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Comments on ERISA's Claims Review Procedures
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I am an attorney practicing in Salt Lake City, Utah. I graduated from the University of Utah College of Law in 1985 and for the last thirty years or so I have been representing almost exclusively plaintiffs with claims against life, health, and disability insurers. I have been an A rated lawyer with Martindale-Hubbell for over two decades.

The great majority of the work I do involves denied mental health and substance use disorder claims. I have represented hundreds of individuals whose mental health and substance use disorder claims have been denied by health benefit plans governed by the Employee Retirement Income Security Act ("ERISA"). In the past ten years I have also brought many claims involving the Mental Health Parity and Addiction Equity Act ("MHPAEA").

REALITIES OF ERISA CLAIMANT BENEFIT LITIGATION

I have learned a few consistent realities about ERISA, MHPAEA, and health benefit plans and their insurers over the last thirty years.[1]

First, it is not in the interest of insurance companies to pay claims. Their ability to survive in our competitive market economy largely depends on identifying reasons not to pay

[1] Unless otherwise noted, I use the term "insurer" in this presentation for the role of insurers who are retained to act as third-party administrators ("TPA") of self-funded ERISA governed employee welfare benefit plans as well as when insurers' own assets are used to pay benefits for group insurance plans. Similarly, the word "insureds" encompasses participants and beneficiaries of both fully insured and self-funded welfare benefit plans.

claims. That is an imperative based on financial survival. As such, insurers are predisposed to look for ways to validly deny claims. And motivated reasoning about what constitutes a "valid" basis for denying claims creates many denials that are unreasonable to insureds, regulators, and judges.[2]

Second, insurers do not want to be held accountable, to be required to answer for their behavior. They want insureds, regulators, and judges to provide them with the greatest latitude and discretion possible. And they want any review of their decisions to be toothless and deferential. Again, economic incentives dictate this reality.

Third, it is in the financial interest of insurers to provide as little information as possible and to make what information they do provide as incomprehensible as possible. An ignorant or confused insured helps insurers carry out their activities without being accountable. An insured who does not have the tools or knowledge to challenge the insurers decision is likely, sooner or later, to simply give up any effort to challenge insurers with seemingly unlimited resources. That is especially true if insurance claim specialists and lawyers are not available to assist insureds. As I often say to my clients to orient them to the reality they face, "insurers treat you like mushrooms: keep you in the dark and feed you manure." Which leads me to my last observation:

Fourth, to create a more level playing field between insurers and insureds, regulators and the federal judiciary must put in place through their regulatory activities and judicial rulings a more robust framework for, and interpretation of, ERISA's claims and appeals procedures. My comments today address recent case law in this area and thoughts about the way forward.

[2] Insurers contend that conflicts of interest do not exist when an insurer is only acting as a TPA of a self-funded plan rather than when they must pay claims of a fully insured plan out of their own assets. This is true, they argue, because their own assets are not used to pay claims for self-funded plans. Insurers are simply paying or denying claims involving funds of other entities in that situation. However, my experience is that because TPAs compete with other TPAs to save money for the employers sponsoring self-funded plans, the conflict of interest is little different for TPAs than it is for insurers who process claims when their own assets are at stake.

RECENT CASE LAW ON ERISA'S CLAIMS PROCEDURE REGULATIONS IN PROVIDING ADEQUATE TOOLS TO PROTECT CONSUMERS

ERISA provides tools I use regularly in litigation to protect the interests of my clients, participants and beneficiaries of ERISA plans. The rights insureds have under ERISA include notice and disclosure requirements and the statutory penalties associated with violation of those mandates,[3] fiduciary duty requirements,[4] and civil enforcement protections.[5] ERISA's claims procedure requirements mandating that insurers provide to insureds adequate written notice of claim denials and a full and fair review of appeals of denied claims,[6] together with the regulations fleshing out detail of what the statutory language requires,[7] are indispensable to making ERISA's protections of welfare benefits meaningful to insureds. But the degree to which the claim procedure requirements are effective at protecting insureds depends largely on the extent to which insurers believe they will be, and are, held accountable to those standards by regulators and judges.

I have seen progress in litigation over the past several years in the federal judiciary holding insurers' feet to the fire on ERISA's claims procedure requirements. In the last few months, the Tenth Circuit Court of Appeals has issued three published opinions that have focused on insurer violations of the claims procedure regulations and have provided meaningful remedies for those violations.

