No.

IN THE

Supreme Court of the United States

UNITED BEHAVIORAL HEALTH AND ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR ACTIVE MANAGEMENT EMPLOYEES,
Petitioners,

v.

DAVID K., KATHLEEN K., AND AMY K.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Employee Retirement Income Security Act of 1974 (ERISA) requires plans to provide members written notice of the reasons for a benefits denial in understandable terms. In *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831–34 (2003), this Court held that courts may not require plans denying benefits to also explain why they disagree with the member's treating physicians. The Court noted, however, that the Department of Labor ("DOL") could potentially undertake rulemaking to add that requirement. *Id.* at 831. Thirteen years later, DOL revised its *disability benefits* regulations to require a discussion of treating provider opinions. But DOL has never similarly amended its *health benefits* regulations. In the decision below, the Tenth Circuit nevertheless imposed on health benefits plans the same treating provider requirement rejected in *Nord*—even though DOL has not adopted that requirement by regulation. That holding conflicts with the approach of five other Circuits and many district courts, threatening the uniformity ERISA was designed to ensure.

The Tenth Circuit also changed judicial review of benefits decisions in another way. It refused to review the *whole* administrative record to determine if the decision is supported by substantial evidence, holding that courts must focus on the decision letters and disregard other record evidence—even when a plan relies on such evidence simply to rebut arguments raised during the appeals process. This narrow view of the scope of review for benefits decisions is a clear break from the precedent of most circuits. And it undermines Congress's intent that benefits decisions be simply explained in understandable terms.

The Questions Presented are:

1. Is an ERISA-governed plan that denies health benefits required to discuss contrary opinions from the member's treating providers in the decision letter?

2. Should courts consider the whole administrative record when deciding whether substantial evidence supports a plan's denial of health benefits, instead of limiting their review to the decision letters?

PARTIES TO THE PROCEEDING BELOW

Petitioners United Behavioral Health ("UBH") and Alcatel-Lucent Medical Expense Plan for Active Management Employees (the "Plan") were appellants in the court of appeals.

Respondents David K., Kathleen K., and Amy K. were appellees in the court of appeals.

STATEMENT OF RELATED PROCEEDINGS

The following are related proceedings within the meaning of this Court's Rule 14.1(b)(iii):

D.K. v. United Behavioral Health, U.S. District Court for the District of Utah, No. 2:17-CV-01328-DAK. Judgment entered June 22, 2021.

D.K. v. United Behavioral Health, U.S. Court of Appeals for the Tenth Circuit, No. 21-4088. Judgment entered May 15, 2023.

RULE 29.6 STATEMENT

Petitioner United Behavioral Health ("UBH") is a wholly owned subsidiary of OptumHealth Holdings, LLC. OptumHealth Holdings, LLC is a wholly owned subsidiary of Optum, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated. UnitedHealth Group Incorporated, a publicly held corporation, does not have a parent corporation, nor does any publicly held corporation own 10% or more of UnitedHealth Group Incorporated's stock.

Petitioner Alcatel-Lucent Medical Expense Plan for Active Management Employees (the "Plan") (now known as the Nokia Medical Expense Plan for Active Employees, and formerly known as the Alcatel-Lucent Medical Expense Plan for Management Employees) is an employee welfare benefit plan established and maintained by Nokia of America Corporation ("NoAC"). NoAC is an indirect wholly owned subsidiary of Nokia Corporation, a Finnish corporation based in Espoo, Finland. Nokia Corporation's shares are publicly traded on the Nasdaq Helsinki, Euronext Paris, and New York Stock exchanges.

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UBH and the Plan respectfully submit this petition for a writ of certiorari to review the Tenth Circuit's decision, which imposes new burdens on health benefits plans that cannot be squared with this Court's precedent, DOL's implementing regulations for ERISA, and Congress's intent. The Court should grant certiorari to reject this attempt to impose new requirements on health benefits plans by judicial fiat rather than through notice-and-comment rulemaking.

First, the Tenth Circuit held that plans that deny benefits claims must explain, in their decision letters, why they disagree with the claimants' treating providers. That holding flatly contradicts this Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), which rejected the same judicial innovation. That holding also changes the requirements for benefits decisions outside of the rulemaking process, without stakeholder input. If DOL wishes to require health benefits plans to discuss treating provider opinions in their decision letters, then it should undertake notice-and-comment rulemaking—as it did to add that requirement to the disability benefits regulations in 2016. The decision below thus presents an exceptionally important issue of regulatory process, in addition for an opportunity for this Court to reconfirm that it meant what it said in *Nord* and restore uniformity regarding the content of health benefits decision letters.

Second, the Tenth Circuit held that, when reviewing the plan's decision under the deferential arbitrary-and-capricious standard, courts should focus on the decision letters sent to the claimants and

refuse to consider other evidence from the record—even to rebut arguments raised by the claimant during the appeals process. The appellate court's limitation of the scope of judicial review to the decision letters puts it at odds with many of its sister circuits, which either allow or require courts to consider the *whole* administrative record. The Tenth Circuit's extreme narrowing of the scope of judicial review is also inconsistent with the fiduciary principles on which ERISA is premised, which require deference to the administrator's assessment of the record. This new, limited approach dramatically changes judicial review of plan decisions, and will force a corresponding change in how plans write their decision letters.

Each of these changes to judicial review of ERISA health benefits decisions significantly increases the burden on plans. Together, they undermine Congress's desire that ERISA provide "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards[.]" *Conkright v. Frommert*, 559 U.S. 506, 516–17 (2010) (citation omitted). The Court should grant certiorari to reaffirm *Nord*, hold DOL to its obligation to undertake rulemaking if it seeks to add a new regulatory requirement, and restore uniformity among the courts on the scope of review for benefits decisions.

OPINIONS BELOW

The Tenth Circuit's decision is reported at *D. K. v. United Behavioral Health*, 67 F.4th 1224 (10th Cir. 2023), and is reprinted at App. A. The decision of the district court is not reported, but available at *D.K. v. United Behavioral Health*, No. 2:17-CV-01328-DAK, 2021 WL 2554109 (D. Utah June 22,

2021), and reprinted at App. D. A further decision of the district court is also not reported, but available at *D.K. v. United Behavioral Health*, No. 2:17-CV-01328-DAK, 2021 WL 4060937 (D. Utah September 7, 2021), and reprinted at App. F.

JURISDICTION

The Tenth Circuit entered its judgment on May 15, 2023. The Tenth Circuit denied a timely petition for rehearing on August 1, 2023. On October 20, 2023, this Court extended the deadline to file any certiorari petition until November 29, 2023. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 503 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1133(1), and select sections of its implementing regulations, including 29 C.F.R. §§ 2560.503-1(g)(1)(v)(B), (vii)(A)(i) are reprinted in the appendix. Section 2590.715-2719 of the Rules and Regulations for Group Health Plans under Title 29 of the Code of Federal Regulations is likewise printed in the appendix.

STATEMENT

I. STATUTORY AND REGULATORY BACKGROUND

A. Congress's intent to encourage adoption of benefits plans through uniform claims processing requirements.

ERISA "is an enormously complex and detailed statute, and the plans that administrators must construe can be lengthy and complicated." *Conkright*,

559 U.S. at 509 (internal quotation marks omitted). Congress went to great lengths when crafting the statute to strike "a careful balanc[e] between ensuring fair and prompt enforcement of rights under a[n] [employee benefit] plan and the encouragement of the creation of such plans." *Id.* at 517 (internal quotation marks omitted).

Congress particularly sought to avoid imposing administrative costs that would discourage employers from offering ERISA plans while simultaneously "induc[ing] employers to offer benefits." *Id.*; *see also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (noting "Congress' desire to offer [claimants] enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place").

B. The regulatory requirements for ERISA benefits decisions.

ERISA says little as to the contents of coverage denial letters. Plans (or their claims administrators) must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant[.]" 29 U.S.C. § 1133(1); *see also* 29 C.F.R. § 2560.503-1(g)(1) (requiring administrators to "provide a claimant with written or electronic notification of any adverse benefit determination").

Under DOL's implementing regulations for health benefits claims, the required written

notification—often a letter—must "set forth, in a manner calculated to be understood by the claimant" the following information: "[t]he specific reason … for the adverse determination;" "[r]eference to the specific plan provisions on which the determination is based;" "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;" and "[a] description of the plan's review procedures and the time limits applicable to such procedures[.]" 29 C.F.R. § 2560.503-1(g)(1). Somewhat more explanation is required if the plan denies health benefits for lack of medical necessity; then, the letter must provide "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances[.]" *Id.* § 2560.503-1(g)(1)(v)(B).

Separate DOL regulations govern denials of disability claims, though they require much of the same content as health benefits claims. For example, disability claim denial letters similarly must include "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances" if the denial is based on medical necessity, as well as "the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in" denying the claim. *Id.* § 2560.503-1(g)(1)(vii).

But unlike the health benefit regulations, the disability regulations *further* require "[a] discussion of the decision, including an explanation of the basis for disagreeing with … [t]he views presented by the claimant to the plan of health care professionals

treating the claimant and vocational professionals who evaluated the claimant." *Id.*

C. This Court's decision in *Nord*.

This Court addressed the scope of ERISA's claim procedure requirements in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). There, it analyzed whether those regulations required plan administrators to adopt a "treating physician rule" for ERISA disability claims processing, as is expressly required for Social Security disability benefit determinations. *Id.* at 825. At the time, § 2560.503-1(g)'s claim procedure regulations for medical (*i.e.*, health) and disability benefits were nearly identical.

The Court explained that the "treating physician rule" at issue in *Nord* has procedural and substantive components. *See id.* at 834 n.4. The "procedural" component "requires a hearing officer to explain why she rejected the opinions of a treating physician[.]" *Id.* The substantive component requires deference to the opinions of a claimant's treating provider. *Id.* This Court held that no treating physician rule—procedural or substantive—was appropriate for ERISA disability claims processing:

> Nothing in the Act . . . suggests that plan administrators must accord special deference to the opinions of treating physicians. Nor does the Act impose a heightened burden of explanation on administrators when they reject a treating physician's opinion.

Id. at 831. The Court therefore explicitly instructed that courts may not "impose on plan administrators a *discrete burden of explanation* when they credit

reliable evidence that conflicts with a treating physician's evaluation." *Id.* at 834 (emphasis added).

Explaining why it had rejected that rule, the Court cautioned that "judicial innovation is narrower in areas where other federal actors"—*i.e.*, DOL—"are engaged." *Id.* at 831–32. Although the Ninth Circuit had thought the treating physician rule might increase the accuracy of disability benefits determinations, the Court explained that "[i]ntelligent resolution of the question" "might be aided by empirical investigation of the kind courts are ill equipped to conduct," including because there may be circumstances where deference to a treating physician's judgment "make[s] scant sense." *Id.* But, if DOL "found it meet to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference." *Id.* at 831.

D. DOL's amendments to the ERISA benefits regulations after *Nord*.

In 2015 and 2016, DOL revised its ERISA health benefits regulations and disability benefits regulations respectively. The 2015 rule amending the health benefits regulations primarily implemented regulatory changes stemming from the Affordable Care Act, but also included some changes to health benefits claims processing. *See* 80 Fed. Reg. 72,192 (Nov. 18, 2015) (the "2015 ACA amendments"). It did not, however, impose any requirement to discuss contrary treating provider opinions. The 2016 final disability benefits rule, in contrast, added a new requirement to discuss contrary provider opinions to the disability benefits claims processing regulations. 81 Fed. Reg. 92,316-01, 92,319 (Dec. 19, 2016).

1. The 2015 ACA amendments to the health benefits regulations.

DOL's 2015 ACA amendments updated group health plans' claims and appeal procedures. 80 Fed. Reg. at 72,192. The "largest impact" was to require insurers that offered plans on the individual health insurance market to comply with DOL's internal claims procedure regulations. *Id.* at 72,223. The amendments also added some new requirements for the content of health benefits denial letters, including details sufficient to identify the claim, a "discussion of the decision," and a description of the plan's appeal processes. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E). But the 2015 ACA amendments did *not* add any requirement that plans discuss provider opinions when denying health benefits claims.

DOL explained that it would next "revise and strengthen the current DOL claims procedure regulations … applicable to plans providing disability benefits[.]" 80 Fed. Reg. at 72,207. DOL issued a proposed rule updating the disability benefits regulation that day. 80 Fed. Reg. 72,014-01 (Nov. 18, 2015).

2. The 2016 amendments to the disability benefits regulations.

In 2016, DOL issued a final rule revising the disability benefits regulations. 81 Fed. Reg. at 92,319. While many of the revisions tracked the 2015 amendments, DOL did *not* adopt all of the health benefits amendments in the disability benefits context. Rather, it "carefully selected … and incorporated . . . only certain of the basic improvements[.]" *Id.* at 92,318. And DOL made "adjustments . . . to

account for the different features and characteristics of disability benefit claims." *Id.*

Critically here, DOL enacted new regulatory text requiring: "In the case of an adverse benefit determination with respect to disability benefits," the plan must provide "[a] discussion of the decision, including an explanation of the basis for disagreeing with . . . [t]he views presented by the claimant to the plan of health care professionals treating the claimant[.] *Id.* at 92,341.

DOL has never amended the health benefits regulations to impose the same requirement.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. The Plan's terms.

The Plan is a self-funded employee benefit plan. For services to be covered, "they must be Medically Necessary and provided in conformance with all terms and conditions of the Plan." App.7a.

The Plan identifies the following criteria, among others, for showing that care is Medically Necessary:

> It is accepted by the health care profession in the U.S. as the most appropriate level of care . . . . It is the safest and most effective level of care for the condition being treated. . . . [and] There is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of the place of service or supply given.

Id.

