Nos. 12-55210

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PACIFIC SHORES HOSPITAL,
Assignee of Ann Knutson,
Plaintiffs-Appellants,

v.

UNITED BEHAVIORAL HEALTH and
WELLS FARGO & COMPANY
HEALTH PLAN,
Defendants-Appellees.

On Appeal from the United States District Court for the
Central District of California, Case No. 2:10-cv-05828-PSG-CW
The Honorable Philip S. Gutierrez

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANT'S

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STATEMENT OF THE ISSUE

Based on a selective review and faulty understanding of the relevant medical facts, the third-party administrator of a health care plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, et. seq., concluded that continued hospitalization was no longer medically necessary for an 83-pound anorexic and suicidal woman suffering from serious medical complications. The question addressed in the Secretary of Labor's brief is whether, under these circumstances, the district court erred in upholding the administrator's determination by giving undue weight to facts which, considered in isolation, could be viewed as supporting this determination, rather than deciding the reasonableness of the denial of benefits based on the entire record.

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

This case concerns proper application of the standard of review for a denial of benefits under ERISA. In her role as the head of the primary agency charged with enforcing and administering Title I of ERISA, see 29 U.S.C. §§ 1132, 1134, 1135, the Secretary has a substantial interest in ensuring that plan participants receive full and fair review of benefit denials as ERISA requires. The Secretary therefore files this brief as amicus curiae under Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

1. Factual Background

Ann Knutson, a 43-year-old employee of Wells Fargo & Company, was covered by the company's self-funded health plan. Excerpts of Record (ER) 4. The plan grants discretion to Wells Fargo, as plan administrator, to determine benefits and to delegate this discretionary authority to claims administrators, which defendants claim Wells Fargo did with regard to mental health claims through its summary plan description (SPD) and administrative services agreement with defendant United Behavioral Health (UBH), although plaintiff Pacific Shores Hospital (PSH) disputes that this was permissible. ER 4-5. The plan provides for coverage of "medically necessary" care. ER 6. The SPD defines "medically necessary" treatment as "care . . . within clinically accepted medical services . . . of the general medical community" provided at "an appropriate level of care" to restore or maintain . . . health." ER 656. The SPD also provides that a determination by UBH that mental health or substance abuse treatment is "medically necessary" is a prerequisite to coverage and that this determination will be made based on applicable UBH coverage criteria guidelines. ER 6.

Knutson suffered from anorexia nervosa, causing her to limit her daily caloric intake to 200 calories, and engage in oral purging and laxative abuse, including ingestion of approximately 130 laxatives each day. ER 25, 129, 990-91.

On January 25, 2010, she was admitted to PSH for anorexia, malnutrition, recurrent and severe major depressive disorder, and pneumonia. ER 990-991, 1005. When admitted, she weighed between 81 and 88 pounds[1] (65% of her medically ideal body weight (IBW)), was suffering from fainting spells, and had an active desire to kill herself by overdosing on Tylenol, or laxatives, or by starvation. ER 991-993, 995. Knutson had a history of severe depression, at least two prior inpatient hospitalizations, one of which was at PSH, and at least one prior suicide attempt by laxative overdose in 2007. ER 9, 992. Based on these facts, UBH approved hospitalization for Knutson and UBH determined that she should transfer to a residential treatment facility after four weeks when she reached 85% of her ideal body weight, stopped oral purging, had no suicidal intent, and was no longer abusing laxatives. ER 10, 993.

During the next several weeks, PSH weaned Knutson off her laxative abuse but, as a result, she developed pancreatitis, hypokalemia, abdominal pain, and difficulties with her bowels. ER 10-12, 15. Moreover, during her first four days, her weight dropped to 75.5 pounds. ER 996. During her treatment, Knutson expressed a persistent intent to commit suicide and a fear that she would kill

[1] UBH's files gave conflicting accounts of her weight at admission, but indicated she weighed as much as 88 pounds. ER 993.

herself, telling her doctors on February 8, 2010, for instance, that she would overdose on laxatives if released. ER 1005.