The most important recent decision, *D.K. v. United Behavioral Health*, 67 F.4th 1224 (10th Cir. 2023) *cert. den.* 144 S.Ct. 808; 2024 U.S. LEXIS 748 (2/20/24), involved an insurer's denial

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[3] 29 U.S.C. §§ 1021-1024 and 29 U.S.C. § 1132(a)(1)(A) and (c)(1).
[4] 29 U.S.C. §§ 1101-1114.
[5] 29 U.S.C. § 1132.
[6] 29 U.S.C. § 1133.
[7] 29 C.F.R. §§ 2560.503-1 and 2590.715-2719. Many attorneys are not aware of the important role that 29 C.F.R. §2590.715-2719, "Internal Claims and Appeals and External Review Processes," regulations promulgated as part of passage of the Affordable Care Act, are important regulatory supplements for health benefit claims under ERISA.

of payment for long-term residential treatment of an adolescent girl, A.K., with serious mental health disorders. A.K. had been treated in a revolving door pattern of inpatient and outpatient settings to treat serious episodes of depression, anxiety, and self-harm. When her symptoms persisted, her treating clinicians recommended long-term residential treatment on an inpatient basis for A.K. but the insurer denied payment of that treatment. Her parents submitted many written appeals with several letters from A.K.'s treating clinicians outlining in detail why long-term residential treatment was medically necessary for her. In response, both the insurer and an external reviewer maintained the insurer's denial. However, their reviews and the letters responding to A.K.'s parents were conclusory and did not cite to the specifics of either the letters of medical necessity from the treating clinicians or the medical records submitted with the parents' appeal letters.

The district court reversed the insurer's denial and ordered payment of benefits. The insurer appealed and the Tenth Circuit affirmed the district court's decision to reverse the benefit denial on the basis that the insurer did not "fairly engage with the medical opinions" of the treating clinicians and that the insurer's "denials did not contain reasoned analysis or specific citations to the medical record." 67 F.4th at 1235, fn. 5.

The Tenth Circuit carried out an extensive analysis of the obligations of the insurer to provide adequate notice of the reasons for the claim denial and the need for the insurer to carry out a "full and fair review" of the family's appeal of the claim denial. 67 F.4th at 1236-1243. The decision identified ERISA's fiduciary duty standards as creating "a special duty of loyalty to the plan beneficiaries" that informed the analysis of the panel in the case. 67 F.4th at 1236. It stated that the regulation's reference to "minimum" standards did not allow insurers to "shirk their broad fiduciary responsibilities by pointing to a lack of specified minimum standards in a narrow

area:" "[t]here is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are 'ordinary and natural means' of achieving the 'objective' of the plan." 67 F.4th at p. 1239 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 504).

One important aspect the Tenth Circuit ruling in *D.K.* was that it rejected that insurer's argument that courts should consider as justification for a benefit denial under an abuse of discretion standard of review information in the insurer's claim file that could support the denial of benefits but that the insurer failed to disclose to the insured in the claims review process. 67 F.4th at 1236-1237, 1239-1240. The Tenth Circuit pointed out that "ERISA denial letters play a particular role in ensuring full and fair review" by facilitating a "meaningful dialogue" between insurers and insureds. 67 F.4th at 1239. Failing to provide all the reasons for denial and information justifying those reasons does not comply with the claim procedure regulations. Reversal of the claim denial is necessary even under an abuse of discretion standard of review.

The Tenth Circuit also faulted the insurer for failing to sufficiently explain its basis for denying the claim, specifically, for failing to make any references to information in A.K.'s medical records that supported the insurer's conclusion that her residential treatment was not medically necessary. The decision noted the claims procedure regulation requirement that the insurer was required to "take into account all comments, documents, records, and other information submitted by the claimant relating to the claim" when evaluating the insured's appeal. 67 F.4th at 1242. Given the "extensive information" in the insured's appeal, the insurer's "conclusory responses without citing do the medical record …. did not constitute a full and fair review." *Id.* The insurer's denial letters failed to contain "any analysis, let alone a reasoned analysis." *Id.* As such, the insurer's denial was arbitrary and had to be reversed.

Finally, another important ruling in *D.K.* was its discussion of the relationship between changes to the claims procedure regulations that distinguished between health and disability benefit claims. The insurer argued that the language of the regulations allowed it to provide less extensive disclosure of the reasons for denial, information supporting those reasons, and analysis of the information presented by insureds in their appeals because the claims at issue in the case were health benefit rather than disability benefit claims. The Tenth Circuit rejected this argument: "[w]e recognize the textual difference in the ERISA disability and ERISA medical regulations …. but disagree that the …. [difference] absolves …. [the insurer] from its duty to engage in meaningful dialogue that includes a full and fair review of the insured's claim." 67 F.4th at 1238. The decision went on to discuss at length the timing and language of the ACA claim procedure guidelines for health claims and the supplemental claim procedure guidelines for disability claims and stated that it was "simply not the case" that the regulations established more lax claim procedure mandates for health claims than for disability claim. *Id.*

The insurer argued that the inherent differences between health and disability benefits made it unfeasible for insurers to carry out the kind of full and fair review and "meaningful dialogue" the district court had ruled was necessary. But the Tenth Circuit rejected that argument and identified in fn. 9 of its opinion how the differing nature of health benefit claims may require varying intensities of review by insurers to satisfy the obligation to carry out a full and fair review. In short, what constitutes an adequate full and fair review of a two-paragraph appeal of a denied $1,500 dental bill may look very different than what is necessary to reasonably carry out a full and fair review of a denied mental health claim involving multiple letters of medical necessity from treating clinicians, 2,000 pages of medical records, and $120,000 of unreimbursed expenses.