B. D.K.'s claims.

When Respondents ("Claimants") sought benefits to cover their daughter A.K.'s stay at a residential care facility, UBH (the delegated claims administrator for behavioral health benefit claims under the Plan) assessed whether the services were Medically Necessary, as required for coverage under the Plan. The Guidelines applied by UBH to assess Medical Necessity at that time required consideration of whether the treatment was "consistent with generally accepted standards of clinical practice," "backed by credible research," and "clinically appropriate for the member's behavioral health condition." App.8a. The Guidelines also required UBH's reviewers to consider "if the member's treatment could occur safely at a lower level of care" such as "in day programing rather than inpatient care." *Id.*

Claimants requested coverage for a full year of residential treatment. Under the Guidelines, however, the purpose of such intensive, 24/7 treatment is to address factors that precipitated admission until the condition can be safely, efficiently, and effectively treated in a "less intensive setting." App.38a. An independent third-party reviewer granted three months of residential care coverage, and UBH later agreed to cover seven more days to enable A.K. to transition to a less intensive level of care. Claimants nonetheless requested that residential treatment coverage be continued for nine more months.

Based on a review by a board-certified psychiatrist,[1] UBH concluded that continued residential treatment was not "medically necessary," including because a physician did not supervise and reassess the treatment plan and the facility was not offering active behavioral health treatment. App.45a–46a. The record also showed that A.K. was not seeing a psychiatrist twice a week, as required under the Plan and Guidelines. *Id.* at 45a, 61a. UBH did not conclude that *no* further care was needed or would be covered; rather, only that continued 24/7 *residential* treatment—an extreme step that takes a young person away from her home and support system—was not medically necessary in these circumstances.

Instead, the reviewers both found that A.K. could have continued care at a lower level, such as outpatient treatment plus therapy. *See id.* at 29a–30a, 54a. That is consistent with generally accepted standards of care for children with mental illnesses. *See* American Academy of Child & Adolescent Psychiatry, *Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers* 1 (June 2010) ("The best place for children and adolescents is at home with their families. A child or adolescent with mental illness should be treated in the safest and least restrictive environment and needed services should be 'wrapped-around' to provide more intensive home or community-based services."). Claimants appealed, and the

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[1] UBH initially denied coverage based on a prior Plan version that excluded residential treatment care entirely, but re-initiated the review process after realizing its mistake.

appeal was denied for similar reasons by a different board-certified psychiatrist. App.14a.

UBH's medical reviewers' notes in the record show that UBH thoughtfully considered A.K.'s medical history, including letters from her pre-admission doctors, as well as A.K.'s treatment and symptoms during residential treatment. For example, one of the reviewer's notes included a lengthy discussion of A.K.'s pre-residential treatment symptoms and treatment at other facilities. *See* App.62a–63a. A second reviewer's notes similarly confirmed that he had reviewed the whole record and discussed A.K.'s progress, noting that she was able to discuss thoughts of self-harm when they occurred and no longer had symptoms that would require round-the-clock treatment. *See id.* at 63a.

Claimants requested an external review, which was conducted by a board-certified psychiatrist unaffiliated with UBH. He issued an eleven-page letter cataloging the materials he reviewed, discussing A.K.'s treatment records, and concluding that continued residential care was not medically necessary. *Id.* at 47a–48a. The external reviewer explained, *inter alia*, that the records showed that A.K. had improved, indicating that she could have been treated in a less intensive setting. *Id.* at 47a–48a. The reviewer stated that A.K. "required structure and support," but there was no evidence that "a residential setting was the safest and most effective level of care." *Id.* at 47a.

C. The district court's decision.

Claimants sought judicial review. The district court granted Claimants' motion for summary judgment on their ERISA claims. App.68a.

The court found that many aspects of the reviewers' decision were not arbitrary and capricious—including on the key question of whether A.K. could have been discharged to a lower level of care. App.54a ("The court finds that . . . the final three reviewers did not abuse their discretion because the evidence could reasonably be interpreted to show that A.K. could have been discharged to a lower level of care . . . ."). And the court noted that the "claims administrators clearly reviewed [A.K.'s] treating professionals' opinions"—but then found the reviewers had failed to "engage" with these opinions because they had not discussed them in their decision letters. *Id.* at 57a–58a.

The district court refused to consider the physician reviewers' notes, instead confining its review to the decision letters themselves. *Id.* at 62a. Thus, based on the failure to "engage" with claimant's evidence (including provider opinions) and include supporting record evidence in the denial letters themselves, the court deemed the denial of benefits arbitrary. *Id.* at 64a–65a.

D. The Tenth Circuit's decision.

The Tenth Circuit affirmed. *D.K. v. United Behav. Health*, 67 F.4th 1224 (10th Cir. 2023); App.1-34a. It concluded that UBH acted arbitrarily and capriciously by "not providing an explanation for rejecting or not following" the opinions of A.K.'s treating providers. App.20a.

In so holding, the Tenth Circuit adopted an argument advanced by the DOL in an amicus brief supporting Claimants. DOL argued that plans must "take into account all comments, documents,

records, and other information submitted by the claimant[.]" ECF No. 10894872 at 13 (Feb. 22, 2023) (quoting 29 C.F.R. § 2560.503-1(h)(2)(iv)). DOL then argued that "a fiduciary 'takes into account' a claimant's treating provider's opinions by fairly engaging with them, and by being able to demonstrate such engagement *in the denial letter provided to the claimants*[.]" *Id.* at 16 (emphasis added).

The Tenth Circuit recognized "the textual difference in the ERISA disability and ERISA medical regulations." App.20a. But the court accepted DOL's argument that the 2016 rule amending the disability regulations specifically to require a discussion of treating provider opinions "was merely making explicit requirements for claims review that were already required under ERISA." *Id.* at 22a.

Rejecting Appellants argument that UBH's physician reviewers' notes show they considered A.K.'s treating providers' views, the Tenth Circuit stated that the "district court was correct to focus its review on the denial letters." App.23a-24a. The court also refused to consider the reviewers' notes and other record evidence when assessing whether the administrator's reasons for denying benefits were supported, instead focusing solely on the denial letters, which the court characterized as "conclusory" and therefore arbitrary and capricious. *Id*. at 29a-31a.

REASONS TO GRANT THE PETITION

I. THE TENTH CIRCUIT'S REQUIREMENT THAT A HEALTH BENEFITS DECISION LETTER DISCUSS TREATING PROVIDERS' OPINIONS CONTRADICTS *NORD* AND ALLOWS DOL TO BYPASS THE RULEMAKING PROCESS.

The core obligations of an ERISA health benefits plan in denying a claimant's request for benefits are relatively simple. The plan must communicate its "specific reason" for denying benefits, citing the relevant plan provisions. 29 C.F.R. § 2560.503-1(g)(1). If, as here, the reason is medical necessity, the plan must give "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances[.]" *Id.* § 2560.503-1(g)(1)(v)(B).

By holding in *D.K.* that plans must discuss contrary provider opinions in their decision letters, the Tenth Circuit judicially grafted a new requirement onto the ERISA health benefits regulations—the same one this Court rejected in *Nord* as beyond the statutory or regulatory text. 538 U.S. at 834 n.4 (rejecting "treating physician rule").

As this Court stated in *Nord*, the Department of Labor might "f[ind] it meet" to impose a treating providers requirement through notice-and-comment rulemaking. *Id.* at 831. Stakeholders could then explain and DOL consider both the benefits and costs of imposing such a requirement on plans. DOL undertook just such a process in 2016, when it added such a requirement *for the disability regulations only*. Now, at DOL's urging in its amicus brief, the

panel has judicially imposed that requirement on health benefits plan administrators without the benefit of that important regulatory process. The Tenth Circuit was wrong to adopt DOL's litigating position as law, and thereby relieve that agency of its rulemaking responsibilities.

The panel's decision should not stand. It is contrary to *Nord*; ignores a clear textual difference between the disability and health benefits regulations, thus allowing DOL to avoid notice-and-comment rulemaking, and undermines ERISAs' careful balance. The Court should grant certiorari and then reaffirm the conclusion it reached in *Nord*: Courts cannot impose obligations on ERISA plan administrators that neither Congress nor DOL have imposed through the legislative or regulatory processes.

A. The panel's holding contradicts *Nord*.

By requiring ERISA health benefits plans to "respond to the opinions" of the claimants' medical provider, *D.K.*, 67 F.4th at 1241, the Tenth Circuit judicially imposed the very requirement this Court rejected in *Nord*. Specifically, this Court held that courts may not "impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Nord*, 538 U.S. at 834; *see also id.* at 831 ("Nothing in the Act . . . suggests that plan administrators must accord special deference to the opinions of treating physicians. Nor does the Act impose a heightened burden of explanation on administrators when they reject a treating physician's opinion.").

Importantly, when *Nord* was decided (and until the disability benefits regulations were amended in 2016), the disability regulations matched the text of the health benefits regulations as they stand today. In other words, this Court was assessing the same regulatory text that governs health benefits decisions today when it held, in *Nord*, that a plan administrator had no obligation to explain why it disagreed with the claimants' treating providers.

The Tenth Circuit attempted to justify its departure from *Nord*, asserting that "[UBH] was not required to defer to" A.K.'s treating providers' opinions, "but it could not simply and arbitrarily refuse to credit them," and instead had to "provid[e] an explanation for rejecting or not following these opinions[.]" *D.K.*, 67 F.4th at 1237. But, in *Nord*, this Court rejected both a "substantive" and a "procedural" treating physician rule. *Nord*, 538 U.S. at 834 n.4. It explained the "substantive" version of a treating provider rule would require deference to the claimants' physicians' opinions, while the "procedural" variant (at issue here) would require that the plan provide an explanation for "reject[ing] the opinions of a treating physician" at all. *Id.*

Without question, this Court rejected both. *Id.* ("[W]e conclude that ERISA does not support judicial imposition of a treating physician rule, whether labeled 'procedural' or 'substantive.'"). Thus, *Nord* did not merely instruct that administrators need not defer to a claimants' treating providers. Rather, *Nord* instructed that, so long as the administrator provided its own affirmative reasons for its decision, it need offer *no explanation at all* of why the plan had

not adopted the views of the treating providers. *Id.* at 834 & n.4.

To be clear, the *Nord* respondent squarely raised the propriety of the "procedural" variant of the "treating physician rule." *See id.* at 834 n.4 (acknowledging respondent's argument that the Ninth Circuit had *only* employed the "procedural" rule). It argued that the Ninth Circuit's decision "merely requires, where a benefit claim is grounded on such a medical opinion, that a plan administrator provide a reason for rejecting that medical opinion." Brief for Respondent, *Black & Decker Disability Plan v. Nord*, No. 02-469, 2003 WL 1785772, at *13 (Mar. 28, 2003). But this Court disagreed, writing: "ERISA does not support judicial imposition of a treating physician rule, whether labeled 'procedural' or 'substantive.'" 538 U.S. at 834 n.4.

Nord also recognized that the proper avenue for imposing such a "treating physician rule" for ERISA benefits denial letters is rulemaking: "If the Secretary found it meet to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference." *Id.* at 831. That remains true. The Tenth Circuit thus erred when it accepted DOL's request to change the requirements for health benefits decisions outside the rulemaking process.

Notably, DOL itself cautioned, in its amicus brief in *Nord*, against judicial imposition of a treating provider rule. *See* Brief for the United States as Amicus Curiae Supporting Petitioner, *Black & Decker Disability Plan v. Nord*, No. 02-469, 2003 WL 721551, at *11 (Feb. 24, 2003) ("The absence of any requirement in ERISA itself or in the Secretary's implementing

regulations that plan administrators accord special weight to opinions of treating physicians counsels strongly against courts adopting such a requirement[.]"). DOL explained that courts

> should be particularly cautious in invoking [their] authority to impose special rules . . . when Congress has committed that subject matter (here, the review of benefit claims) to the primary jurisdiction of the Secretary, *and* the Secretary in turn has imposed certain specific requirements but otherwise intentionally preserved broad flexibility for employers and others who . . . process claims under them.

Id. at *11-12 (emphasis added). DOL thus agreed, as of 2003, that any "treating provider" requirement should be imposed by agency rulemaking, not by courts.

DOL further opined that, "if a review of the administrator's decision reveals that the administrator reasonably declined to defer to the opinion of a treating physician, the decision is not arbitrary simply because the decision failed to rebut the opinion with specific, legitimate reasons." *Id.* at *15. DOL's about-face in the intervening 20 years does not undermine the validity of its prior view, which informed the Court's decision in *Nord*.

The Tenth Circuit's decision in *D.K.* is not only at odds with *Nord*, but puts that court at odds with at least five other circuits, which have adhered to *Nord's* holding that plans need neither discuss nor defer to the claimants' treating providers' opinions. *See Balmert v. Reliance Standard Life Ins. Co.*, 601 F.3d 497, 504 (6th Cir. 2010) (no additional

explanation is needed for rejecting treating provider's opinion)[2]; *Demirovic v. Building Serv. 32 B-J Pension Fund*, 467 F.3d 208, 212 (2d Cir. 2006) (quoting *Nord* and rejecting argument that plan had to explain why it did not credit treating physicians' opinions); *see also Inciong v. Fort Dearborn Life Ins. Co.*, 570 F. App'x 724, 726 (9th Cir. 2014) (quoting *Nord* and rejecting argument that administrator unreasonably preferred the opinions of its own medical consultants over treating physician); *Becknell v. Long Term Disability Plan for Johnson & Johnson & Affiliated Cos.*, 510 F. App'x 317, 320 (5th Cir. 2013) (quoting *Nord* and declining to require administrator to give greater credence to treating provider's opinion); *Shaw v. Conn. Gen. Life Ins. Co.*, 353 F.3d 1276, 1287 (11th Cir. 2003) (quoting *Nord* and holding it was "error" to "g[i]ve special weight to the opinions of Shaw's treating physicians").