On February 16, 2010, UBH determined that, as of February 14, 2010, Knutson no longer required hospitalization and denied further coverage of her treatment at PSH as of that date. At the time of this determination, Knutson weighed either 83 or 84 pounds. ER 12, 587. Her precise weight on admission and on February 14, 2010, cannot be determined due to inconsistencies in UBH's files, but during this time she either gained a mere two or three pounds, or lost as much as five pounds. Moreover, UBH acknowledged that she weighed only 67%, of her IBW on February 14, 2010, far less than the 85% UBH originally set as her target for discharge, or the 75% PSH insisted was necessary. ER 587, 1012. Only two days before Knutson's benefits ceased, her doctors told UBH that her desire for suicide had lessened, but that she still threatened to overdose or starve herself if released, she still suffered from acute pancreatitis, requiring round-the-clock management, and stomach distension, and still needed meal supervision and prompting. ER 1010-11. Despite this, UBH justified denying further coverage of her hospitalization by reasoning that Knutson's history of low body weight permitted a lower body weight in her discharge criteria. ER 14.

PSH appealed the decision on Knutson's behalf, and UBH referred that appeal to an independent medical review company with which it had contracted,

Prest & Associates (to which Wells Fargo does not appear to have delegated discretionary authority); an employee of Prest, Dr. Barbara Center, upheld the initial denial. ER 15-16. Although Dr. Center reviewed UBH's case notes and consulted with Knutson's doctors at PSH, her case summary contained numerous errors, including misstating Knutson's weight on the date of admission, misstating her overall weight gain, understating her laxative abuse, minimizing her suicidal intent at the times of admission and denial, and failing to note her history of suicide attempts and her other medical complications at the time of denial. Based on this haphazard review, Dr. Center denied further benefits because she concluded that Knutson was no longer abusing laxatives, was motivated for recovery, and was compliant with her meal plan. ER 15-16. Again, her low weight and negligible weight gain were dismissed as insignificant given her history of anorexia, ER 15-16, and Dr. Center made no mention of her persistent threat to overdose or her pancreatitis and stomach distention. Moreover, the letter did not explain why UBH denied further benefits after just less than three weeks when it had originally approved four. Despite this determination, PSH continued its inpatient treatment of Knutson until February 25, 2010.

2. Level of Care Guidelines

    a. Acute Inpatient

UBH used two different Level of Care Guidelines to evaluate Knutson's claim. The Acute Inpatient standard, any one of the following criteria must be met to receive inpatient hospital care as an initial matter:

1. Serious and imminent risk of harm to self or others due to a behavioral health condition, as evidenced by, for example:
    a. Recent and serious suicide attempt(s) as indicated by the degree of intent, impulsivity, and/or impairment of judgment.
    b. Current suicidal ideation with intent, realistic plan and/or available means, or other serious life threatening, self-injurious behavior(s).

. . . .

2. Serious and acute deterioration in functioning from a behavioral health condition that significantly interferes with the members' ability to safely and adequately care for themselves in the community.
3. Severe disturbance in mood, affect, or cognition that results in behavior that cannot be managed safely in a less restrictive environment.
4. Imminent risk of deterioration in functioning due to the presence of severe, multiple and complex psychosocial stressors that are significant enough to undermine treatment at a lower level of care.
5. Recommended behavioral health treatment of a member with a serious medical condition that requires 24-hour management.
6. Community support services that might otherwise augment ambulatory mental health services and avoid the need for hospitalization are unavailable.

b. Continued Service

The Continued Service Guidelines list additional criteria that must be met in order to be entitled to continuing hospitalization. As relevant here, these criteria are:

1. The member continues to meet the criteria for the current level of care.
2. The member is presenting with symptoms and a history that demonstrate a significant likelihood of deterioration in functioning/relapse if transitioned to a less restrictive or less intensive level of care.

….

9. The member cannot effectively move toward recovery and be safely treated in a lower level of care.

….

At the time of her discharge, three weeks after admission, UBH found that 1, 2, and 9 were no longer met. ER 7-8.

3. Procedural History

PSH argued that UBH operated under a conflict of interest warranting increased scrutiny because it wanted to keep its contract with Wells Fargo, and Wells Fargo had an interest in minimizing its payments for benefits. PSH also argued that, regardless whether UBH was conflicted, its decision was arbitrary and capricious, because it was contrary to the medical standards for treating eating disorders, Dr. Center's decision contained numerous errors, and UBH disregarded or minimized Knutson's suicidal threats, negligible weight increase and extremely low body weight, and medical complications. Further, PSH noted that the discharge criteria UBH initially enumerated had not been met, as Knutson had only reached 67%, not 85%, of her IBW. ER 21-22.

