that is "fairly traceable" to the defendant's conduct, sufficient for constitutional standing, when the defendant denies coverage based on an improper standard that is contrary to plan terms.

2. Whether plaintiffs suing under ERISA section 502(a)(1)(B) who prove that the defendant denied coverage based upon a standard that is contrary to plan terms are entitled to have their claims reprocessed by the defendant, or whether they must instead prove that they would have been entitled to coverage under the proper standard.

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

The Secretary of Labor has primary authority to interpret and enforce the provisions of Title I of ERISA to ensure fair and impartial plan administration and compliance with ERISA's requirements and purposes. *See* 29 U.S.C. §§ 1132, 1135; *Donovan v. Cunningham*, 716 F.2d 1455, 1462-63 (5th Cir. 1983). One of ERISA's purposes is to provide participants and beneficiaries "ready access to the Federal courts." 29 U.S.C. § 1001(b). To that end, the Secretary has an interest in ensuring that participants and beneficiaries challenging coverage denials—perhaps the most common type of ERISA claim—are not denied access to court based on a cramped interpretation of standing principles. The Secretary also has an interest in ensuring that participants challenging coverage denials are able to obtain a remand to

the plan administrator for claim reprocessing when they demonstrate that the administrator applied an improper standard in denying coverage.

The Secretary files this brief as amicus curiae under Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

I. Facts

UBH administers "mental health or substance abuse disorder treatment" for Plaintiffs' ERISA-covered health plans. 1-ER-60. Those plans expressly cover such treatment if it is "consistent with generally accepted standards of care." *Id.*

To determine whether to grant or deny claims for mental health and substance abuse treatment, UBH developed and applied its own internal medical necessity guidelines—so called "Level of Care Guidelines" and "Coverage Determination Guidelines" (Guidelines). 1-ER-61. UBH organized the Level of Care Guidelines by type of service, such as inpatient hospitalization, residential treatment, and intensive outpatient and outpatient treatment. *Id.* UBH organized the Coverage Determination Guidelines by diagnosis. *Id.* The Coverage Determination Guidelines incorporate the Level of Care Guidelines. *Id.*

"All of the class members' requests for coverage were denied under UBH's [Guidelines]." *Id.*

II. Procedural History

Plaintiffs, on behalf of a putative class of participants and beneficiaries in ERISA-governed health-benefits plans administered by UBH, asserted two claims under ERISA section 502(a)(1)(B). First, they alleged that UBH breached its fiduciary duties by adopting and using Guidelines that were more restrictive than the plan terms, which promised coverage for treatment consistent with generally accepted standards of care. 1-ER-62. Second, they alleged that UBH arbitrarily and capriciously denied their claims for residential treatment, intensive outpatient treatment, and outpatient treatment based on the improper Guidelines. 1-ER-62-63. To remedy the denial of coverage, Plaintiffs sought to have their denied claims reprocessed by UBH under a standard that complied with plan terms. 1-ER-63. To the extent such relief was unavailable under ERISA section 502(a)(1)(B), Plaintiffs alternatively sought "appropriate equitable relief" under ERISA section 502(a)(3). 1-ER-63.

The Court certified three classes, which covered 67,000 claims for residential, outpatient, and intensive outpatient treatment. 2-ER-236-237, 248, 258-261. UBH opposed class certification on the grounds that Plaintiffs did not meet the commonality requirement because their claims turned on individualized issues of medical necessity. 1-ER-64. Plaintiffs argued in response that they were "not asking this Court to determine whether Class members were owed benefits" in the particular circumstances of their individual claims. *Id.* Rather, Plaintiffs argued that they were "seek[ing] a reprocessing remedy"—*i.e.*, a remand to UBH to re-adjudicate the denied claims—based on the allegation that "UBH used an arbitrary process, premised on fatally flawed Guidelines, to deny their requests for coverage." *Id.*

After the classes were certified, UBH moved for summary judgment, seizing on Plaintiffs' acknowledgment, at the class certification stage, that they were not seeking individualized benefit determinations. On the basis of that statement, UBH argued that Plaintiffs lacked standing under Article III of the Constitution because they could not show they suffered an "injury-in-fact" that was traceable to UBH's application of the challenged aspects of the Guidelines. 1-ER-

71-72. For similar reasons, UBH sought summary judgment on the merits of Plaintiffs' claim for benefits under section 502(a)(1)(B), which, according to UBH, could not proceed as a "'class-wide 'procedural challenge.'" 1-ER-70-71. On August 17, 2017, the district court denied summary judgment to UBH on their Article III and merits arguments. 1-ER-77-83.