The Tenth Circuit's decision will also deepen a growing divide among district courts' understanding and application of *Nord*. *Compare Woodruff v. Blue Cross & Blue Shield of Alabama*, No. 2:16-cv-00281, 2018 WL 571933, at *8 (N.D. Ala. Jan. 26, 2018) (citing *Nord* for the proposition that "plan

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[2] The Sixth Circuit's post-*Nord* decisions have not been entirely consistent. In *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 296 (6th Cir. 2005), that court found a reviewing physician's report inadequate because, even though he "mention[s] [the claimant's doctors] by name, he does not explain why their conclusions ... were rejected[.]" *See also Kalish v. Liberty Mut./Liberty Life Assur. Co. of Bos.*, 419 F.3d 501, 510 (6th Cir. 2005) (finding decision inadequate because it failed to rebut contrary conclusions reached by the examining physician). That court appears to have corrected course, but this internal conflict highlights the need for this Court to reaffirm *Nord*.

administrators do not have to explain why they credit reliable evidence that conflicts with a treating physician's evaluation") *with Greenwell v. Group Health Plan for Employees of Sensus USA Inc.*, No. 5:19-CV-577, 2022 WL 3134110, at *17 (E.D.N.C. Mar. 29, 2022) (construing *Nord* to mean that while a plan need not "recite every fact" in treating providers' evaluations, it must "address" any "inconsistency between" plaintiffs' "doctors' reports and evaluations" and the plan's conclusion) (citation omitted) *and Doe v. Blue Shield of California*, 620 F.Supp.3d 875, 880 (N.D. Cal. 2022) (finding benefits denial arbitrary and capricious because plan "failed to discuss" the claimants' treating providers' evidence, and instead relied on "an independent psychiatrist"). District courts within the Tenth Circuit, for their part, have already taken the *D.K.* decision to heart, rejecting plan decisions that do not discuss treating provider opinions. *E.g.*, *Robert B. v. Premera Blue Cross*, No. 1:20-cv-00187, 2023 WL 7282726, at *11 (D. Utah Nov. 3, 2023) (plans must "engage with medical opinions" and "respond to the opinions" in their decision letters). This growing divide undermines the national uniformity of ERISA requirements and the predictability of plan liabilities, contrary to Congress's intent.

The Court should grant certiorari to reaffirm what it held in *Nord*: Plans need not discuss treating providers' opinions in their decision letters, which fulfill ERISA's requirements so long as they provide reasons for the decision based on plan terms and record evidence.

B. The Tenth Circuit judicially imposed a burdensome new regulatory requirement on health benefits plans, allowing DOL to bypass notice-and-comment rulemaking.

Unlike the disability regulations after DOL's 2016 rulemaking, ERISA's health benefits regulations include no textual requirement that plans explain their basis for disagreeing with a claimant's treating professionals' opinions. This Court should not permit the Tenth Circuit to judicially impose such a requirement and thereby relieve DOL of its obligation to conduct notice-and-comment rulemaking—just as DOL did in 2016 for the disability benefits regulations.

1. ERISA's health benefits regulations require only an explanation for why the plan denied coverage, not a discussion of contrary provider opinions.

ERISA's health benefits regulations specify what must be contained in a plan's denial letter. The required contents include the reason for denying coverage, the provisions in the plan on which the denial is based, the internal rule, guideline, protocol, or other criterion relied upon in denying coverage, any additional material the claimant could muster to "perfect the claim" and why, and a description of the plan's review procedures and time limits. 29 C.F.R. § 2560.503-1(g). Further explanation is necessary if the denial is based on medical necessity; specifically, a statement of the "scientific or clinical judgment" for that determination. *Id.* § 2560.503-1(g)(1)(v)(B). But even then, nowhere does the regulatory text require an explanation as to why the plan

administrator disagreed with a claimant's treating provider's opinion.

These requirements are purposefully minimal. Denial letters are not supposed to be long, detailed documents akin to agency decisions or judicial opinions. Rather, they must be written "in a manner calculated to be understood by the claimant." *Id.* § 2560.503-1(g)(1); *see also* 29 C.F.R. § 2590.715-2719(e). This serves Congress' goals by reducing administrative burden and incentivizing employers to offer benefit plans. And it is consistent with DOL's stated desire to "reduce the potential burden" on plans with respect to the contents of denial letters when amending § 2560.503-1, including by limiting the detail required. 65 Fed. Reg. 70,246, 70,251 (Nov. 21, 2000).

DOL's position here—now adopted by the Tenth Circuit—that plan administrators must provide detailed explanations that include a discussion of contrary provider opinions is thus at odds with its own past statements as well as Congress' careful balancing of claimants' and plans' interests.

2. DOL has not undertaken rulemaking to add this requirement to the health benefits regulations, as it did for the disability regulations in 2016.

In 2016 (13 years after *Nord*), DOL amended its disability benefits regulations to impose precisely the requirement at issue here. 29 C.F.R. § 2560.503-1(g)(1)(vii) (requiring "an explanation of the basis for disagreeing with or not following" "[t]he views presented by the claimant to the plan of health care professionals treating the claimant").

The rulemaking process leading to that change was robust, with participation from a wide range of stakeholders. For example, the NFL Player Disability & Neurocognitive Benefit Plan ("NFL Plan") explained that benefits in the disability and health contexts serve different purposes: "Disability benefits are intended to replace income, and generally involve a monthly stream of payments over a period of time, extending as long as the recipient's life span. Health benefits generally involve payment for a product or service[.]" Comment on 2016 Claims Procedure Regulation Amendment, 5 (Jan. 19, 2016). That disability benefits coverage denials would require a more demanding explanation is unsurprising. As the NFL Plan explained, "[d]isability claims decisions require a sensitive, often much more complex holistic analysis of the claimant's physical and mental condition" whereas "[h]ealth claims decisions typically look only at whether the product or service sought to be covered is appropriate[.]" *Id.*

DOL never similarly revised its health benefits regulations. The relevant regulatory text stands just as it stood when the Court examined the same words in *Nord*. The current text of the ERISA disability regulations and the health benefits regulations therefore differ in regard to whether a plan must explain why it disagrees with the claimants' physicians or other medical providers where those providers have submitted letters opining that the treatment should be covered. *Compare* 29 C.F.R. § 2560.503-1(g)(1) *with id.* § 2560.503-1(g)(1)(vii). And, unlike disability benefits plan stakeholders, health benefits plan stakeholders have had no opportunity to weigh in on whether it makes sense to

impose a treating provider requirement in the health benefits context.

Instead of undertaking rulemaking to change its regulations and providing such an opportunity, DOL urged the Tenth Circuit, in an amicus brief supporting Claimants, to read the health benefits regulations as silently imposing its desired treating physician rule. There are several things wrong with this.

First, DOL's position improperly renders the 2016 rule superfluous. *See Yates v. United States*, 574 U.S. 528, 543 (2015) (declining to read statutory text to "render superfluous an entire provision").

Next, revision-by-brief is not an acceptable alternative to rulemaking. This Court and others have emphasized agencies' duty to undertake notice-and-comment rulemaking where they seek to change regulatory requirements and processes. *See, e.g.*, *Azar v. Allina Health Services*, 587 U.S. --, 139 S.Ct. 1804, 1810-12 (2019) (holding that DHS was required to undertake notice-and-comment rulemaking before changing the formula for calculating hospitals' payments for treating Medicare patients); *Glycine & More, Inc. v. United States*, 880 F.3d 1335, 1345 (Fed. Cir. 2018) (if an agency wishes to "rewrite or amend [a] regulation, such a regulation . . . must be adopted with notice-and-comment rulemaking"). As Justice Gorsuch explained in *Kisor v. Wilkie*:

> An agency wishing to adopt or amend a binding regulation thus must publish a proposal in the Federal Register, give interested members of the public an opportunity to submit written comments on the

> proposal, and consider those comments before issuing the final regulation.

588 U.S. --, 139 S.Ct. 2400, 2434 (2019) (Gorsuch, J., concurring)

That is why this Court declined to defer to a DOL opinion letter in *Christensen v. Harris County*, 529 U.S. 576, 588 (2000), explaining that the DOL's new interpretation of its regulation would have, in essence, allowed the agency "to create *de facto* a new regulation." DOL's amicus brief below sought to do the same here. But as this Court explained in *Kisor*, "a court should not afford [an agency's interpretation] deference unless the regulation is genuinely ambiguous." 139 S.Ct. at 2415. The health benefits regulations at issue here are not ambiguous—they contain no requirement to address treating provider opinions—and so no deference is due. And even if they could be viewed as ambiguous, courts "should decline to defer to a merely 'convenient litigating position'" adopted by an agency outside of rulemaking. *Id.* at 2417 (citation omitted).

DOL's new interpretation of the ERISA health benefits regulations as silently requiring what DOL amended the disability regulations to explicitly require is just that—convenient. DOL has the rulemaking tools to make the text of those regulations what it wishes. 5 U.S.C. § 553(b). This Court should grant certiorari to hold DOL to its duty to use those tools if it wishes to change the rules for health benefits claim administration.

3. DOL's revision of the disability benefits regulations to require discussion of treating provider opinions did not codify a preexisting duty.

DOL's own statements in the preamble to the 2016 rule contradict its claim, accepted by the Tenth Circuit, that the 2016 rule only "ma[de] explicit" something that was already required. *D.K.*, 67 F.4th at 1238. True, some language in that rule's preamble suggests that DOL was attempting to reinforce certain existing rules. But the preamble distinguished between "new" requirements—like providing the basis for disagreeing with a claimant's treating providers—and clarifications of old duties.

DOL explained that, while the prior regulation required only "a reasoned explanation" for a disability decision, it was "revis[ing]" the regulations "to *require* that adverse benefit determinations on disability benefit claims contain a discussion of the basis for disagreeing with the views of health care professionals who treated the claimant[.]" 81 Fed. Reg. at 92,320–21 (emphasis added). In contrast, DOL explained that the requirement that an administrator explain any disagreement with the opinions of *its own internal medical experts* "is not a new substantive element" and that DOL "revise[d] paragraphs (g)(1)(vii)(A) and (j)(6)(i) to *clarify*" this requirement. *Id.* (emphasis added). The 2016 rule itself thus dispels any argument that the addition of a regulatory requirement to discuss treating provider opinions when denying disability benefits claims only made explicit a preexisting requirement—an argument that is plainly contrary to *Nord*, in any event.

The Tenth Circuit's decision thus not only contradicts *Nord*, but is directly at odds with the regulatory text and history, improperly imposing a new requirement without notice-and-comment rulemaking. The Court should grant certiorari to address this important issue of regulatory process.

II. THE TENTH CIRCUIT NARROWED THE SCOPE OF REVIEW FOR BENEFITS DECISIONS, PUTTING ITSELF AT ODDS WITH MOST CIRCUITS.

The Tenth Circuit's decision changed the ERISA claim administration and review process in another important way: by rejecting the longstanding principle that, on arbitrary and capricious review of a benefits decision, courts should review the *entire* administrative record to determine whether substantial evidence supports that decision.

In holding that courts should instead focus on the decision letters alone, the Tenth Circuit has placed itself at odds with most circuits, which either allow or instruct courts to consider the full administrative record to determine if substantial evidence supports the decision. Most circuits also allow reliance on record evidence, such as physicians' notes, to rebut arguments raised during the appeals process—which is exactly the role the physicians' notes played here.

The Tenth Circuit's new approach of ignoring all of the record except for the decision letters is also inconsistent with the trust principles underpinning ERISA, which require deference to the plan's expertise in assessing the information before it. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). And by limiting courts' review to decision

letters, the *D.K.* decision requires administrators to turn those letters into comprehensive tomes cataloging the record evidence, which also is at odds with ERISA's requirement that the coverage decision be simply explained. 29 U.S.C. § 1133.

This Court should grant certiorari to restore the broader, whole-record approach to judicial review of ERISA benefits decisions warranted where a plan vests deference in its administrator.

A. The Tenth Circuit's new approach to review of ERISA claims decisions puts it at odds with most other circuits.

Until *D.K.*, the Tenth Circuit had held that courts must consider the *entire* administrative record when reviewing a benefits denial under the arbitrary-and-capricious standard, which asks whether the plan administrator's decision is supported by substantial evidence. *See Adamson v. Unum Life Ins. Co. of Am.*, 455 F.3d 1209, 1212 (10th Cir. 2006) (court assesses whether plan's decision is supported by "substantial evidence . . . evaluated against the . . . administrative record as a whole"); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992) (same). Now the Tenth Circuit has changed course, requiring reviewing courts to "focus . . . review on the denial letters" and ignore record evidence not discussed in those letters. *D.K.*, 67 F.4th at 1239. That change puts the Tenth Circuit at odds with almost all of its sister circuits.

The First, Sixth, Seventh, and Eleventh Circuits have squarely directed courts to consider the "whole" record. *See Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57-58 n.3 (1st Cir. 1999) (the scope of review includes

"the information that [the plan] did have and the reasoning reflected in its own medical records"); *McClain v. Eaton Corp. Disability Plan*, 740 F.3d 1059, 1066 (6th Cir. 2014) ("For this determination, the whole of the administrative record must be reviewed."); *see also Canter v. AT&T Umbrella Benefit Plan No. 3*, 33 F.4th 949, 957–58 (7th Cir. 2022) ("When determining whether an administrator's decision was arbitrary and capricious," court assesses the "evidence that was before the administrator when it made its decision."); *Williamson v. Travelport, LP*, 953 F.3d 1278, 1289 (11th Cir. 2020) (describing scope of review as involving "consideration of the full administrative record that was before the administrator").