PSH sued UBH as assignee of Knutson's claim. The district court upheld the denial of benefits, holding that UBH had not abused its discretion. ER 26. The district court held that there was no conflict of interest that needed to be considered on abuse of discretion review. ER 20. Because the payer, Wells Fargo, and the decision-maker, UBH, were two separate entities, and because UBH used an

independent medical company to decide PSH's appeal, the court found that the plan "was not operating under a structural conflict of interest." ER 20. Further, the court found that UBH had not abused its discretion, instead concluding that the errors in Dr. Center's report could have been explained by miscommunication with PSH's doctors, and that errors regarding her status at admission had little impact on the decision to discontinue benefits three weeks later. The court reasoned that Knuston's successful reduction of her laxative abuse, her increased caloric intake, her weight gain, and her participation in group therapy were sufficient reasonable bases to deny continued inpatient treatment. ER 25-26.

SUMMARY OF THE ARGUMENT

A reviewing court must determine whether a denial of benefits is an abuse of discretion based on a thorough consideration of the entire record, regardless whether the administrator was operating under a conflict of interest. In Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955 (9th Cir. 2006) (en banc), the Ninth Circuit explained that the abuse of discretion standard, while deferential, nevertheless requires the court to review the reasonableness of the decision in light of all relevant facts and circumstances. Because Abatie involved an administrator acting under a conflict of interest, some Ninth Circuit decisions may be misconstrued as mandating review of the entire record only in conflict cases, and otherwise requiring affirmance so long as "any reasonable basis" supports an

administrator's determination," regardless whether the determination appears unreasonable when viewed in light of all the surrounding facts and circumstances. However, the Supreme Court's ruling in Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105 (2008), makes clear that the Abatie totality-of-the-circumstances approach is required regardless whether the decision-maker was operating under a conflict of interest. Although this Court has not yet expressly extended this totality-of-the-circumstances test to non-conflict cases, the Ninth Circuit case law is best read, consistently with the Supreme Court's decision in Glenn, to provide a single abuse of discretion standard of review that requires consideration of all relevant factors in determining if the decisionmaker, whether or not conflicted, acted reasonably in denying benefits under the plan.[2]

Under this totality-of-the-circumstances test, UBH's denial of benefits for Knutson's continued hospitalization for the period between February 14, 2010 and February 25, 2010, was unreasonable. Rather than conduct a full and fair review, UBH cherry-picked the record, emphasizing a few facts that favored discharge while deemphasizing or entirely ignoring or misconstruing the overwhelming weight of the evidence that favored continuing coverage. In upholding this denial, the district court minimized the administrator's selective review of the medical evidence, as well as the many mistakes and deficiencies in the administrator's

[2] The Secretary's brief will not address the conflict issue.

review and understanding of the relevant facts. Consequently, its decision affirming the denial of benefits is not consistent with the more searching abuse of discretion review mandated by Abatie and Glenn and should be reversed.

ARGUMENT

I. AN ADMINISTRATOR'S BENEFITS DECISION IS AN ABUSE OF DISTRICTION IF IT IS NOT BASED ON A FULL AND FAIR REVIEW OF ALL RELEVANT FACTS AND CIRCUMSTANCES.

A. The abuse of discretion standard applicable to benefit determinations by a fiduciary who is granted discretionary authority requires a consideration of all factors relevant to the reasonableness of the determination.

In Abatie, this Court considered the standard under which courts review benefits determinations when the plan gives the administrator discretionary authority and the administrator is operating under a conflict of interest. This Court looked first to Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), in which the Supreme Court drew on "general trust principles" to conclude that, where the plan grants discretionary authority to a fiduciary to make benefit determinations, courts must review the fiduciary's decisions under a deferential, abuse of discretion standard of review. Abatie, 458 F.3d at 962 (citing Firestone, 489 U.S. at 110-11). While stating that this review is deferential, this Court held that, "in any given case, all the facts and circumstances must be considered" in determining the reasonableness of the administrator's denial of benefits. Abatie,

458 F.3d at 968. Where the administrator operates under a financial conflict of interest, the conflict becomes one of the factors for consideration. Id.