On March 5, 2019, following a 10-day bench trial, the district court entered judgment on liability for Plaintiffs with respect to both the fiduciary-breach and denial-of-benefits claims. 2-ER-327-334. The court found that UBH's Guidelines were more restrictive than generally accepted standards of care for a host of reasons. Chief among them was that "in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members' underlying conditions." 2-ER-270. The court thus found that UBH arbitrarily and capriciously denied Plaintiffs' requests for coverage using Guidelines that were more restrictive than the generally accepted standards of care. 2-ER-334. The court also found that UBH breached its fiduciary duties by adopting

and applying improper Guidelines that did not comply with plan terms. 2-ER-332.

On November 3, 2020, the court issued a remedies order awarding Plaintiffs prospective declaratory and injunctive relief and requiring UBH to reprocess all of the claims denied using the flawed Guidelines under a new standard that comported with plan terms. 1-ER-101, 169; 1-ER-110, 132-148.

SUMMARY OF THE ARGUMENT

1. UBH erroneously contends that Plaintiffs lack Article III standing because they did not suffer an injury-in-fact traceable to UBH's conduct. To the contrary, each Plaintiff individually suffered one of the quintessential injuries ERISA seeks to remedy—a denial of coverage under an ERISA plan. Such a coverage denial is a concrete injury with deep historical and statutory roots, and remains an injury whether or not it inflicted financial harm on Plaintiffs.

UBH further argues Plaintiffs' coverage denials are not "traceable" to the improper Guidelines at issue in this case because Plaintiffs, at the class certification stage, disclaimed having to show that they were entitled to coverage under a proper interpretation of

their plans (free of UBH's Guidelines). This erroneously conflates Article III standing with the question of whether Plaintiffs are ultimately entitled to coverage. For purposes of standing, Plaintiffs need only show that their coverage denials were "fairly traceable" to UBH's decisions denying them coverage. On that score, a straighter line could not be drawn.

2. UBH similarly contends that the district court had to first "assur[e] itself of liability"—*i.e.*, that benefits would have been due but-for the improper Guidelines—before entering judgment for Plaintiffs on their ERISA section 502(a)(1)(B) action and remanding their denied claims to UBH for reprocessing. But where, as here, the defendant denies a claim for benefits by applying an incorrect standard that deviates from plan terms, this Court has made clear that the appropriate remedy is to remand the claim to the plan administrator for reprocessing under the correct standard. Were a court required to first "assure itself of liability" before ordering a remand, as UBH contends, the remand remedy would serve no purpose; the court could simply award benefits. While a court, before remanding, must "assure itself" that the defendant used an incorrect standard in denying coverage, it

need not conclude that coverage would have been due under the correct standard.

ARGUMENT

I. Plaintiffs' Denials of Coverage Under their Plans Were Article III Injuries in Fact that are Fairly Traceable to UBH's Decisions Denying Coverage

To establish Article III standing, Plaintiffs "must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1546 (2016) (citation omitted). UBH contends that Plaintiffs cannot satisfy the first two prongs of standing. Because there is no dispute that each member of the class was denied coverage under their ERISA plans, and that their coverage denials are directly traceable to UBH's decisions, Plaintiffs have standing.

A. UBH's Coverage Denials Were Cognizable Injuries in Fact

"To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Spokeo*, 136 S. Ct. at 1548 (citation omitted). Because

UBH's denials of Plaintiffs' claims for coverage inflicted injuries that were both particularized and concrete, Plaintiffs suffered Article III "injuries in fact."