Indeed, some circuits even permit review of *extra-record* evidence. *See Doe v. Harvard Pilgrim Health Care, Inc.*, 974 F.3d 69, 75 (1st Cir. 2020); *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119, 125 (2d Cir. 2003); *Helton v. AT&T Inc.*, 709 F.3d 343, 356 (4th Cir. 2013); *Anderson v. Cytec Indus., Inc.*, 619 F.3d 505, 515–16 (5th Cir. 2010); *Est. of Blanco v. Prudential Ins. Co. of Am.*, 606 F.3d 399, 402 (7th Cir. 2010). These decisions are in extreme tension with the Tenth Circuit's rule that even evidence *within the record* must be disregarded if not discussed in the decision letter.

Other circuits have taken a more limited approach, restricting judicial review of the plan's decision to the administrative record (*i.e.*, courts will review the full record, but cannot look beyond it). *E.g.*, *Fleisher v. Standard Ins. Co.*, 679 F.3d 116, 121 (3d Cir. 2012); *Ruessler v. Boilermaker-Blacksmith Nat'l Pension Tr. Bd. of Trs.*, 64 F.4th 951, 958–59 (8th

Cir. 2023); *Harris v. Lincoln Nat'l Life Ins. Co.*, 42 F.4th 1292, 1296 (11th Cir. 2022); *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 493 (D.C. Cir. 1998). But these decisions are still at odds with the Tenth Circuit's new approach, which considers only a small subset of the administrative record: the decision letters sent to claimants.

Only the Ninth Circuit has come close to taking the Tenth Circuit's approach. In *Lukas v. United Behavioral Health*, 504 F. App'x 628, 629–30 (9th Cir. 2013), that court found a health benefits claim denial arbitrary and capricious because the decision letter lacked explanation, noting that this lack of explanation was "rendered even more problematic by the fact that they had in their possession internal notes containing a much more complete articulation of their rationale." While this statement could be read to suggest that the content of the internal notes should have been provided in the decision letter, the court focused on the fact that the plan failed to provide the notes even after claimants requested the compete case file, in violation of 29 C.F.R. § 2560.503–1(h)(2)(iii). *See id.* No such regulatory violation was alleged here; indeed, claimants' appeal letters cite to the reviewing physicians' notes, showing they had access to them.

The Tenth Circuit's new rule requiring courts to "focus" on decision letters also departs from circuits that allow reliance on record evidence to show that the plan considered arguments raised by claimants on appeal. *E.g.*, *Balmert*, 601 F.3d at 504 (examining "the record" to confirm that the plan considered a doctor's opinions regarding a claimant's disability status when determining coverage). Or, as some

circuits have explained, so long as a plan is not citing record evidence to provide a *new reason* for denying coverage not stated in the decision letters, that evidence may be considered when assessing whether the decision was supported. *E.g.*, *Rossi v. Precision Drilling Oilfield Servs. Corp. Emp. Benefits Plan*, 704 F.3d 362, 366 (5th Cir. 2013) (it is appropriate for a plan to provide additional factual information in subsequent denial letters if those facts "[did] not provide the [plan] with a different basis for affirming the Administrator's initial denial … but rather, it provide[d] the [plan] with a concrete affirmation that the Administrator's original assessment . . . was correct") (internal quotation marks omitted).

That is how UBH sought to rely on its physicians' notes. As ERISA requires, UBH told claimants in the decision letters that benefits were denied for lack of medical necessity, and gave reasons why. UBH then argued—in response to arguments raised by claimants during the appeals process and in litigation—that its physicians' notes discussing A.K.'s medical history and treatment at the residential facility showed that UBH *did* consider A.K.'s treating providers' opinions (and thus engaged with them). *See* App.62a–63a (referring to reviewer notes describing medical history and cited information from residential treatment center's records). And UBH pointed to physician notes and other record evidence more generally to show that the reason given for denying benefits in its decision letters—medical necessity—was supported. But the Tenth Circuit still refused look beyond the denial letters.

There is thus now inter-circuit conflict in regard to (a) whether plan administrators must supply not only the reason for denying benefits, but the

supporting record evidence, in their decision letters, and (b) whether administrators can point to record evidence, such as physicians' notes, to rebut claimants' appeals arguments. This conflict undermines Congress's goal of providing "a predictable set of liabilities, under uniform standards of primary conduct," *Conkright*, 559 U.S. at 516–17, and therefore should be resolved by this Court.

B. The Tenth Circuit's narrow review of claims decisions undermines Congress's intent and contractual expectations.

In support of its refusal to consider the full administrative record when reviewing UBH's decision, the Tenth Circuit reasoned: "It cannot be that the depth of an administrator's engagement . . . would be revealed only when the record is presented for litigation." *D.K.*, 67 F.4th at 1241. This reasoning conflicts with the fiduciary principles on which ERISA is modeled; Congress' desire for efficient claims decisions and easy-to-understand denial letters; and the contractual expectations of plans and employers.

Under ERISA, the administrator's duty is to follow the terms of the plan and render decisions after weighing all of the relevant evidence. *See* 29 U.S.C. § 1104(a)(1)(D). Circumscribed judicial review confined to denial letters will necessarily exclude evidence supporting a denial decision. That, in turn, undermines plan administrators' discretion, contrary to a core ERISA principle. *See Firestone*, 489 U.S. at 111 ("[W]here discretion is conferred upon the trustee . . . its exercise is not subject to control by the court except to prevent an abuse . . . of [ ] discretion[.]").

Further, Congress explicitly conveyed that it did not intend benefits decision letters to catalog all evidence supporting a denial. Rather, Congress stated that denial decisions must only "provide adequate notice," written "in a manner calculated to be understood by the participant," of the "specific reasons for such denial." 29 U.S.C. § 1133(1). Absent this Court's intervention, ERISA denial letters will cease to be what Congress intended: simple explanations of the reasons for denial.[3]

Finally, the Tenth Circuit's myopic approach to reviewing benefits decisions undermines the contractual expectations of plans and the employers who adopt them. Generally, plans cannot waive issues of "the existence or nonexistence of coverage." *Juliano*, 221 F.3d at 288; *see also Keiser v. CDC Inv. Mgmt. Corp.*, No. 99 Civ. 12101, 2003 WL 1733729, at *5 (S.D.N.Y. Mar. 25, 2003) (explaining coverage turns on what was bargained for in the plan). The Tenth Circuit's approach will force courts to find benefits due even when the plan's terms require a denial of coverage. Review of the entire record is necessary to accurately determine whether a claimant's treatment was medically necessary and consistent with the plan, and benefits are therefore due.

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[3] This concern has led the Second Circuit to permit plans to advance, in litigation, new bases for the denial: "If plan administrators lost the ability to assert in court reasons for declining coverage that were not asserted at the time reimbursement was declined, the notices would threaten to become meaningless catalogs of every conceivable reason [for the decision]." *Juliano v. Health Maint. Org. of New Jersey, Inc.*, 221 F.3d 279, 288 (2d Cir. 2000).

III. CONTRARY TO CONGRESS'S INTENT, THE TENTH CIRCUIT'S DECISION INCREASES THE BURDEN ON PLANS THAT ORGANIZED THEIR OPERATIONS TO COMPLY WITH THE REGULATIONS.

Both aspects of the Tenth Circuit's decision discussed above are of great practical import, imposing substantial new burdens of explanation on health benefits plans that organized their claims processes based on the regulations in place. It is problematic as a practical matter—and fundamentally unfair—for plans to be forced to adjust their operations based on the latest judicial view of what should be required in decision letters, as opposed to what is actually required by regulatory text.

Plans (or their delegated administrators, like UBH) must issue tens of thousands of health benefits decisions a year. It is impossible for them to include, in benefit denial letters to claimants, the level of detail that one might expect in a federal agency adjudication. Plans and other stakeholders should have the opportunity to provide their views through notice-and-comment rulemaking before any new requirements are added to the pantheon of regulatory mandates with which they must comply—particularly where those requirements concern the content of decision letters, which are written by medical professionals rather than legal counsel.

As explained in *Conkright*, Congress "sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" 559 U.S. at 517; *see also id.* (recognizing the importance of avoiding "inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits,

and those without such plans to refrain from adopting them"). DOL also recognized—although apparently it has since forgotten—the need to streamline the claims process when it enacted regulations that require only the reason for a denial and, where that reason is medical necessity, some evidence-based explanation. 29 C.F.R. § 2560.503-1(g).

The requirements newly imposed by the Tenth Circuit at DOL's urging are not only unmoored from regulatory text, but fundamentally inconsistent with how Congress envisioned ERISA plans should be managed and decisions made. If they stand, those costs and burdens will be borne not only by plans, but by employers opting to provide health benefits and employees that opt into benefits plans.

The Court should grant certiorari in regard to both of the Questions to reaffirm *Nord*, return the health benefits claims process to what the statutory and regulatory text actually require, and restore the balance that Congress struck when enacting ERISA.

CONCLUSION

The petition should be granted.

November 29, 2023

Respectfully submitted,

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APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

[Filed May 15, 2023]

No. 21-4088

D.K.; K.K.

Plaintiffs-Appellees,

v.

UNITED BEHAVIORAL HEALTH;
ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR
ACTIVE MANAGEMENT EMPLOYEES,

Defendants-Appellants.

SECRETARY OF LABOR,

Amicus Curiae.

Appeal from the United States District Court
for the District of Utah
(D.C. No. 2:17-CV-01328-DAK)

Amy Shafer Berman (April N. Ross and Amy M. Pauli, with her on the briefs), Crowell & Moring, LLP, Washington, D.C., for Defendant-Appellant.

Brian S. King, Brian S. King, P.C., Salt Lake City, Utah, for Plaintiff-Appellee.

Susanna Benson (Rachel Uemoto with her on the brief), U.S. Department of Labor, Washington, D.C., for Amicus Curiae Acting Secretary of Labor Julie Su.[1]

Before CARSON, Circuit Judge, LUCERO, Senior Circuit Judge, and ROSSMAN, Circuit Judge.

LUCERO, Senior Circuit Judge.

This case considers the procedural requirements for medical claims in insurance plans subject to the Employee Retirement Income Security Act ("ERISA"). Middle schooler A.K.[2] struggled with suicidal ideation for many years and attempted suicide numerous times, resulting in frequent emergency room visits and in-patient hospitalizations. A.K.'s physicians strongly recommended she enroll in a residential treatment facility to build the skills necessary to stabilize. Despite these recommendations and extensive evidence in the medical record, United Behavioral Health ("United") denied coverage for A.K.'s stay at a residential treatment facility beyond an initial three month period. Her parents appealed United's denial numerous times, requesting further clarification, and providing extensive medical evidence, yet United only replied with conclusory statements that did not address the evidence provided. As a result, A.K.'s parents brought this lawsuit contending United violated its fiduciary duties by failing to provide a "full and fair review" of their

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[1] Pursuant to FRAP 43(c)(2), Acting Secretary Julie Su is automatically substituted for former Secretary of Labor Seema Nanda.

[2] Along with her parents, A.K. was an original plaintiff in the underlying decision. In the pendency of this appeal, A.K. passed away and accordingly has been removed from the caption. A.K.'s parents remain appellees against their insurer for claims denied and expenses incurred.

claim for medical benefits. Both sides moved for summary judgment, and the district court ruled against United.

We consider whether United arbitrarily and capriciously denied A.K. medical benefits and whether the district court abused its discretion in awarding A.K. benefits rather than remanding to United for further review. We ultimately conclude that United did act arbitrarily and capriciously in not adequately engaging with the opinions of A.K.'s physicians and in not providing its reasoning for denials to A.K.'s parents. We also conclude the district court did not abuse its discretion by awarding A.K. benefits outright. Exercising jurisdiction under 28 U.S.C. § 1291, we AFFIRM the district court's grant of summary judgment and award of benefits.

I

A

A.K.'s struggles with anxiety began as a young child. By age seven, she began seeing a counselor for emotional outbursts, and by sixth grade her symptoms included signs of depression and anxiety. She began cutting herself with razor blades, requiring stitches. In the seventh grade she attempted suicide. After her suicide attempt, and over the next several years, A.K. was admitted to numerous inpatient hospitalization units, partial hospitalization programs, and short-term residential treatment centers.[3] Despite the best efforts of her parents and treatment team, the admissions developed into a repeated cycle in which A.K.

[3] Inpatient care refers to 24-hour care in a hospital setting. Day, or partial hospitalization, programs involve day-long treatments in which patients return to their home at night. Residential treatment programs allow the patient to live on-site and get day programming outside a hospital setting.

would be admitted to an intensive hospitalization unit after self-harming, transferred to a less intensive day program because United denied coverage, and attempt suicide soon after.

In March 2012, A.K. was sent to the emergency room following another suicide attempt and was admitted to the Seay Behavioral Center ("Seay") inpatient unit for treatment for mental health disorders. After one week, she transitioned to Seay's day program and was discharged ten days later. One week after discharge, A.K. ran away from home, and told police she intended to kill herself. She was then readmitted to Seay's inpatient unit, where she was diagnosed with "major depressive disorder."

In April, after two weeks at Seay, A.K was transferred to Cedar Crest Residential Treatment Center ("Cedar Crest"). After five weeks at Cedar Crest, she was discharged to a day program at Children's Medical Center. At that point, A.K. seemed to be stabilizing and her parents reenrolled her in school to begin the eighth grade. However, A.K. soon began cutting herself again—on several occasions so badly that she needed to go to the emergency room. As a result, she was reenrolled in the day program at Children's Medical Center, but ran away from home and attempted to strangle herself one week later. She was thereafter admitted to the inpatient program at the Center.

One week later, in October, United reconsidered if A.K.'s stay at Children's Medical was medically necessary. Due to A.K.'s multiple treatment episodes and remissions, her treatment team at Children's Medical felt she was "at risk of self harm if not in an [inpatient] or [residential treatment center] setting." United denied coverage. United's denial letter stated that A.K. "could be treated by providers in a partial hospitalization

program setting" because she denied having suicidal thoughts or intentions. A.K. was thus switched from the Children's Medical inpatient program to its day program. Three days later, she attempted to strangle herself and was readmitted to the inpatient unit.