Two years later, the Supreme Court considered the same issue and reached the same conclusion in Glenn. The Court began, as Abatie did, with Firestone, reiterating Firestone's conclusion that "[i]n 'determining the appropriate standard of review,' a court should be 'guided by principles of trust law'; in so doing, it should analogize a plan administrator to the trustee of a common law trust; and it 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)." Glenn, 554 U.S. at 111 (quoting Firestone, 489 U.S. at 111-13, additional citations omitted). Where the plan grants discretionary authority to the administrator or other fiduciary making benefits determinations, these "trust principles make a deferential standard of review appropriate.'" Glenn, 554 U.S. at 111 (quoting Firestone, 489 U.S. at 111 and citing Restatement (Second) of Trusts § 187 (1959); G. Bogert & G. Bogert, Law of Trusts and Trustees § 560, at 193-208 (rev. 2d ed. 1980)) (emphasis in original). Again citing the Restatement, the Court noted that if the administrator or fiduciary that is granted discretion is "operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." Glenn, 554 U.S. at 111 (internal quotations and citations omitted).

Significantly, the Supreme Court held that the existence of a conflict does not change the standard of review from deferential to de novo, nor does it require application of special procedural or evidentiary rules. Glenn, 554 U.S. at 116. Instead, "conflicts are but one factor among many that a reviewing judge must take into account" in conducting its abuse of discretion review. Id. (emphasis added). Thus, the Court adopted a "combination-of-factors method of review" for determining whether an administrator abused its discretion, endorsing the Sixth Circuit's consideration of a number of factors that raised "serious concerns," including that "MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its . . . medical experts with all of the relevant evidence." Id. at 117-18.

Thus, in clarifying that courts should factor in conflicts, the Supreme Court did not create a new standard separate from the abuse of discretion review applied in trust law under which judges "determine lawfulness by taking account of several different, often case-specific, factors, reaching a result by weighing all together." Glenn, 554 U.S. at 117 (citing Restatement (Second) of Trusts § 187, Comment d). The standard remains the same regardless: a reviewing court must consider the reasonableness of an administrator's decision by weighing all relevant factors and circumstances. In conflict cases and non-conflict cases alike, "[a] district court,

when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage," and "[a] straightforward abuse of discretion analysis allows a court to tailor its review to all the circumstances before it." Abatie, 458 F.3d at 486 (citation omitted, emphasis added). Glenn, like Abatie, merely clarifies that, when a conflict exists, it becomes one of the factors to consider. Glenn, 554 U.S. at 117 ("when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one"); Abatie, 458 F.3d at 965 (noting that "[a]buse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest" but "that the existence of a conflict of interest is relevant to how a court conducts abuse of discretion review"). Whether or not there is a conflict, neither the claims administrator, acting as a fiduciary, nor the reviewing court may rely on isolated facts that support the denial of benefits, while disregarding other relevant facts that significantly undermine such a determination. Glenn, 554 U.S. at 118.

Both Glenn and Abatie, therefore, instruct courts to "tailor [their] review to all the circumstances before" them. Abatie, 458 F.3d at 968 (emphasis added). Moreover, the Supreme Court and this Court, have already outlined many factors a court should consider in an ERISA case, only some of which are even arguably relevant to establishing the extent of a conflict. As most relevant here, these

include: (1) the quality and quantity of the medical evidence, Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 630 (9th Cir. 2009); (2) whether the administrator reviewed the claimant's evidence with a selectivity that appears self-serving, by, for example, crediting one part of the advice of a treating doctor, but not his other advice, Glenn, 554 U.S. at 118; (3) whether the administrator made factual errors in its decision, Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 669 (9th Cir. 2011); (4) whether it rendered a decision without any explanation, Anderson v. Suburban Teamsters of N. Ill. Pension Fund Bd. of Trs., 588 F.3d 641, 649 (9th Cir. 2009); (5) whether it construed provisions of the plan in a way that conflicted with the language of the plan, id.; (6) whether it developed the facts necessary to the determination, see id. and Abatie, 458 F.3d at 968-69; (7) whether it provided inconsistent reasons for the benefit denial, Harlick v. Blue Shield of Cal., 656 F.3d 832, 839 (9th Cir. 2011); (8) whether it subjected the claimant to an in-person medical evaluation, or relied instead on a paper review of the claimant's existing medical records, Montour, 588 F.3d at 631; and (9) whether it provided its independent experts with all relevant evidence, see Glenn, 554 U.S. at 118 and Montour, 588 F.3d at 631. See also Howley v. Mellon Fin. Corp., 625 F.3d 788 795 (3d Cir. 2010); Finley v. Special Agents Mut. Benefit Ass'n, 857 F.3d 617, 621 (8th Cir. 1992); Holmstrom v. Metro. Life Ins. Co., 615 F.3d 758, 777 (7th Cir. 2010).