"For an injury to be 'particularized,' it 'must affect the plaintiff in a personal and individual way.'" *Id.* Each Plaintiff individually experienced a denial of coverage based on UBH's use of its improper Guidelines. As the district court explained, "the Guidelines that are at the heart of Plaintiffs' claims were used to deny Plaintiffs' claims for coverage, allegedly due to flaws that resulted from UBH's failure to adhere to its duties to plan members as a fiduciary." 1-ER-83; *see also* 2-ER-230-33, 252, 334; *see* 1-ER-66-67 (class members' coverage claims were "denied by UBH . . . based upon" its Guidelines); *see also* 1-ER-204-05 (removing Plaintiffs who received benefits from class because it was "always . . . the Court's understanding that class members were, in fact, denied coverage"). Plaintiffs therefore satisfy the particularity requirement of an Article III injury.

Plaintiffs' injuries are also concrete. In order for an injury to be concrete, it "must be '*de facto*'; that is, it must actually exist." *Spokeo*, 136 S. Ct. at 1549 (citation omitted). While "tangible injuries are

perhaps easier to recognize . . . intangible injuries can nevertheless be concrete." *Id.* "In determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." *Id.*

UBH argues that Plaintiffs cannot establish a concrete "injury in fact" without showing an actual loss. *See* UBH Br. 21, 24. As UBH puts it, "the [district] court found standing based solely on an 'intangible,' 'procedural' right to 'fair adjudication' and the mere showing that some part of the guidelines was used in some way in making benefits determinations." *Id.* at 26. UBH contends that "Plaintiffs 'cannot satisfy the demands of Article III by alleging a bare procedural violation' that 'may result in no harm.'" *Id.* (citation omitted).

But Plaintiffs' injuries are far from the "bare procedural violation" of being subjected to UBH's Guidelines in the abstract. As the district court found, the "Guidelines that are at the heart of Plaintiffs' claims *were used to deny Plaintiffs' claims for coverage*." 1-ER-83 (emphasis added). Indeed, the district court specifically excluded from the class those individuals whose claims were processed under the Guidelines but were ultimately paid, stating that it was "always . . . the Court's

understanding that class members were, in fact, denied coverage." 1-ER-204-05 (finding "serious issues as to the rights" of individuals with approved claims "to assert the claims at issue in this case").

These denials of coverage were a concrete injury to Plaintiffs, who were deprived of their contractual right to benefits. "This follows from the fact that plan participants are contractually entitled to plan benefits." *Mitchell v. Blue Cross Blue Shield of N. Dakota*, 953 F.3d 529, 536 (8th Cir. 2020). As UBH acknowledges, "ERISA plan sponsors (typically employers) establish written plans—essentially, 'contracts'—governing the benefits they choose to offer employees." UBH Br. 5. (quoting *CIGNA Corp. v. Amara*, 563 U.S. 421, 440 (2011)). Indeed, ERISA's "statutory scheme . . . is built around reliance on the face of written plan documents," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995), and ERISA's "principal function [is] to 'protect [those] contractually defined benefits.'" *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100-01 (2013) (citation omitted).

Accordingly, the Eighth Circuit recently surveyed the ERISA landscape and found it "persuasive" that "[s]everal circuits" have recognized that "[t]he wrongful denial of plan benefits breaches the

parties' contract and deprives the participant of the benefit of their bargain," resulting in an Article III injury. *Mitchell*, 953 F.3d at 536 (citations omitted). As the court explained, "[t]raditionally, 'a party to a breached contract has a judicially cognizable injury for standing purposes' because the other party's breach devalues the services for which the plaintiff contracted and deprives them of the benefit of their bargain." *Id.* Thus, "[a]n improper denial of vested ERISA benefits is the quintessential injury-in-fact." *See Smith v. Health Care Service Corp.*, 2021 WL 963814, at *3 (N.D. Ill. March 15, 2021) (citing *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615, 1619 (2020)). "Like any private contract claim, [the] injury does not depend on allegation of financial loss. [The] injury is that he was denied the benefit of [the] bargain." *Springer v. Clev. Clinic Employee Health Plan Total Care*, 900 F.3d 284, 292 (6th Cir. 2018) (participant "suffered an injury within the meaning of Article III because he was denied health benefits he was allegedly owed under the plan"); *Mitchell*, 953 F.3d at 536 ("[P]articipants are injured not only when [a] provider charges them for the balance of a bill," but by the denial of the claim alone.).