The second case from the Tenth Circuit is *David P. v. United Healthcare Ins. Co*., 77 F.4th 1293 (10th Cir. 2023). This case also involved a denied claim for residential treatment of an adolescent's mental health conditions. As in *D.K.,* it faults the insurer for failing to reference either the multiple letters of medical necessity submitted in the pre-litigation appeal process or the information in the medical records in its denial letters. 77 F.4th at 1304-1305. While insurers need not defer to the opinions of treating physicians, they also may not disregard reliable evidence in the record, including the opinion of treating clinicians. 77 F.4th at 1308 (citing *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003)). It reaffirms the holding of *D.K.* that internal notes never disclosed to the insured during the pre-litigation appeal process may not be used by the insurer in litigation to bolster a claim denial. 77 F.4th at 1313-1314. One specific way in which the decision faulted the insurer was that it failed to consider the substance use symptoms and diagnosis of the patient in evaluating the medical necessity of her treatment. 77 F.4th at 1309-1310. As in *D.K*., the decision specifically criticized the insurer for failing to "engage" with the opinions of the treating clinicians and the information in the medical records. 77 F.4th at 1310-1312. *David P.* goes on to specifically reject the idea that simply because an external review has occurred and supports the insurer's denial, deficiencies in an insurer's claims process are cured. 77 F.4th at 1314.

An important distinction between *David P.* and *D.K*. is that the Tenth Circuit reversed the district court's order that the proper remedy was to require the insurer to pay benefits. Instead, the decision remanded the case to the insurer for additional consideration. 77 F.4th at 1315-1316. However, the Tenth Circuit noted that this action did not "provide the plan administrator the opportunity to reevaluate a claim based on a rationale not raised in the administrative record … and not previously conveyed to the [insured]. 77 F.4th at 1316.

The third case in the triad of Tenth Circuit opinions regarding ERISA claims procedure issues for health claims is *Ian C. v. UnitedHealthCare Ins. Co*., 87 F.4th 1207 (10th Cir. 2023). Like *D.K.* and *David P.,* this case involved a young man's residential treatment for mental health and substance use disorders. The Tenth Circuit found the insurer erred in denying the claim and reversed the district court's decision to affirm that denial of coverage. Like *D.K.* and *David P.,* the decision faults the insurer for ignoring the opinions of the treating physicians and information in the medical records and rejects the insurer's efforts to buttress its denial bases with information in the claim file it never disclosed to the insureds. And like *David P.,* one of the reasons for reversal of the claim denial is that the insurer failed to consider the patient's substance use symptoms and diagnosis. Importantly, *Ian C.* rejects the insurer's argument that the insured had an obligation to show that substance abuse was the "primary driver" of the residential treatment for the insurer to be required to specifically address it in its denial letter. 87 F.4th at 1224. *Ian C.* also delves into the insurer's faulty application of its internal medical necessity criteria as a basis for reversal of the denied claim. As in *David P.,* the Tenth Circuit remanded the case to the district court for additional consideration rather than order payment of benefits.

It's noteworthy that all three Tenth Circuit cases were decided under an abuse of discretion standard of review. Discretionary authority does not give insurers latitude to violate ERISA's claims procedure requirements.

THE WAY FORWARD IN HOLDING INSURER'S ACCOUNTABLE IN THEIR CLAIMS PRACTICES

The trend in these Tenth Circuit cases is hopeful. They put more teeth and accountability into ERISA's claim procedure statute and regulations than many federal courts have in the past. To the extent that courts require a more rigorous application of ERISA's claims procedure

requirements, with the application of the statute's fiduciary duty standards as a critical component of those claims processing mandates, it will help ensure that insureds receive the protections they are entitled to under ERISA.

One aspect of the three Tenth Circuit cases worth noting is that the Department of Labor and the federal judiciary have work to do in addressing whether remand to an insurer that has been found to have violated ERISA's claims processing and fiduciary duty standard is proper. To the extent remand may properly be ordered by either a district judge or circuit court of appeal panel, it would be helpful to have more regulatory guidance in the form of restrictions and guardrails on insurers to prevent abusive "second bites at the apple" by insurers who have shown themselves unworthy of their fiduciary responsibilities. If remand simply gives insurers the opportunity to figure out how to more securely shore up an unwarranted claim denial, reversal without an order of payment of benefits is simply a second injustice added to the initial wrongful denial.