Thus, under Glenn and Abatie, a district court must consider these and any other factors that may be relevant to the particular facts of each case. It cannot determine whether a decision is reasonable without engaging in this kind of full-picture consideration of the entire administrative record.

B. This Court's ERISA precedent should be clarified to ensure a single standard of abuse of discretion review requiring a full consideration of all relevant facts, regardless whether there is a conflict of interest.

Because both Glenn and Abatie concern administrators operating under a conflict of interest, the defendants suggest that a less searching standard of review is appropriate when there is no conflict. Such an approach is fundamentally inconsistent with Glenn and Abatie, as this Court should now clarify.

Since Glenn, this Court has published opinions in two ERISA cases in which it found no conflict of interest. Anderson, supra; Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan, 572 F.3d 727, 732 (9th Cir. 2009). In Anderson, before finding that there was no conflict of interest, this Court considered whether the administrator provided an explanation, construed plan provisions in harmony with the plan's plain language, and developed facts necessary to its determination. 588 F.3d at 649. Thus, despite the lack of an explicit statement on the applicable standard where there is no conflict, Anderson's consideration of factors was consistent with the Glenn approach.

In Sznewajs, this Court discussed whether it should review an administrator's decision de novo or for abuse of discretion, and whether there was a conflict of interest. The Court broadly stated that a "decision is not arbitrary [and therefore not an abuse of discretion] unless it is not grounded on any reasonable basis." 572 F.3d at 734-35 (emphasis in original). However, the Court did not discuss the abuse standard at length, and it expressly stated that the standard of review was not determinative of the outcome in that case. Id. at 732.

More recently, this Court reiterated that, where "the plan gives the administrator discretion, and the administrator has a conflict of interest, we are to judge its decision to deny benefits to evaluate whether it is reasonable," explaining that "[r]easonableness does not mean that we would make the same decision." Salomaa, 642 F.3d at 675. Nevertheless, deferential review does not "avoid the process of judgment." Id. (quoting Glenn, 554 U.S. at 119). Moreover, following Glenn, this Court held that the "any reasonable basis" test articulated in Sznewajs "is no longer good law when . . . an administrator operates under a structural conflict of interest." Salomaa, 642 F.3d at 674.

Thus, Salomaa, explicitly discarded the "any reasonable basis" test for conflict cases. This Court has not yet done so in a non-conflict case. Instead, there is dicta in a recent conflict case that "[i]n the absence of a conflict of interest, judicial review of a plan administrator's benefits determination involves a

straightforward application of the abuse of discretion standard. In these circumstances, the plan administrator's decision can be upheld if it is 'grounded on any reasonable basis,'" Anderson, 588 F.3d at 629 (internal citations omitted), and "the existence of a 'single persuasive medial opinion' supporting the administrator's decision can be sufficient to affirm, so long as the administrator does not construe the language of the plan unreasonably or render its decision without explanation." Id. at 630 (internal citations omitted).

Thus, under this Court's precedent, when there is a conflict of interest, a district court must consider all relevant factors in determining whether a claims administrator abused its discretion in denying a claim for benefits. This Court has not yet stated that it will likewise consider all relevant factors where the decision-maker is not conflicted, but because language in Montour, Sznewajs, and Salomaa, might be misconstrued to eschew Glenn's "combination-of-factors method of review" in a non-conflict case, these cases have created confusion in the lower courts. Compare Skeen v. Rite Aid Corp., 2010 WL 231383, at *5 (E.D. Cal. 2010) (noting that the "any reasonable basis" test applies "where there is no risk of bias on the part of the administrator," but that where the administrator operates under a structural conflict, abuse of discretion review "requires a more complex analysis"), with Patrick v. Hewlett-Pakcard Co. Emp. Benefits Org. Income Prot. Plan, 638 F. Supp. 2d 1195, 1205-06 (S.D. Cal. 2009) (abuse of discretion review

requires a consideration of relevant factors, regardless of whether there is a conflict of interest).

This Court should now clear up this confusion. As previously outlined, precedent from this Court and the Supreme Court does not permit an administrator to deny benefits based on a few, isolated facts. Indeed, Glenn makes clear the Supreme Court's intent to avoid a proliferation of standards, and plainly instructs courts to consider conflict of interest alongside myriad other case-specific factors under a single abuse of discretion standard. This Court has agreed, admonishing that its case law "should not be mistaken to imply that the existence of a conflict of interest alters the standard of review itself, rather than merely its application." Montour, 588 F.3d at 630-31.