This Court reached a similar conclusion in *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz., Inc.*, holding that the provider plaintiffs (armed with assignments from ERISA plan participants) had Article III standing because the participants "had the legal right to seek payment" pursuant to their plan, regardless of whether they were billed. 770 F.3d 1282, 1289-91 (9th Cir. 2014); *see N. Cypress Med. Ctr. v. Cigna Healthcare*, 781 F.3d 182, 193 (5th Cir. 2015) (finding Article III standing where failure to pay for covered services "denie[d] the patient the benefit of her bargain" under ERISA plan); *HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001) (same); *accord Johnson v. Allsteel, Inc.*, 259 F.3d 885, 887-89 (7th Cir. 2001) (plaintiff contesting ERISA plan amendment that "decreased the value of his bargained-for-entitlements" suffered Article III injury).

Violations of Plaintiffs' contractual rights to coverage under their Plans—irrespective of financial loss—also have "a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit in English or American courts." *Spokeo*, 136 S. Ct. at 1549. "A breach of contract always creates a right of action," even when no

financial "harm was caused." Restatement (First) of Contracts § 328, & Cmt. *a*, pp. 502–503 (1932). Courts have likewise traditionally presumed that a violation of a contract results in a cognizable injury. *Spokeo*, 136 S. Ct. at 1551, 1553 (Thomas, J., concurring); *Tenn. Elec. Power Co. v. Tenn. Valley Auth.*, 306 U.S. 118, 137-38 (1939) (standing is available where "the right invaded is a legal right, . . . arising out of [a] contract"); *In re Thorpe Insulation Co.*, 677 F.3d 869, 887 (9th Cir. 2012) (appellants have Article III standing based on, among other things, bankruptcy plan's "affect [on their] contractual rights"); *Sisley v. Spring Commc'ns Co., L.P.* 284 Fed. App'x 463, 465-66 (9th Cir. 2008) (reversing district court's dismissal of breach of contract claim for lack of Article III standing); *Dods v. Evans*, 143 Eng. Rep. 929, 930-931 (C.P. 1864) (breach of contract as injury); *Marzetti v. Williams*, 109 Eng. Rep. 842, 845 (K.B. 1830) (breach of contract, without damages, can itself create injury).[1]

[1] Numerous circuit courts agree. *Kuhns v. Scottrade, Inc.*, 868 F.3d 711, 716 (8th Cir. 2017) (Plaintiff "has standing regarding his breach of contract and contract-related claims based on allegations that he did not receive the full benefit of his bargain."); *United Steel, Paper & Forestry, Rubber, Mfg., Energy, Allied Indus. & Serv. Workers Int'l Union, AFL–CIO/CLC v. Cookson Am., Inc.*, 710 F.3d 470, 474-75 (2d

Plaintiffs' asserted injury finds further support in the "judgment of Congress." *See Spokeo*, 136 S. Ct. at 1549. ERISA requires plan administrators such as UBH to act "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). In order to fulfill the statute's "principal function . . . to 'protect contractually defined benefits,'" *US Airways*, 569 U.S. 88 at 100-01, ERISA "provides a mechanism through which [plaintiffs] can enforce those underlying, bargained-for rights." *Springer*, 900 F.3d at 292 (Thapar, J., concurring). A participant or beneficiary can accordingly "bring a civil action" not just "to recover benefits due to him under the terms of his plan", but also "to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); *see Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (noting ERISA's "repeatedly emphasized purpose to protect contractually defined benefits"). As a result, "history and the judgment of Congress both indicate that the denial of plan

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Cir. 2013); *Katz v. Pershing, LLC*, 672 F.3d 64, 72 (1st Cir. 2012); *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 263 (3d Cir. 2008).

benefits constitutes a cognizable injury in fact for purposes of constitutional standing." *Mitchell*, 953 F.3d at 536.