After a few days at Children's Medical, A.K. was transferred to Meridell Achievement Center ("Meridell"), a residential treatment center. United initially denied coverage of A.K.'s stay at Meridell but overturned the denial after A.K.'s parents appealed. After two months, A.K. was discharged from Meridell to the day program at Excel Center ("Excel"), and began to cut herself again. Nonetheless, A.K. was discharged from Excel after five weeks, and returned to middle school. Two months later, A.K. cut her wrists again. At that point, she was admitted to inpatient care at University Behavioral Center ("University") for major depressive disorder and suicidal ideation.

A.K. spent ten days in treatment at University before being discharged in April 2013. Two days after discharge, she began cutting herself again. Following emergency room care, she was admitted to Glen Oaks Hospital ("Glen Oaks") for inpatient treatment. She was discharged a week later. Two weeks later, she cut herself again, went to the ER, and was readmitted to University's inpatient unit.

After a week at University, A.K. was discharged to Meridell for residential treatment. According to A.K.'s parents, Meridell staff indicated A.K. needed eight to eighteen months of residential treatment to address the underlying mental health disorders leading to her suicidal behavior. In response, A.K.'s parents began researching long-term care facilities and United's coverage options. In the midst of their search and during A.K.'s tenth week at Meridell, United denied continued

coverage on grounds that A.K. "has been successful in working toward her recovery" and "no longer appears to be a threat to herself or others." A.K.'s parents appealed, but United upheld the denial. A.K. was then discharged from Meridell to the day program at Excel. Three days later, returning to form, she cut herself in the arm and groin, nearly severing her femoral artery. A.K. was readmitted to the Children's Medical inpatient program, whose physicians noted she "need[ed] long term placement."

A.K. spent over a week in inpatient treatment at Children's Medical before being discharged to Meridell for residential treatment in August 2013. The treatment team at Children's Medical also recommended A.K. attend a residential treatment program for ten to eighteen months. They reported A.K. required concentrated time to develop the emotional regulation, positive coping, and relationship skills, among others, needed to return home safely. A.K. improved at Meridell while her parents researched and applied to waitlists for long-term care facilities. However, United cited A.K.'s improvement to again deny further coverage at Meridell, noting that she "move[d] in her recovery by improving her coping skills and working with her treatment team. [So] [i]t appears [A.K.] is ready to transfer to a longer term residential [facility.]"

In summary, between her first emergency room visit in March 2012 and her discharge from Meridell in November 2013, A.K. had no less than ten psychiatric emergency room visits. She also spent over 55 total days in inpatient care, over 55 total days in partial hospitalization day programs, and over 235 total days in residential treatment centers. Because she was moved to lower-level care upon stabilization or slight improvement, she lacked the stability necessary to

develop the skills to succeed outside of a 24-hour care setting. These hospitalizations and treatments disrupted her sixth- and seventh-grade years, further harming her ability to thrive as an ordinary middle school child.

It is uncontested that for 20 months A.K. moved between emergency rooms, inpatient facilities, and day programs. During the same period, United repeatedly scaled down A.K.'s treatment.

B

A.K. is a beneficiary of her father's medical plan, administered by United. The plan covers medically necessary treatment that conforms to plan requirements. A particular service is medically necessary if "medically appropriate for the diagnosis or treatment of an Illness, Pregnancy or accidental injury." The plan established guidelines to evaluate the medical appropriateness of particular areas of treatment based on the following general standards:

> (i) It is accepted by the health care profession in the U.S. as the most appropriate level of care. . .
>
> (ii) It is the safest and most effective level of care for the condition being treated.
>
> (iii) It is appropriate and required for the diagnosis or treatment of the accidental injury, Illness or Pregnancy.
>
> (iv) There is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of the place of service or supply given.

The plan specifically developed guidelines to evaluate coverage of treatment for Major Depressive Disorder

and Dysthymic Disorder. To be covered, treatment must be "consistent with generally accepted standards of clinical practice," "backed by credible research," "consistent with [United]'s clinical best practice guidelines," and "clinically appropriate for the member's behavioral health condition based on generally accepted standards of clinical practice and benchmarks." That is, the service must meet certain quality standards and appropriately address the diagnosis. A reviewer considers if the intensity of care is appropriate and if the member's treatment could occur safely at a lower level of care. For mental health care, for example, the reviewer may consider if a patient can achieve their goals in day programming rather than inpatient care. To that end, "[t]here is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time." For this consideration, reviewers look at the member's ongoing needs. They are guided to "weigh[] the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends" and consider improvement "within the broader framework of the member's recovery and resiliency goals." Discharge from care may be appropriate if "[t]he goals for the current episode have been accomplished."

A.K.'s plan included coverage for Residential Treatment Centers, facilities with 24-hour care and behavioral health treatment for patients who do not need the intensity of inpatient care. These facilities act as "an extension of or an alternative to acute Hospital care," and "provide[] services which are less intensive than acute In-Patient care, but satisf[y] the requirement for a protected and structured environment in cases where Outpatient treatment is not appropriate." However, the plan discontinues coverage for Residential Treatment

Centers and recommends discharge[4] if treatment becomes "custodial," defined as "services that don't seek to cure, are provided when the member's condition is unchanging, are not required to maintain stabilization, or don't have to be delivered by trained clinical personnel." Reviewers evaluating A.K. for discontinued coverage were required to specifically address her ongoing needs and levels of functioning.

A.K.'s plan sets out specific requirements for denial procedures. Denials must include "[t]he specific reason or reasons for the denial" and "[s]pecific reference[s] to pertinent Plan provisions on which the denial was based." Denials based on medical necessity must include "an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's circumstances or a statement that such explanation will be provided upon request." Claimants may appeal denials. In responding to such appeals, the "decision on review" must also provide "[t]he specific [] reasons for the adverse benefit determination," and "specific reference to pertinent Plan provisions on which the adverse benefit determination is based." For medical necessity determinations, the "decision on review" must also provide "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's circumstances or a statement that such explanation will be provided upon request." Finally, the plan allows claimants to request a third-party review of appeals.

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[4] For discharge, indications that care is custodial includes: 1) The member's signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved; 2) The member's condition is not improving; or 3) The intensity of active treatment in Inpatient is no longer required.

C

In November 2013, A.K.'s parents recognized that her cyclical treatment course had not provided her with stability necessary for sustained improvement, particularly because United repeatedly recommended discharge immediately upon stabilization in 24-hour care. Having been advised of A.K.'s need for a long-term residential facility, A.K.'s parents applied for a "case exception" with United and requested coverage for twelve months of treatment. They provided extensive evidence in support of their assertion that A.K. required a long-term residential facility, including letters from A.K.'s treating physicians. In one letter, Ms. Weaster, a program therapist at Meridell, recommended "ongoing specialized residential treatment . . . upon discharge from Meridell in order to keep [A.K.] safe and give her the best possible chance for full recovery from her complex clinical issues." Ms. Weaster stated that despite A.K.'s improvement during residential treatment, "she continues to exhibit emotional reactivity that places her at ongoing risk of relapse when discharged to home. She is precariously balanced and quickly regresses to self-injury and suicidal thoughts and/or behaviors when not in a monitored 24-hour a day therapeutic setting."

In another letter, Dr. Diederich, an attending physician at Children's Medical wrote that "[o]ver the course of working with [A.K.] through multiple inpatient admissions with her as well as seeing the results of the more typical intermediate-duration residential placements, she has struggled to make the needed progress to be successful in the home." He considered A.K. part of "a small subset of children that cannot make the needed changes unless they are in a single, consistent program that will keep them until they can develop

the needed skills to be safe." He noted that while A.K. may be processing and progressing, "her speed of [] processing is much slower than her peer group," which "will make many of the processes seem slower and ineffective, when really she needs a greater length of time to allow these skills to be developed." He recommended A.K. be placed in long-term residential treatment.

Finally, Dr. Riedel, the medical director of Meridell, provided his medical opinion of A.K. based on her numerous admissions. He wrote that A.K. seemed to respond "well to the external structure provided by the residential treatment center setting," but tended to "decompensate[] upon discharge[] due to her not having been able to internalize and consolidate gains." He advised that A.K. "needs a long-term residential treatment center placement to accomplish the goals necessary for her to succeed and have a chan[c]e at sustaining a healthy life."

In sum, multiple treatment professionals reported that A.K. would need long-term residential treatment to address her underlying mental health disorders. These professionals uniformly noted that A.K. needed to develop various skills to address her disorders and only long-term residential treatment would position her to do so. Short-term and day treatment were simply inadequate for A.K.

United's third-party reviewer, IPRO, handled A.K.'s case exception request. IPRO considered if two months of residential treatment would be appropriate given that A.K. recently spent over two months in residential treatment at Meridell. They determined A.K.'s suicide attempts days after her discharge from Meridell indicated that "another two month stay . . . is not enough treatment as it is too risky to discharge her out of a 24-hour residential treatment." IPRO noted A.K. needed

specialized treatment to improve coping skills and emotional regulation needed to exist outside a 24-hour setting and avoid self-harm. Nonetheless, IPRO approved residential treatment for three months rather than the requested twelve, but indicated an additional assessment would occur after three months to determine continued coverage. In coming to their conclusion, IPRO specifically noted the concerns of the treating professionals outlined in their letters and discussed A.K.'s extensive medical history. In November 2013, based on the IPRO approval, A.K.'s parents enrolled her in Discovery Girls Ranch ("Discovery"), a residential facility.

In February 2014, as A.K.'s initial three-month stay at Discovery was coming to an end, A.K.'s parents requested coverage for additional time at Discovery. This began a series of denials, appeals for reconsideration, and requests for more information. United's first reviewer stated A.K. "appears to require Mental Health Residential Treatment Center long term Level of Care." However, the reviewer mistakenly believed A.K.'s plan categorically excluded out-of-network residential treatment. Though this was a misreading of A.K.'s plan, the reviewer denied coverage on those grounds.

A.K.'s parents appealed, pointing out the exclusion did not apply to their plan and thus the reviewer's denial was erroneous. Nevertheless, the second reviewer repeated the error. That reviewer noted that "[b]ased upon current medical records, [A.K.] appears to require Mental Health Residential long term level of care." The reviewer again mistakenly denied care, believing that A.K.'s plan excluded coverage for out-of-network residential treatment.

The parents appealed again, repeating that their plan did not categorically exclude coverage, as the

reviewers had believed. This request provided United with a description of A.K.'s medical records, including an additional letter from Discovery's Dr. Lowe, who stated that early discharge was highly risky because A.K. "has not learned to regulate her mood outside a structured therapeutic facility and would return to old patterns of self-harm as evidenced by her recent poor relationship[] choices, increased anxiety, emotional reactivity, refusal to use healthy coping skills, resulting in increased depression, suicidal thoughts and cutting herself."

United recognized its error in categorically denying coverage and re-started the appeals process. In December 2014, *ten months after* initially requesting to extend residential treatment at Discovery, A.K.'s parents received United's first denial review that directly considered medical necessity, not the mistaken exclusion. This third denial letter stated that "medical necessity was not met," citing A.K.'s lack of injurious behavior while at Discovery and her stable diagnosis.

A.K.'s parents appealed for a third time, pointing out the inconsistent denial rationales and requesting justification for the medical necessity denial. They included an additional letter from Dr. Riedel of Meridell in their appeal, which stated that as of July 2013, "[A.K.] is on a slow but steady course" and "[i]t will be critical and crucial that medical stability be reached and she be allowed to continue the work that she is doing and to continue to consolidate gains." He went on to say that "discharge at this time would certainly jeopardize [A.K.'s] prognosis," "[g]iven [her] extensive history since childhood, [including] the multiple acute psychiatric hospitalizations that have been very disruptive to [her] and her family and have [fostered]

more negative cognitive sets of being a failure and damaged."

The third appeal specifically requested: 1) further clarification as to the weight given to the medical opinions of A.K.'s various treatment professionals, 2) clarification on how medical necessity could not be found, given the clinical record provided, and 3) evidence of the clinical references relied on for the opinion. The fourth reviewer found that continued treatment was not medically necessary because A.K.'s goals of admission had been met, "which were to consolidate [A.K.]'s gains so that she could control her[] self injurious behavior." That reviewer did not include information about the weight given to medical opinions, did not discuss the clinical record, and provided no direct clinical references.

A.K.'s parents requested an external review—their fourth appeal. They stated United had not shown "positive proof that a fair review was ever conducted" and requested a "full, fair, and thorough independent third party review." The third-party reviewer noted the various medical evidence provided and the prior denial letters. That reviewer found A.K. had made some improvement and was able to focus on schoolwork. The reviewer remarked that "there is not evidence during [A.K.'s time at Discovery] that remainder in a residential setting was the safest and most effective level of care" and posited that A.K.'s behavior could be managed in day programs. The reviewer concluded it was not medically necessary for A.K. to remain in residential treatment.

D

After the fifth denial, A.K.'s parents filed this lawsuit which asserted United breached its fiduciary

duty to provide a full and fair review of claim denials. Specifically, they claimed United improperly categorized their claim as not medically necessary, that United's denial letters disregarded and did not engage with the opinions of A.K.'s treating physicians, and that United failed to apply the terms of the plan to specific portions of A.K.'s medical records. In the district court, both parties moved for summary judgement.

The district court found United acted arbitrarily and capriciously for four independent reasons: 1) United abused its discretion in classifying A.K.'s care as custodial; 2) United did not fairly engage with the medical opinions of A.K.'s treating professionals; 3) United's denials did not contain reasoned analysis or specific citations to the medical record; and 4) United demonstrated a shifting and inconsistent rationale for denying benefits.[5] The district court ordered United to pay for A.K.'s treatment at Discovery, rather than remanding for internal review. United now appeals that ruling to us.