Given this, Montour should not be construed to mean that an administrator can successfully defend a denial of benefits by relying on a single, supporting factor, especially where there are numerous countervailing facts. Montour is better read as providing but one example of how the factors in a non-conflict case may be weighed. For instance, in reviewing multiple factors, a court may find that factors weighing in a beneficiary's favor are weak; in light of a strong medical opinion supporting a denial, those weak factors would fail to overcome an administrator's adverse decision. This does not mean, however, that a single medical opinion would always trump any other relevant factor; it merely means that one such

opinion can, in view of the other factors, be sufficient to uphold an administrator's decision. In other words, Montour can and should be harmonized with Glenn's "combination-of-factors method of review," which requires consideration of all relevant facts; a decision is not "reasonable" if only a few facts are relied upon and other salient facts are disregarded or misapprehended.

Sznewajs and Salomaa similarly should be read in concert with Glenn and Abatie. Although a court may not reweigh the evidence in either a conflict or a non-conflict case, it may uphold a fiduciary's denial of benefits only where its explanation is reasonable based on the court's consideration of the entire record. The court would thereby preserve its ability to provide meaningful review to plan participants because, although the abuse of discretion standard is deferential, it should not relegate the court to being a rubber stamp for all administrator decisions, no matter how thinly reasoned or supported by the evidence. See Glenn v. MetLife, 461 F.3d 660, 666 (6th Cir. 2006).

Some courts, however, including the Ninth Circuit, have equated abuse of discretion review and "arbitrary and capricious" review and held that, under the latter, the court need only be satisfied that "substantial evidence" supports the decision. Jordon v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869, 875 (9th Cir. 2004). And in this context, this Court has held that "a decision 'grounded on any reasonable basis' is not arbitrary and capricious," or clearly

erroneous, id., just as, in the administrative law context, "arbitrary and capricious" review generally requires only a "rational" foundation for the agency decision. See Motor Vehicle Mfgrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 42-43 (1983). These standards are specifically identified in the Administrative Procedure Act itself, 5 U.S.C. § 706(2)(A) and (E), and they reflect a special measure of deference reflected in the separation of powers and statutory allocations of governmental powers. See, e.g., FCC v. Pottsville Broadcasting Co., 309 U.S. 134, 141 (1940).

ERISA's cause of action to recover benefits under a plan does not incorporate those standards. Instead, it draws on the distinct body of private trust law which "sets forth a special standard of care upon a plan administrator" as a plan fiduciary to exercise its discretion "solely in the interests of the participants and beneficiaries of the plan," by providing a "full and fair review" to claimants. Glenn, 554 U.S. at 111. For this reason, this Court should reject the "any reasonable basis test" and recognize that, whether or not the administrator operates under a conflict, abuse of discretion review in the ERISA context examines the reasonableness of the decision based on the record as a whole, Glenn, 554 U.S. at 117 (citing Restatement (Second) of Trusts § 187, Comment d), a standard that is not as deferential as in the administrative agency context. See Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1564 n.7 (11th Cir. 1990)

(noting that "[d]ecisions in the ERISA context involve the interpretation of contractual entitlements; they are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers," and "the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies") (overruled on other grounds). See also Conkright v. Frommert, 130 S. Ct. 1640, 1646 (2010) (reiterating applicability of trust-law's reasonableness standard). But even in the administrative law context, judges must "determine lawfulness by taking into account several different, often case specific, factors, reaching a result by weighing all together." Glenn, 554 U.S. at 117 (citations omitted).

Accordingly, at a minimum, weighing relevant factors is a basic component of the abuse of discretion test, which calls upon "a court to tailor its review to all of the circumstances before it." Abatie, 458 F.3d at 968. Requiring this kind of review whether or not the fiduciary deciding the claim is conflicted ensures that "deferential review is not no review," Hess v. Hartford Life & Accident Ins. Co., 274 F.3d 456, 451 (7th Cir. 2001), and that the district court does not simply "rubber stamp the administrator's decision." Jones v. Metro. Life Ins. Co., 385 F.3d 654, 661 (7th Cir. 2004). This case offers the Court the opportunity to clarify the law and clearly state that all of the evidence must be considered in conflict and

non-conflict cases alike under the combination-of-factors review mandated by the Supreme Court in Glenn.