The Supreme Court's decision in *Thole* does not suggest otherwise. *See* UBH Br. 26-27. In *Thole*, the Court held that participants in a defined-benefit plan alleging that the fiduciaries mismanaged plan assets did not suffer an "injury-in-fact" where they had "been paid all of their monthly pension benefits so far, and they are legally and contractually entitled to receive those same monthly payments for the rest of their lives." 140 S. Ct. at 1618. In contrast to the *Thole* plaintiffs, Plaintiffs here were denied coverage under the terms of their plans. And in cases, like this one, where participants assert such violations of their contractual rights to benefits, the Court in *Thole* made clear that "they would of course have Article III standing to sue." *Id.* at 1619. *Thole* thus supports, rather than undermines, the finding that Plaintiffs suffered an Article III injury-in-fact.[2]

[2] UBH cites *Spokeo's* reference to risk-based injuries to argue that Plaintiffs cannot satisfy Article III. UBH Br. 27. *Spokeo* discussed risk in the context of future harms caused by procedural injuries. 1550 S. Ct. 1549-50 (citing *Clapper v. Amnesty Int'l*, 568 U.S. 398 (2013)). Because UBH's denial of Plaintiffs' requests for coverage is neither procedural nor prospective, UBH's risk-based arguments are inapposite.

B. Plaintiffs' Failure to Receive Contractually Promised Coverage is Directly Traceable to UBH's Decisions Denying Coverage

Plaintiffs also satisfy Article III's requirement that there "be a causal connection between the injury and the conduct complained of." *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560 (1992). That standard "requires only that the plaintiff's injury be fairly traceable to the defendant's conduct," *Lexmark Int'l v. Static Control Components, Inc.*, 572 U.S. 118, 134 n.6 (2014), and that it does not "result [from] the independent action of some third party not before the court.'" *Lujan*, 504 U.S. at 560; *see Allen v. Wright*, 468 U.S. 737, 757-58 (1984) (the "line of causation" cannot be "highly indirect"). There is no question here that Plaintiffs' injuries (the denial of their contractual right to coverage) are "fairly traceable" to UBH's conduct (its decisions denying coverage). There is no third party or intervening event that deprived Plaintiffs of coverage; the decisions were UBH's alone.

Nevertheless, UBH contends that Plaintiffs were required to show that their benefit denials were traceable not merely to UBH's decisions, but rather specifically "*to the alleged flaws in UBH's guidelines*." UBH Br. 25 (emphasis added). In other words, according to UBH, Plaintiffs—

to have Article III standing—had to demonstrate that the Guidelines were the cause of their benefit denials, in the absence of which they would have been entitled to coverage. *Id.* at 25-26, 28-31.

UBH improperly conflates standing with the determination of whether Plaintiffs are entitled to coverage. To ultimately receive coverage, Plaintiffs will certainly have to show that they are entitled to that coverage under a correct application of their Plans' terms. But "[t]he purpose of the standing doctrine is to ensure that the plaintiff has a concrete dispute with the defendant, not that the plaintiff will ultimately prevail against the defendant." *Hall v. Norton*, 266 F.3d 969, 976–77 (9th Cir. 2001); *see Lexmark Int'l*, 572 U.S. at 134 n.6 ("Proximate causation is not a requirement of Article III standing."). And there is no question that Plaintiffs' dispute over their alleged injuries (the denial of coverage) is solely with UBH; again, UBH alone made the decisions to deny coverage. While Plaintiffs ultimately may not receive coverage, that outcome in no way means that their coverage denials are not "fairly traceable" to UBH's decisions.[3]

[3] The same principle applies in other statutory contexts. For example, plaintiffs suing under the Administrative Procedure Act are not required to demonstrate, in order to have standing, that they would be

UBH illuminates its own error by identifying "disparities within the classes" that it says "exacerbated the problem" with Plaintiffs' ability to show causation. *Id.* at 28-30. These "disparities" are reflected in three subsets of individuals within the class: (1) those who allegedly were denied coverage based "only [on] a third set of guidelines" that "the court never found . . . were flawed," and that Plaintiffs challenged only to the extent that they incorporated the flawed Guidelines; (2) those whose denials were independently supported by grounds other than the Guidelines; and (3) those who accepted coverage at a lower standard of care after their claims for a higher standard of care were denied. *Id.* But here again, these "disparities" go to the merits of Plaintiffs' claims, not to whether their injuries are "fairly traceable" to UBH's decisions. For example, if in fact some truly independent ground justified UBH's decision to deny coverage to certain Plaintiffs—meaning that the

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entitled to benefits or other relief under the proper standards or procedures. *See Lujan v. Defenders of Wildlife*, 555 U.S. 555, 572, n.7 (1992) (plaintiff living near the site for the proposed construction of a federally licensed dam "has standing to challenge the licensing agency's failure to prepare an environmental impact statement, even though he cannot establish with any certainty that the statement will cause the license to be withheld or altered.").