II

We review the district court's grant of summary judgement *de novo,* applying the same standard as the district court. *Eugene S. v. Horizon Blue Cross Blue Shield of N.J.,* 663 F.3d 1124, 1130 (10th Cir. 2011).

Because United had "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," we review the denial of benefits under an arbitrary and capricious standard. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989).

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[5] We uphold the second and third of these independent grounds and decline to consider the other independent reasons for the district court's decision.

This deference arises out of ERISA's roots in trust law and imposition of fiduciary responsibility on administrators. *Id.* at 110. Under arbitrary and capricious review, the actions of ERISA administrators are upheld if reasonable and supported by substantial evidence. *Adamson v. Unum Life Ins. Co. of Am.,* 455 F.3d 1209, 1212 (10th Cir. 2006).

We review a district court's choice of remedy for abuse of discretion. *Dowie v. Indep. Drivers Ass'n Pension Plan,* 934 F.2d 1168, 1170 (10th Cir. 1991). Under the abuse of discretion standard, we defer to the district court's judgment if it is rationally "sustainable on the law and facts." *Shook v. Bd. of Cnty. Comm'rs,* 543 F.3d 597, 603 (10th Cir. 2008).

III

United challenges the district court's conclusion that it violated multiple ERISA requirements.[6] ERISA

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[6] We address United's motion to file a corrected appendix, partially under seal. Under the Tenth Circuit Rules of Appellate Procedure, appellants must provide an appendix "sufficient for considering and deciding the issues on appeal." 10th Cir. R. 30.1(B)(1). United's initial appendix did not include certain documents required under our Local Rules, as United concedes. However, once notified, United immediately moved to file and produced a substantive supplemental appendix which meets our requirements. We may certify a supplemental record when material is lacking due to "error or accident." Fed. R. App. P. 10(e)(2)(c). We do not decline an appeal if an insufficient appendix is mere "noncompliance with some useful but nonessential procedural admonition," but rather concern ourselves when such insufficiencies raise "an effective barrier to informed, substantive appellate review." *McGinnis v. Gustafson,* 978 F.2d 1199, 1201 (10th Cir. 1992). A.K.'s parents have not demonstrated how United's quickly remedied error could foreclose our effective review. Thus, United's motion is GRANTED and we decline the assertion that we should dismiss this appeal based on an insufficient appendix.

sets minimum standards for employer-sponsored health plans, which may be administered by a separate entity. 29 U.S.C. § 1001. Administrators, like United, are analogous to trustees of common-law trusts and their benefit determinations constitute fiduciary acts. *Metro. Life Ins. v. Glenn,* 554 U.S. 105, 111 (2008). That is, in determining benefit eligibility, "the administrator owes a special duty of loyalty to the plan beneficiaries." *Id.*

ERISA requires administrators to follow specific procedures for benefit denials. Administrators must "provide adequate notice in writing . . . setting forth the specific reasons for such denial" and "afford a reasonable opportunity . . . for a *full and fair review* by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133 (emphasis added). Claimants' full and fair review of a denial must include: "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of the evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Sage v. Automation, Inc. Pensions Plan & Trust,* 845 F.2d 885, 893-94 (10th Cir. 1988).

Arbitrary and capricious review of the reasonableness of a benefits decision considers if it (1) "was the result of a reasoned and principled process, (2) is consistent with any prior interpretations by the plan administrator, (3) is reasonable in light of any external standards, and (4) is consistent with the purposes of the plan." *Flinders v. Workforce Stabilization Plan of Phillips Petrol. Co.,* 491 F.3d 1180, 1193 (10th Cir. 2007) (internal citations omitted). The "consistent with the purposes of the plan" requirement means a plan administrator acts arbitrarily and capriciously if

the administrator "fail[s] to consistently apply the terms of an ERISA plan" or provides "an interpretation inconsistent with the plan's unambiguous language." *Tracy O. v. Anthem Blue Cross Life & Health Ins.,* 807 F. App'x 845, 854 (10th Cir. 2020).

A

United alleges it did not arbitrarily and capriciously fail to engage with the opinions of A.K.'s treating physicians. First, United claims it was not required to engage with treating physician opinions. Second, United claims the district court erred in only looking for proof of engagement with treating physician opinions in the denial letters provided to the claimant. United argues the district court should have considered the internal notes of reviewers, which would show it engaged with the treating physician opinions. The district court reviewed the denial letters alone and found United failed to engage as required with the medical opinions of A.K.'s treating physicians. We agree.

To their first argument, United says it was not required to engage with treating physician opinions. United claims that ERISA requirements differ for medical benefit claims and long-term disability claims, and lesser requirements for medical claims relieve them of any duty to review A.K.'s treating physician opinions. To determine United's duty, we consider ERISA caselaw and regulations.[7]

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[7] To assist our evaluation of ERISA regulations, the Department of Labor (DOL) submitted an amicus brief. The nonprofit ERISA Industry Committee moved to submit an amicus brief responding to the DOL's amicus brief. The ERISA industry brief raises issues of judicial overreach into notice-and-comment rulemaking. We may consider arguments raised only in *amicus* briefs, but only in exceptional circumstances, such as "jurisdic-

When reviewing a claim for benefits, an administrator is not required to defer to the opinions of a treating physician. *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 831 (2003). However, a reviewer may not arbitrarily refuse to credit such opinions if they constitute reliable evidence from the claimant. *Id.* at 834. Medical opinions are regularly proffered as proof of a claim, and we have held reviewers "cannot shut their eyes to readily available information . . . [that may] confirm the beneficiary's theory of entitlement." *Gaither v. Aetna Life Ins. Co.,* 394 F.3d 792, 807 (10th Cir. 2004). Therefore, if United arbitrarily refused to credit and effectively "shut their eyes" to the medical opinions of A.K.'s treating physicians, it acted arbitrarily and capriciously.

In reviewing A.K.'s claim, United specifically declined A.K.'s parents' request to consider extensive treatment opinions. A.K.'s parents provided treatment opinions from Ms. Weaster of Meridell, Dr. Diederich of Children's Medical, Dr. Reidell of Meridell, and Dr. Lowe of Discovery. Each of these treating physicians recommended that A.K. stay long-term at a residential treatment facility. Ms. Weaster noted that "ongoing specialized residential treatment . . . [would] give [A.K.] the best possible chance for a full recovery from her complex clinical issues." Dr. Diederich recommended A.K. be placed in a "single consistent program that will keep [her] until [she] can develop the needed skills to be safe." Dr. Riedel advised that A.K. "needs a long-term residential treatment center placement to

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tional questions or . . . issue[s] of federalism or comity that could be considered sua sponte." *Tyler v. City of Manhattan,* 118 F.3d 1400, 1404 (10th Cir. 1997). The *amicus* brief discusses the appropriate role for courts in reviewing regulations, a topic we may consider sua sponte, and the motion is thus GRANTED.

accomplish the goals necessary for her to succeed and have a chance at sustaining a healthy life." Dr. Lowe asserted that A.K. "has not learned to regulate her mood outside a structured therapeutic facility and would return to old patterns of self-harm" if discharged. United was not required to defer to Ms. Weaster, Dr. Diederich, Dr. Riedel, or Dr. Lowe's opinions but it could not simply and arbitrarily refuse to credit them. These readily available opinions would have confirmed A.K.'s theory of entitlement to coverage for her care, and United was required to engage with and address them. By not providing an explanation for rejecting or not following these opinions, that is, not "engaging" with these opinions, United effectively "shut its eyes" to readily available medical information. We hold United acted arbitrarily and capriciously.

United argues its actions were not arbitrary and capricious because it met certain ERISA regulatory requirements. It points to regulations which discuss requirements for engagement with medical opinions in ERISA *disability* plans. We recognize the textual difference in the ERISA disability and ERISA medical regulations pointed out by United, but disagree that the dialogue absolves United from its duty to engage in meaningful dialogue that includes a full and fair review of the insured's claim.

The regulations at issue updated the requirements administrators must follow when reviewing ERISA disability claims. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92,316, 92,316 (Dec 19, 2016). For ERISA health benefit claims, the Affordable Care Act ("ACA") strengthened procedural requirements for claim review. Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent

Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72,192, 72,217 (Nov. 18, 2015). The Department of Labor chose to update ERISA disability claims largely to match. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,318.

The regulations require that administrators of ERISA disability claims issue benefit determinations containing "[a] discussion of the decision, *including an explanation of the basis for disagreeing with or not following:* the views presented by the claimant to the plan of health care professionals treating the claimant." *Id.* at 92,341; 29 CFR § 2560.503-1 (g)(1)(vii)(A)(i) (emphasis added). The information required upon review of the determination is identical. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,341; 29 CFR § 2560.503-1 (j)(6)(i)(A). The preamble noted that, in the Department's view, many of the requirements of the final rule were already required by existing ERISA regulations. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,317. However, they had found plans regularly did not apply "the letter or spirit" of existing regulatory requirements, thus an additional, more precise regulation was necessary. *Id.* at 92320. The preamble noted the Department was particularly concerned about the disproportionate litigation by ERISA disability plans, the "aggressive posture insurers and plans can take to disability claims," and the "judicially recognized conflicts of interest insurers and plans often have in deciding benefit claims." *Id.* at 92317.

United argues that the regulations established stricter requirements for ERISA disability claims while declining to establish the same requirement for ERISA medical claims. *Id.* at 92,318. This is simply not

the case. These were guidelines clarifying the requirements for ERISA disability claims and were not requesting nor clarifying requirements for ERISA health plans. *Id.* at 92,316.[8] Further, the rule specifically noted the Department was merely making explicit requirements for claims review that were already required under ERISA, as prompted by confusion and litigation among claimants and insurers. *Id.* at 92,317. The Department's action detailing more precise requirements in ERISA disability claims does not absolve United of providing a full and fair review for health benefit claims.

These regulations, like ERISA itself, serve as minimum guidelines. 29 U.S.C. § 1001. Even if the regulations could be read as setting different baseline requirements for medical and disability claims,[9] ERISA

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[8] Such clarification is permissible. *See Ramsey v. Commissioner of Internal Revenue,* 66 F.2d 316, 318 (10th Cir. 1933) ("A regulation may make explicit what is general and clear up uncertainty.").

[9] It may be that a different baseline level of review is required for ERISA health benefit and disability claims. In that case, we consider that insurers commenting on the proposed rule suggested that most health benefits claims differ from disability claims in that they occur for a short period of time, rarely involve outside consultation, are isolated, and have limited medical information. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,318. This logic implies that plans reviewing health benefit claims involving 1) human review of claims, 2) extensive medical information, 3) outside consultation, 4) complex determinations, and 5) a long period of time should specifically engage with medical opinions.

Applying those factors to A.K.'s situation, the result is clear: United should have engaged with the treating physician opinions. A.K. provided extensive medical information for United's review. Her treating teams consistently referred her to outside treating professionals who uniformly stated her need for residential care.

nevertheless holds administrators to their greater fiduciary duty. An administrator must provide full and fair review of the evidence presented, through a reasonable process, as consistent with the plan. *Flinders v. Workforce Stabilization Plan of Phillips Petro. Co.,* 491 F.3d 1180, 1193 (10th Cir. 2007). Administrators may not shirk their broad fiduciary responsibilities by pointing to a lack of specified minimum standards in a narrow area. "There 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." *Varity Corp. v. Howe,* 516 U.S. 489, 504 (1996). The regulations do not relieve United of its responsibility to engage with medical opinions in health benefit claims.

United's second argument is that if required to engage with the opinions of A.K.'s physicians, its internal notes prove it did so. It argues the district court should have looked beyond the denial letter provided to A.K. and considered the internal notes of United's reviewers. The district court limited its review to the denial letters and found little evidence therein that reviewers engaged with treating professionals' opinions. The sole reference to treating professional's opinions the district court found in the denial letters was a passing comment that the purpose of the treatment was to consolidate A.K.'s gains. The district

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A.K.'s case was decidedly complex, involving multiple diagnoses. Twenty months passed from A.K.'s first visit to the E.R. for cutting her wrists to her intake at Discovery. Even if the regulations establish a different baseline for some claims, a reasonable interpretation is that United is required to specifically engage with A.K.'s treating physician opinions.

court concluded United did not engage with A.K.'s extensive professional opinions.

The district court was correct to focus its review on the denial letters. ERISA denial letters play a particular role in ensuring full and fair review. ERISA regulations require that denial letters be comprehensive and include requests for additional information, steps claimants may take for further review, and specific reasons for the denial. 29 C.F.R. § 2560.503-1(f)(3); 29 C.F.R. § 2560.503-1(h)(3), (4). We have followed the Ninth Circuit in interpreting these regulations to call for a "meaningful dialogue." *Gilbertson v. Allied Signal,* 328 F.3d 625, 635 (10th Cir. 2003) (citing *Booton v. Lockheed Medical Benefit Plan,* 110 F.3d 1461, 1463 (9th Cir. 1997)). As that circuit noted:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied . . . the reason for the denial must be stated in reasonably clear language, . . . if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.

Booton, 110 F.3d at 1463. Accordingly, United must engage in reasonable, "meaningful dialogue" in their denials.

A.K.'s parents attempted to engage in meaningful dialogue with United regarding the denial of coverage by referencing the treating physician opinions. When United denied coverage due to medical necessity, notably in its third denial overall, the reviewer stated

that "[t]he purpose of the admission was to consolidate [A.K.'s] gains, as she had a history of regressing when not in a structured environment." In a three-page letter, the reviewer reasoned that further time at Discovery was not medically necessary because 1) A.K.'s diagnoses upon admission to Discovery of two different depressive disorders, anxiety disorder, and personality issues had not changed during her time there, and 2) A.K. had not attempted self-injury "in the three months prior to the adverse determination." Notably, A.K. was in active treatment at Discovery during those three months.