II. THE PLAN FIDUCIARIES ABUSED THEIR DISCRETION BY DENYING CONTINUED COVERAGE FOR INPATIENT HOSPITAL TREATMENT FOR AN ANOREXIC PATIENT WHO HAD GAINED, AT MOST, THREE POUNDS, CONTINUED TO BE SERIOUSLY UNDERWEIGHT, SUFFERED FROM CONTINUING MEDICAL COMPLICATIONS, AND REMAINED SUICIDAL

In this case, as in Glenn, the administrator emphasized facts in the medical record "that favored a denial of benefits," while it "deemphasized certain other reports that suggested a contrary conclusion." 554 U.S. at 118. In deferring to this decision to deny continued hospitalization to Knutson, the district court minimized the administrator's selective review of the medical evidence, as well as the many mistakes and deficiencies in the administrator's review and understanding of the relevant facts. Although the district court did not say that it was applying an "any reasonable basis" standard of review, its decision affirming the denial of benefits is not consistent with the kind of review mandated by Abatie and Glenn. Here, applying the Glenn decision's "combination of factors" review should lead the court to conclude that UBH's decision was "(1) illogical, (2) implausible, or (3) without support in inferences that may be drawn from the facts in the record." Salomaa, 642 F.3d 676.

First, the administrator erred in applying its own Acute Inpatient and Continued Service standards. See supra at 5-6. UBH found that criteria 1, 2, and 9 were not met. Criteria 1, however, requires that the "member continues to meet the criteria for the current level of care." The criteria for the current level of care are outlined under the Acute Inpatient standard, which included establishing recent and serious suicide attempts, "current suicidal ideation with intent, realistic plan and/or available means, or other serious life threatening, self-injurious behavior(s)," and "[r]ecent and serious physically destructive acts that indicate a high risk for recurrent and serious injury to self or others." Not only was Knutson suicidal at admission, a mere three weeks before UBH denied her benefits, but UBH's own notes show that just two days before the benefits end date, Knutson threatened to suicide by either overdosing or starvation. Relying on its own assessment that Knutson lacked a "realistic plan and/or available means" to commit suicide, UBH ignored the fact that she was being held in a restricted hospital setting where she was still being monitored and coached during her meals and was unable to overdose because the hospital restricted access to medications. And taking out of context her doctor's assessment that Knutson was making progress in the hospital and that her desire for suicide had lessened, UBH disregarded her doctors' assessment that she continued to be a serious risk for suicide if discharged. Thus,

UBH's conclusion that Knutson had no plan or means provides little or no support for UBH's conclusion that no further inpatient treatment was unnecessary.

Similarly, UBH unreasonably concluded that Knutson did not meet criteria 2. According to her doctors, Knutson's continued suicide threats and her history indicated a significant likelihood of relapse if she were not continually monitored. ER 9, 992.

Nor was it reasonable to conclude that Knutson failed to meet Continued Service criteria 9, which requires that the "member cannot effectively move toward recovery and be safely treated in a lower level of care." As noted previously, Knutson gained very little, if any, weight during her stay, suffered serious medical complications as a result of her treatment, and continued to threaten to (or fear that she would) kill herself, prompting her doctors to conclude that she could not safely be treated through outpatient care.

Second, the American Psychiatric Association's (APA) "Practice Guideline for the Treatment of Patients with Eating Disorders (Third Addition)" is a clinically accepted guideline, ER 385-512, which UBH says it uses generally and which Dr. Center admits she considered. ER 554-64, 549-50. In light of these admissions, and given the SPD's definition of "medically necessary" treatment as "clinically accepted medical services . . . of the general medical community" at "an appropriate . . . level of care," ER 656, the district court erred in failing to consider

Knutson's argument that she met the Guideline for inpatient treatment and that, as a consequence, UBH's determination that she was not entitled to continued inpatient treatment was unreasonable. See ER 9 n.2 (holding that Guideline was extrinsic evidence that should not be considered).