Guidelines were not the but-for cause of their coverage denials—that would simply mean that those Plaintiffs are not entitled to coverage. It would not mean they lack Article III standing to sue for their injuries (the denials of coverage). *See In re Zappos.com, Inc.*, 888 F.3d 1020, 1029 (9th Cir. 2018) (explaining that "multiple causation" arguments are "less about standing and more about the merits of causation and damages.").

In short, the link between Plaintiffs' injuries—failure to receive coverage under the plan—and UBH's decisions denying that coverage, is not just "fairly traceable." It is direct. Plaintiffs therefore satisfy Article III's traceability requirement.

II. Plaintiffs Need Not Establish Their Entitlement to Coverage Under ERISA Section 502(a)(1)(B) In Order for the Court to Remand their Claims for Reprocessing

UBH contends that the district court erred by entering judgment for Plaintiffs on their section 502(a)(1)(B) cause of action, and remanding Plaintiffs' claims to UBH for reprocessing, without first requiring Plaintiffs to show that their coverage denials were "proximately caused" by UBH's use of the improper Guidelines. UBH Br. 31. Put differently, UBH asserts that the court was required to first "assure itself of

liability"—here, that Plaintiffs would have been due coverage had UBH applied the proper standard—before ordering a remand. *Id.* at 32. UBH's argument is irreconcilable with the practice in this circuit (and many others) of remanding a claim denied under an improper standard for reprocessing under the correct standard.

As previously noted, ERISA section 502(a)(1)(B) empowers a plan participant or beneficiary to sue "to recover benefits due him under the terms of the plan, to enforce his rights under the terms of the plan or to clarify his rights to future benefits under the plan." 29 U.S.C. § 1132(a)(1)(B). To be sure, plaintiffs challenging coverage denials decided under improper standards must establish that the defendant used those standards in denying coverage. *See Mitchell*, 953 F.3d at 537 ("The Mitchells have alleged a 'colorable claim' that BCBSND unreasonably interpreted the 'Allowed Charge' for 'Ambulance Services' and denied their claim for benefits based on that interpretation."); *Panaras v. Liquid Carbonic Indus. Corp.,* 74 F.3d 786, 790 (7th Cir.1996) (stating that "a plaintiff need have only a nonfrivolous claim for the benefit in question."). Here, there is no question that UBH applied its improper Guidelines in deciding Plaintiffs' claims. As the

district court explained, "the Guidelines that are at the heart of Plaintiffs' claims were used to deny Plaintiffs' claims for coverage, allegedly due to flaws that resulted from UBH's failure to adhere to its duties to plan members as a fiduciary." 1-ER-83.

Once plaintiffs prove that their claims for coverage were decided under an improper standard, as Plaintiffs did in this case, this Court and others routinely remand the claim so the administrator can apply the proper standard in the first instance. *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir. 1996) ("[R]emand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination."); *accord, e.g.*, *Barlow v. Sun Life & Health Ins. Co.*, 488 Fed. Appx. 458, 459–60 (11th Cir. Aug. 31, 2012) ("Therefore, remand is warranted so that Sun Life will have the opportunity to consider and apply the correct definition of 'regular occupation' in determining whether Ms. Barlow is "totally disabled"); *King v. Hartford Life and Acc. Ins. Co.*, 414 F.3d 994, 1005 (8th Cir. 2005) ("Under these circumstances, we believe the proper remedy is to

return the case to the administrator for reevaluation of the claim under what Hartford says is the correct standard."); *Jones v. Metro. Life Ins. Co.*, 385 F.3d 654, 665 (6th Cir. 2004) ("Because application of the correct definition of accident and the ultimate resolution of Jones's claim requires additional findings of fact, we will remand this case to MetLife.").