When A.K.'s parents appealed the denial of coverage for medical necessity, they even specifically requested justification with reference to treating physician opinions. A.K. provided the opinion of Dr. Riedel from Meridell, to address the third reviewer's reasoning that lack of change to A.K.'s diagnosis demonstrated residential treatment was no longer necessary. That opinion stated A.K. was on a "slow but steady course" and needed "to continue the work she is doing and to continue to consolidate gains," noting that A.K.'s extensive hospitalization history had been disruptive, and discharge could jeopardize progress. A.K.'s parents requested they be informed "what weight is given [to] the above professional opinions when making your next determination."

When the fourth reviewer responded to this appeal, however, they did not discuss or engage with Dr. Riedel's opinion or previously provided treating physician opinions. The fourth reviewer repeated the statements of the third reviewer in a two-page letter, stating that A.K.'s diagnoses did not change in her time at Discovery and there was no evidence of self-injurious behavior. That letter concluded that A.K.'s

treatment was not medically necessary without mentioning or addressing the treating physician opinions provided on appeal.

When A.K.'s parents appealed for a fourth time, they requested an external review. They again specifically requested that "an explanation of what weight was given to the opinions of [A.K.]'s treatment team who provided first-hand knowledge of her treatment." They noted the fourth reviewer did not address the issues they raised in their previous appeal.

The external reviewer, the fifth reviewer of A.K.'s claim, repeated the prior reviewers' reasoning. That reviewer found A.K.'s continued residential treatment not necessary because A.K. "had improved" and necessary structure could be gained in an outpatient setting. Noting that A.K. "continued to have treatment resistant behaviors" and "act[ed] out behaviorally," the reviewer nonetheless stated that "[t]hese [issues] could have been managed at a therapeutic school with intensive outpatient behavioral supports." The reviewer further noted that A.K.'s prior physicians had recommended a lengthy residential program, but dismissed those recommendations without addressing the specific reasons the physicians gave.

If the fifth reviewer had addressed those reasons, they necessarily would have wrestled with medical advice stating that A.K. needed ongoing 24-hour residential programming to build the skills necessary to survive at home, despite her temporary stabilization when in 24-hour care. For example, the reviewer would have had to address the opinion of Dr. Diederich, who stated that A.K. was part of "a small subset of children that cannot make the needed changes unless they are in a single, consistent program that will keep them until they can develop the needed skills to be safe."

Moreover, that A.K.'s acting out and treatment-resistance were because "her speed of [] processing is much slower than her peer group," which "will make many of the processes seem slower and ineffective, when really she needs a greater length of time to allow these skills to be developed." Similarly, the reviewer would have had to address the assertion by Dr. Lowe of Discovery, who stated that early discharge carried high risks because A.K. "has not learned to regulate her mood outside a structured therapeutic facility and would return to old patterns of self-harm as evidenced by her recent poor relationship[] choices, increased anxiety, emotional reactivity, refusal to use healthy coping skills, resulting in increased depression, suicidal thoughts and cutting herself." Thus, the reviewer would have had to justify their conclusion that A.K. "acting out" could be managed in an outpatient setting.

United's reviewers were not required to defer to the treating physician opinions provided. However, their duties under ERISA require them to address medical opinions, particularly those which may contradict their findings. This is the core of meaningful dialogue: if benefits are denied and the claimant provides potential counterevidence from medical opinions, the reviewer must respond to the opinions. This back-and-forth is "how civilized people communicate with each other regarding important matters." *Booton,* 110 F.3d at 1463. Interpreting United's legal requirements to be anything less is unreasonable. In refusing to address the treating physician opinions presented to it which could have confirmed A.K.'s need for benefits, United acted arbitrarily and capriciously.

Plan administrators must provide claimants with the rationales for denial prior to litigation because plan administrators who "have available sufficient

information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary," preclude the claimant from "full and meaningful dialogue regarding the denial of benefits." *Spradley v. Owens-Illinois Hourly Emps. Welfare Benefit Plan,* 686 F.3d 1135, 1140 (10th Cir. 2012) (citation and quotation omitted). The Tenth Circuit has expressed concern that ERISA claimants would be denied timely and specific explanations and be "sandbagged by after-the-fact plan interpretations devised for purposes of litigation." *Flinders v. Workforce Stabilization Plan of Phillips Petro. Co.,* 491 F.3d 1180, 1191 (10th Cir. 2007) (citation and quotation omitted). Lack of engagement with medical opinions is a basis for appeal of a claim, so a claimant must be informed if they received a full and fair review. It cannot be that the depth of an administrator's engagement with medical opinion would be revealed only when the record is presented for litigation. For these reasons, the district court appropriately did not credit information that was not shared with the beneficiary.

In sum, we hold United acted arbitrarily and capriciously in not engaging with the medical opinions of A.K.'s treating professionals and the district court did not err in limiting its review to denial letter provided to claimants.

B

We turn next to United's sufficiency of explanation claim. United challenges the district court's conclusion that it failed to explain its denial by applying the terms of the plan to A.K.'s medical records. The district court found United's failure to cite any facts in the medical record constituted conclusory reasoning and

thus United acted arbitrarily and capriciously. We take the district court's view of the matter.

When addressing claimant's evidence, ERISA's full and fair review requires the administrator "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. § 2560.503-1(h)(2)(iv). An administrator's explanation for a denial provided during a full and fair review cannot merely reference the claimant's evidence. *See* Rasenack *ex. Rel. Tribolet v. AIG Life Ins. Co.,* 585 F.3d 1311, 1326 (10th Cir. 2009). Rather, ERISA procedural regulations require the administrator "provide the claimant with a comprehensible statement of reasons for the [initial] denial." *Gilbertson v. Allied Signal, Inc.,* 328 F.3d 625, 635 (10th Cir. 2003). In referring to a claimant's medical records, administrator statements may not be conclusory and any health conclusions must be backed up with reasoning and citations to the record. *McMillan v. AT&T Umbrella Benefit Plan No. 1,* 746 F. App'x 697, 705-06 (10th Cir. 2018). In other words, given that United was provided with extensive information, its conclusory responses without citing the medical record, did not constitute a full and fair review.

The denial letters only contained four statements that referenced A.K.'s condition specifically: 1) that her diagnosis and medications did not change extensively from admission to Discovery to the date of the review, 2) that the record lacked evidence of self-injurious behavior during her time at Discovery, 3) that she had "treatment resistant behaviors," and 4) that she "continued to act out behaviorally." None of these statements were supported by citation to the record or discussed A.K.'s extensive medical history. Moreover, they could have also supported a finding that A.K.

needed ongoing treatment, but the reviewers simply concluded that they indicated A.K. could be treated at a lower level of care. These statements thus lacked "any analysis, let alone a reasoned analysis." *McMillan,* 746 F. App'x at 706. Accordingly, the statements were conclusory and A.K.'s denial was arbitrary.

United again argues that the district court erred in not considering plan administrators' notes, which it claims adequately cite to the medical record. We reiterate our conclusion that ERISA regulations require denial letters themselves to be comprehensive, 29 C.F.R. § 2560.503-1(f)(3); 29 C.F.R. § 2560.503-1(h)(3), (4), in order to form a "meaningful dialogue" for a full and fair review, *Gilbertson,* 328 F.3d at 635. Review of the explanation provided to claimants must focus on the content of the denial letters.

Moreover, A.K.'s plan required that the denial letters contain sufficient explanations. An ERISA administrator is held to the specific promises in the plan because ERISA's "linchpin" is its "focus on the written terms of the plan." *M & G Polymers USA, LLC v. Tackett,* 574 U.S. 427, 435 (2015). We have held that a plan administrator must interpret ERISA plans consistently with the plan's unambiguous language. *Tracy O. v. Anthem Blue Cross Life & Health Ins.,* 807 F. App'x 845, 854 (10th Cir. 2020). Therefore, United must provide the type of explanations unambiguously promised in A.K.'s plan documents.

A.K.'s plan required claims administrators to provide a written denial notification which must include "[t]he specific reason or reasons for the denial" and "[s]pecific reference to pertinent Plan provisions on which the denial was based." For denials based on medical necessity, A.K.'s plan required "an explanation of the scientific or clinical judgment for the determination, or

a statement applying the terms of the Plan to the Participant's circumstances, or a statement that such explanation will be provided upon request." This requirement is similar to United's statutory obligations under ERISA. *See* 29 C.F.R. § 2560.503-1(g)(v)(B). We hold these plan document requirements unambiguously charge the plan administrator with supplying the specific reason for its denial and specific reference to the pertinent plan provision on which it was based. Review of the information provided to claimant may be appropriately limited to the denial letters.

We therefore conclude the district court correctly found that United acted arbitrarily and capriciously in not providing analysis or citations to the medical record in its denial letters.

IV

United also argues the district court abused its discretion when it awarded A.K. benefits outright. A court may remand for further administrative review if it determines the administrator's flawed handling could be cured by a renewed evaluation to address, for example, a "fail[ure] to make adequate findings or to explain adequately the grounds for a decision." *Caldwell v. Life Ins. Co. of N. Am.,* 287 F.3d 1276, 1288 (10th Cir. 2002). *See also Rekstad v. U.S. Bancorp,* 451 F.3d 1114, 1121-22 (10th Cir. 20026) (remanding for plan administrator to examine relevant evidence). By contrast, a court may award benefits when the record shows that benefits should clearly have been awarded by the administrator. *See Weber v. GE Grp. Life. Assurance Co.,* 541 F.3d 1002, 1015 (10th Cir. 2008). That is not the only instance in which a court may award benefits. If a plan administrator's actions were clearly arbitrary and capricious, then remand is unnecessary, and a reviewing court may award benefits.

DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161, 1175-76 (10th Cir. 2006). Other circuits have similarly found remand unnecessary for procedural flaws. As the Second Circuit explained, remand to an insurer is not appropriate if it "serve[s] primarily to give the defendants an opportunity to retool a defective [appeals] system." *Zervos v. Verizon New York, Inc.,* 277 F.3d 635, 648 (2d Cir. 2002). The Ninth Circuit has expressed concern with giving an additional "bite at the apple" to ERISA administrators acting unjustly. *See Grosz-Salomon v. Paul Revere Life Ins. Co.,* 237 F.3d 1154, 1163 (9th Cir. 2001).

In considering if such a rule is appropriate here, we consider the function of judicial review for ERISA administrators. The Supreme Court has reiterated that judicial deference to ERISA plan administrators is premised on their fiduciary roles. *See, e.g., Varity Corp. v. Howe,* 516 U.S. 489, 506 (1996). ERISA requires fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104. When the administrator's actions or structure threaten their ability to act as a proper fiduciary, the Court has given administrators' decisions less deference. *See Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 107-09 (1989) (disallowing the arbitrary and capricious standard of review when there is a possible conflict of interest for the administrator); *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105, 118 (2008) (disallowing deferential review when considering the specific facts of the case). When Congress "careful[ly] balance[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans," *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 54 (1987), it did not give administrators unlimited freedom to act improperly towards claimants.

We conclude that the district court did not abuse its discretion in declining to remand. Considering the administrator's clear and repeated procedural errors in denying this claim, it would be contrary to ERISA fiduciary principles to mandate a remand and provide an additional "bite at the apple."

V

We AFFIRM the decision of the district court, including its grant of summary judgment favoring Plaintiff-Appellees and its order of benefits.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

[Filed: May 15, 2023]

No. 21-4088

(D.C. No. 2:17-CV-01328-DAK) (D. Utah)

D.K.; K.K.; A.K.,

Plaintiffs-Appellees,

v.

UNITED BEHAVIOR HEALTH;
ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR
ACTIVE MANAGEMENT EMPLOYEES,

Defendants-Appellants.

SECRETARY OF LABOR,

Amicus Curiae.

JUDGMENT

Before CARSON, LUCERO, and ROSSMAN, Circuit Judges.

This case originated in the District of Utah and was argued by counsel.

The judgment of that court is affirmed.

Entered for the Court

/s/ Christopher M. Wolpert
CHRISTOPHER M. WOLPERT, Clerk

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

[Filed: August 1, 2023]

No. 21-4088

(D.C. No. 2:17-CV-01328-DAK) (D. Utah)

D.K., *et al.*,

Plaintiffs-Appellees,

v.

UNITED BEHAVIOR HEALTH, *et al.*,

Defendants-Appellants.

SECRETARY OF LABOR,

Amicus Curiae.

ORDER

Before CARSON, Circuit Judge, LUCERO, Senior Circuit Judge, and ROSSMAN, Circuit Judge.

Appellants' petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court

/s/ Christopher M. Wolpert
CHRISTOPHER M. WOLPERT, Clerk

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH

[Filed June 22, 2021]

Case No. 2:17-CV-01328-DAK

D.K. and A.K.,

Plaintiffs,

vs.

UNITED BEHAVIORAL HEALTH AND ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR ACTIVE MANAGEMENT EMPLOYEES,

Defendants.

Judge Dale A. Kimball

MEMORANDUM DECISION AND ORDER

INTRODUCTION

This matter is before the court on the parties' Cross-Motions for Summary Judgment. (ECF No. 75, 77.) On June 21, 2021, the court held a hearing on these motions. At the hearing, Brian S. King represented D.K and A.K (collectively, "Plaintiffs") and Michael H. Bernstein represented United Behavioral Health ("UBH") and Alcatel-Lucent Medical ("ALM") (collectively, "Defendants"). The court took the matter under advisement. Now being fully informed, the court issues the following Memorandum Decision and Order.