Third, factual errors in UBH's decision "suggest[] a less than careful examination of [the patient's] medical record." Salomaa, 642 F.3d at 669. Indeed, Dr. Center's case summary of Knutson's condition contained errors on practically every aspect of her condition and treatment, including mistaking her initial weight and net weight gain, dismissing her pedal edema, abdominal distention, and acute pancreatitis, and declaring her medically stable. ER 16, 26. Most significantly, she wrote that Knutson only expressed vague suicidal thoughts, when in fact she had a prior suicide attempt, had a plan for suicide when she was admitted, and continued to express suicidal thoughts at the time of denial of benefits, specifying that she would overdose or starve herself. ER 9-13, 1005, 1010-12. These facts were clearly material to whether Knutson should be discharged but were misapprehended or ignored by the final decisionmaker.

Fourth, because "every doctor who personally examined" Knutson concluded that her condition was severe enough to require continued hospitalization, UBH's decision disagreeing with that consensus, based primarily on phone conversations with those doctors, is questionable at best. Salomaa, 642,

F.3d 676. Indeed, these phone calls appear to support a conclusion that Knutson continued to threaten to kill herself if released, and for this and other reasons the doctors at Pacific Shores continued to treat her until February 25, 2010, despite UBH's denial of her claim. ER 1010-11.

Fifth, in making factual errors and disregarding the examining doctors' conclusions that Knutson required further treatment, UBH selectively considered the evidence. See Glenn, 554 U.S. at 118. Without giving weight to or even noting the continued medical complications Knutson faced, her history of suicide threats and attempts, and her continuing suicidal intent, UBH justified its decision based on Knutson's participation in group therapy, the support of her spouse, and her history of low body weight, which it treated as supporting termination of inpatient treatment rather than an indication of the extent of her illness. ER 10-13, 26. This selective consideration of the evidence not only indicates that UBH did not properly review Knutson's file, it also undermines the credibility of its own doctors' assessments.

Sixth, the quality and quantity of evidence provided clear indicators that Knutson required continued in-patient care. Knutson's doctors produced reports and communications documenting the persistent and extensive physical ramifications of Knutson's disease. Without explaining why her medical complications were insufficient to justify inpatient care, UBH mostly relied on

factors that were far less measurable and tangible than the physical complications Knutson experienced. UBH noted that she was opening up in her therapy sessions and concluded she was less suicidal, despite her doctors' warnings that she was still suicidal. The only physical evidence UBH noted was her negligible weight gain and her reduced laxative usage, which was only accomplished through the hospital's intervention and caused stomach distension and edema that Dr. Cole failed to note.

Seventh, just as an administrator's shifting reasoning for denial may indicate an abuse of discretion, Salomaa, 642 F.3d at 676, so too may shifting criteria. At the outset, UBH approved hospitalization for four weeks until Knutson reached 85% of her IBW. Ultimately, UBH concluded she should be discharged after only three weeks, at which point she had gained, at most, only two or three pounds and reached only 67% of her IBW. Implausibly, UBH reasoned that Knutson's history of low body weight, the very chronicity of which defines her disease as made clear in the APA Guidelines (and about which UBH was aware of at the outset), justified her discharge at a much lower body weight. This shift in criteria significantly undermined the reasonableness of the benefits denial, particularly in light of the medical complications resulting from Knutson's low body weight and other factors discussed above.

ERISA is designed "to ensure that employees will not be left emptyhanded once employers have guaranteed them certain benefits." Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996). Thus, "[t]here can be no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promised them." Cent. Laborers' Pension Fund v. Heinz, 541 U.S. 739, 743 (2004). Knutson had every reason to believe that when Wells Fargo promised her coverage of medically necessary care it would include the cost of her hospitalization during a period of time in which her doctors feared that, because she weighed only 83 pounds and was suicidal, she might die if discharged. UBH's denial of the claim for hospitalization benefits under these circumstances was not based on a full and fair review of the relevant facts, and the district court was far too deferential in affirming this denial. This Court should clarify that, even when the decisionmaker is not conflicted, the reasonableness of the decision under the applicable abuse of discretion standard must be judged based on the totality of the circumstances, and that, under this test, UBH's denial of continued hospitalization benefits to Knutson, for the period between February 14, 2010 and February 25, 2010, was unreasonable.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests that this Court reverse the district court's decision.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE OF BRIEFS
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Pursuant to Fed. R. App. P. 32(a)(7)(B), I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains six thousand six hundred and three (6, 603) words. Pursuant to Circuit Rule 29-2(c)(2), this brief complies with the 7,000 word limit.

I further certify that a virus scan was performed on the Brief using McAfee, and that no viruses were detected.

Dated: August 13, 2012

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CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of August, 2012, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF systems.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: August 13, 2012

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