If UBH was correct that a court must first "assur[e] itself of liability" before remanding, UBH Br. 32, there would be no need to remand the claims at all; the court could simply award coverage to the plaintiff. Remanding claims for reprocessing would be a dead letter.

But remand is an appropriate interim remedy in many ERISA benefits cases and serves important purposes, as this Court explained in *Saffle*. There the Court found that the plan administrator decided plaintiff's claim using a standard for "total disability" that was contrary to the plan, and therefore abused its discretion. 85 F.3d at 460. But rather than award benefits to the plaintiff, this Court held that where "the administrator construes a plan provision erroneously, the court should not itself decide whether benefits should be awarded but rather should remand to the administrator for it to make that decision under

the plan, properly construed." *Id.* at 456. This is because the plan in *Saffle*, like many plans (including those here), gave the fiduciary discretion to construe the plan's terms in deciding benefits, and that fiduciary "has not yet had the opportunity of applying the Plan, properly construed, to [the participant's] [claim] for benefits." *Id.* at 460. The Court explained that "[i]t should be up to the administrator, not the courts, to make that call in the first instance." *Id.*[4]

UBH seeks to distinguish *Saffle* on the ground that—unlike this case—the Court there "determined that the coverage denial was actually wrongful and that the claimant would be entitled to the benefits for which she applied if the specific questions that required remand were resolved in her favor." UBH. Br. 33. This is wordplay, as the facts in *Saffle* are not materially different from those here. In both

[4] The remand remedy is not limited to ERISA. In suits under the Social Security Act, for example, it is common for a reviewing court to conclude that the Administrative Law Judge should remand to the agency for reconsideration of the claim, without determining whether the claimant would prevail under the correct standards. *See Smith v. Berryhill*, 139 S. Ct. 1765, 1779-80 (2019). Similarly, under the APA, the reviewing court's role is limited to determining whether an error occurred in the agency proceedings and remanding to the agency for reconsideration if the court finds such an error. *See Florida Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985).

cases, the court determined that the claims fiduciary applied improper standards and remanded to the plan administrator to apply the correct standard. Like the district court below, this Court made clear in *Saffle* that it was completely agnostic on the question of whether coverage was actually due, instead allowing the administrator "to make that call in the first instance." *Saffle*, 85 F.3d at 456.

UBH further argues that the only basis for the denial of benefits in *Saffle* was the improper standard at issue in that case, whereas UBH supposedly denied a small number of the claims here for reasons beyond just its Guidelines. UBH Br. 34. If, in fact, UBH justified a subset of benefit denials for reasons truly independent from UBH's flawed Guidelines and unaddressed by the district court, then remand potentially may be inappropriate as to that subset of claims, unless the court rejects those independent grounds.[5] But that would not preclude

[5] Participants generally have a right to "clarify [their] rights to future benefits" under their plans, 29 U.S.C. § 1132(a)(1)(B), but the Secretary is not taking a position on whether remanding claims for that purpose is appropriate under the specific facts of this case. The Secretary also is not taking a position on the appropriateness of remanding claims as to those individuals who were denied coverage by UBH based on its Guidelines but who then allegedly accepted coverage from UBH for a lower level of treatment.

remanding the many claims for which the Guidelines were the sole basis for the denial.

CONCLUSION

For the reasons stated above, the Secretary requests that the Ninth Circuit affirm the district court's rulings on Article III standing and Plaintiffs' claim under ERISA section 502(a)(1)(B).

May 19, 2021

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Appellate Rule 32(g) and Circuit Rule 32-1, I certify that this amicus brief:

(i) complies with the word limit of Rule 29(a)(5) because it contains 5,314 words, excluding the parts of the brief exempted by Rule 32(f); and

(ii) complies with the typeface requirements of Rule 32(a)5) and the type-style requirements of Rule 32(a)(6).

Dated: May 19, 2021

/s/ Melissa Moore

Melissa Moore

CERTIFICATE OF SERVICE

I hereby certify that on May 19, 2021, I electronically filed the foregoing brief with the Clerk of this Court using the CM/ECF system. Counsel for all parties will be served by the CM/ECF system.

/s/ Melissa Moore

Melissa Moore