BACKGROUND

The Plan & Its Terms

The plan (the "Plan") at issue is self-funded by Nokia of America Corporation (formerly known as Alcatel-Lucent USA Inc.). It is undisputed that the Plan is an employee welfare benefit plan governed by ERISA and that at all relevant times, Plaintiff D.K., A.K.'s father, was a member of the Plan. Defendant UnitedHealthcare ("United") and United's affiliate, UnitedHealthcare Behavior Health ("UHB"), are some of the Plan's designated claim administrators.

There are three provisions in the Plan that are germane to this case: the provision detailing "Medical Necessity"; the conditions for qualifying for care in a "Residential Treatment Facility"; and the definition of "Custodial Care." Those provisions are quoted in turn.

Medically Necessary: (Rec. 27)

Medically Necessary treatment must meet the following criteria:

> (i) . . . accepted by the health care profession in the U.S. as the most appropriate level of care
>
> (ii) . . . the safest and most effective level of care for the condition being treated.
>
> (iii) . . . appropriate and required for the diagnosis or treatment of the accidental injury, Illness, or Pregnancy.
>
> (iv) There is not a less intensive or more appropriate place of service . . .
>
> (v) . . . provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to

that as used by the National Institute of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

Residential Treatment Facility: (Rec. 36–37)

To qualify for Residential Treatment the following conditions must be met:

- The member is not in imminent or current risk of harm to self and others and/or property.

AND

- Co-occurring behavior health and physical condition can be safely managed.

AND

- The "why now" factors leading to admission cannot be safely efficiently, or effectively addressed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychological and environmental factors. Examples include:
    - o Acute impairment of behavioral or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
    - o Psychological and environmental problems that are likely to threaten the member's safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

Custodial Care: (Rec. 19)

> Treatment or service prescribed by a medical professional, that could be rendered safely and reasonably by a person not medically skilled, or that is designed mainly to help the patient with daily living activities. These activities are the following:
>
> (a) Personal care such as help in: walking, getting in and out of bed, bathing, eating by spoon, tube or gastronomy, exercising and dress;
>
> (b) Homemaking, such as preparing meals or special diets;
>
> (c) Moving the patient;
>
> (d) Acting as a companion or sitter;
>
> (e) Supervising medication that can usually be self-administered; or
>
> (f) Treatment or services that any person may be able to perform with minimal instruction including, but not limited to, recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

A.K.'s Mental Health Disorders & Treatment Before Long-Term Residential Treatment

Beginning in 2010, A.K. began having issues with her mental health. Initially, A.K. struggled with fairly typical bouts of anxiety, Attention Deficit Disorder ("ADD"), and depression. A.K.'s symptoms escalated quite quickly, and she began secretly cutting herself with razor blades. A.K.'s parents did not discover that she had been cutting herself until February 2012,

when she cut herself so severely that she was frightened into showing her parents. That same month, A.K. began seeing a therapist. Despite the therapy, A.K. attempted suicide by cutting herself on March 4, 2012.

The same day that A.K. attempted suicide, she was admitted to Seay Behavior Center ("Seay"), an inpatient unit where she received treatment for her mental health disorders. On March 13, 2012, A.K. transitioned to Seay's day patient program and, on March 23, 2012, A.K. was discharged from Seay.

On March 31, 2012, A.K. ran away from home and, when the police found A.K., she was readmitted to Seay's in-patient unit. After two weeks at Seay's in-patient unit, A.K. was discharged to Cedar Crest Residential Center ("Cedar Crest"), a sub-acute inpatient mental health provider. While at Cedar Crest, providers diagnosed A.K. with "major depressive disorder, severe and recurrent." On May 21, 2012, A.K. was discharged from Cedar Crest. Following this discharge, A.K. began attending a day program at Children's Medical Center ("Children's Medical"), resumed seeing her therapist, and started seeing a psychiatrist to manage her medications.

In September 2012, A.K. started cutting herself again. Some of these cutting events required visits to the emergency department. Due to her escalating and recurring pattern of self-harm, A.K. was re-enrolled in the day program at Children's Medical. Despite the treatment at Children's Medical, A.K.'s self-harm continued to escalate. A.K. was again discharged from the Children's Medical day program on October 6, 2012.

A month later, A.K. became upset with her parents and ran away from home. When she returned home,

her anger toward her parents escalated and A.K. threatened—and then attempted—to commit suicide by strangulation. That same evening, A.K. was again admitted to Children's Medical. This time, however, A.K. was admitted to Children's Medical's inpatient program. A.K. only stayed a few days at the in-patient unit.

From October 18, 2012, to December 13, 2012, A.K. received treatment at Meridell Achievement Center ("Meridell"), a residential treatment center. After discharge from Meridell, A.K. transitioned to a day patient program at The Excel Center ("Excel"). Things were seemingly improving for A.K. until she failed an exam in March 2013. After failing her exam, A.K. began engaging in self-harming behaviors again.

On March 8, 2013, A.K. was admitted to the University Behavior Center ("University") for major depressive disorder and suicidal ideation. A.K.'s stay at University lasted only one month. The day after being discharged, A.K. was readmitted to the hospital due to suicidal ideation. Following her discharge from the hospital, A.K. continued to cut herself until she was readmitted to University on May 4, 2013. After a week-long stay at University, A.K. restarted the program at Meridell for residential treatment.

Treatment Professionals Recommend Long-Term Residential Treatment for A.K.

In May 2013, while A.K. was at Meridell, the treating professionals began suggesting to A.K.'s parents that A.K. would need long-term residential treatment to treat her mental health disorders. A.K.'s parents then contacted Mr. William Johnson, A "Care Advocate Lead" at Optum Healthcare (a subsidiary of UnitedHealth Group). Mr. Johnson counseled A.K.'s parents to iden-

tify long-term treatment programs in order to request coverage. While A.K.'s parents searched for a long-term treatment program, Defendants decided they would stop coverage for A.K. at Meridell on July 30, 2013. Three days after leaving Meridell, A.K. cut herself again— nearly severing her femoral artery and requiring 12 stitches. This self-harm incident required that A.K. be readmitted to the inpatient program at Children's Medical.

On August 14, 2013, A.K. was transferred from Children's Medical to Meridell. Again, A.K.'s treatment team at Meridell recommended that A.K. be placed in a structured, long-term residential treatment program. Specifically, Ms. Kimberly Weaster, M.Ed., opined that A.K. would need "ongoing specialized residential treatment . . . upon discharge from Meridell." Dr. Andrew Diedrich also wrote that "[b]ased on [his] experience with [A.K.], it [was] [his] clinical recommendation that she needs a long-term residential placement." Dr. K.K. Riedel, M.D., also recommended that A.K. received "a long-term residential treatment center placement to accomplish the goals necessary for her to succeed and have a chance at sustaining a healthy life."

Defendants Approval & Denials for Coverage for Treatment at Discovery

Following the treating team's advice that A.K. receive long-term residential care, A.K.'s parents hired a consultant to help find appropriate long-term residential treatment options. This consultant eventually homed in on two facilities. A.K.'s parents informed Mr. Johnson (Optum Healthcare's Care Advocate) of these options and Mr. Johnson told A.K.'s parents to submit a request for coverage to Defendants. A.K.'s parents submitted their request for long-term treatment.

Eventually, Defendants notified A.K.'s parents that it had approved A.K.'s treatment at Discovery Girls Ranch ("Discovery") for an initial 90 days and that a review should be conducted after the 90 days to see if continued treatment would be necessary. (Rec. 2027.) On November 4, 2013, A.K. enrolled at Discovery. (Rec 2035.)

All told, in the 20 months between her first suicide attempt on March 4, 2012 and her admission to Discovery, A.K. had: 11 psychiatric emergency room visits; five in-patient hospitalizations (totaling 58 days); four stints of residential treatment centers lasting 38 days, 57, days, 63 days, and 79 days (totaling 237 days); six enrollments into partial hospitalization programs (totaling 69 days); weekly individual therapy; family therapy; medication management from a psychiatrist; and some DBT therapy. None of this—or the sum of all these forms of treatment—had proven sufficient to keep A.K. from regressing to her self-harming ways. Discovery and long-term residential treatment were the professionals' recommended—and obvious—next steps.

Near the end of the 90-days, Defendants informed A.K.'s parents that they would be denying coverage for treatment at Discovery beginning on February 9, 2014. This Adverse Benefit Decision stated:

> I have reviewed your child's treatment plan that was submitted by Discovery Ranch for Girls, and I have determined that coverage is not available under your child's benefit plan for the requested services of long term residential treatment. Based upon current clinical member appears to require Mental health Residential Treatment Center long

> term Level of Care but due to excluded service a denial will be submitted.

(Rec. 442–43.) A.K.'s parents did not anticipate this denial—especially a denial based on the service being unavailable under the plan since they received prior approval for treatment at Discovery. So, A.K.'s parents requested more information about why the coverage was denied. Defendants responded by stating that the service was not covered due to the provision titled "Alternative treatment facilities accessed or Out-of-Network is excluded." Defendants had, however, retroactively eliminated this provision from the Plan.

On June 25, 2014, A.K.'s parents appealed the first denial of coverage, pointing out that the provision that Defendants relied on to deny coverage had been removed. On August 1, 2014, Defendants responded again, affirming their denial of coverage. This denial, performed by a different reviewer, stated:

> Based upon current medical records, the member appears to require Mental Health Residential long term level of care but due to excluded service, a denial will be submitted.. . . We are unable to authorize benefit coverage for Long Term Residential treatment as the member's benefit contract does not provide mental health coverage for this type of treatment or service.

(Rec. 1904–05.) Notably, this language is nearly identical to the first denial decision letter.

On September 25, 2014, A.K.'s parents appealed the second denial, reminding Defendants that the exclusion for "Alternative Treatment Facilities Accessed or Provided Out-of-Network" had been deleted from the Plan. Defendants acknowledged that these

denials were erroneous. (Rec. 468.) Upon recognizing—and admitting—that these first two denials were an error, Defendants conducted another review of the submitted claims.

On December 10, 2014, Defendants submitted a third denial letter after conducting a new medical necessity review. In this denial letter, Defendants stated that they reviewed several documents (e.g., medical records, letters from K.K., the Plan's Guidelines, etc.) and concluded that the coverage would be denied because the treatment was not medically necessary. Specifically, the relevant portion of the letter states:

> As of the last covered day, . . . medical necessity was not met. UBH Leve of Care Guidelines for Residential Treatment requires evidence of active treatment. It requires that the physician is seeing the patient two times per week. The attending psychiatrist during your daughter's stay at Discovery Ranch assessed her only on a monthly basis. The guideline also requires the treatment plan is targeted and addresses the "why now" reason for the admission. The purpose of the admission was to consolidate her gains, as she had a history of regressing when not in a structured environment. However, on admission the attending psychiatrist found little evidence of active psychiatric illness. She was described as having had Dysthymia, in partial remission, Major Depressive Disorder, in remission but having an Anxiety Disorder and what is termed a rule out for Group B Traits (meaning personality issues). The treatment record indicates no evidence of ongoing self-injurious behavior in the three

> months prior to the adverse determination (or for that matter during her most recent treatment at Meridell, thus providing objective evidence of significantly improved ability to control self-injurious behavior. The "why now" reason for the admission had been addressed. When the "why now" reason for admission has been addressed, the care is considered custodial.

(Rec. 2004.) The letter also made a brief mention that A.K.'s treatment at Discovery was mainly "focus[ed] on her personality issues" and that "personality issues are a long-term issue and are not expected to respond within a reasonable amount of time. As such the focus of the treatment, the personality issues, also would be considered custodial." (Rec. 2004.)

On February 5, 2015, A.K.'s parents file another appeal. On March 6, 2015, Defendants provided Plaintiffs with a fourth and final, internal denial letter. The letter states that the claims administrator reviewed the medical record, case management notes, appeal letter, and the Level of Care Guidelines before addressing why UBH was denying coverage. The denial portion of the letter states:

> As of the last covered day, 01/31/2014, medical necessity was not met. Optum Level of Care Guidelines for Residential Treatment requires evidence of active treatment, including that the psychiatrist see the patient twice a week, whereas in this case your daughter was seen once a month. On admission, she was described as having had Dysthymia, in partial remission, Major Depressive Disorder in remission but having an Anxiety Disorder and what is termed a rule out for Group B Traits (meaning personality issues). These diagnoses did not

> change and medication changes were minimal. There was no evidence of self-injurious behavior. This would appear to address the goals of admission which were to consolidate your daughter's gains so that she could control her self injurious behavior. When this was achieved, care became custodial, which is not a covered service. Finally, reimbursable residential treatment is defined as a 24 hour/7day assessment and diagnostic services with active behavior health treatment. For all the reasons noted above, the services provided by Discovery Ranch were not consistent with this requirement.

(Rec. 2052–54.) This denial letter's language is almost identical to the reasoning and language from the third denial letter. Having exhausted their internal appeal obligations, Plaintiffs requested an independent, external review.

The external review upheld Defendants' third and fourth denial rationale—namely, that medical necessity was not met. (Rec. 2597–607.) Specifically, this external review stated:

> The patients' providers prior to her hospitalization recommended a lengthy residential program, but the records provided for review do not indicate that as of 02/2014 through 11/2014 she continued to meet criteria for the most appropriate level of care. She had improved. She could have been treated in a therapeutic school environment for example. She was able to focus on school work. She required structure and support but this could be obtained out of an acute residential setting with coordinated therapeutic school, outpa-

> tient providers and either a residential based school or family and individual therapy supports. There is not evidence during this time period that remainder in a residential setting was the safest and most effective level of care. She continued to have residential resistant behaviors. She continued to act out behaviorally. These could have been managed at a therapeutic school with intensive outpatient behavioral supports for individual and family.

(Rec. 2606.) This fifth, external review was the final decision before Plaintiffs brought the present suit.

Procedural History

On December 29, 2017, Plaintiffs filed the present action. (ECF No. 1.) In their Third Amended Complaint, Plaintiffs assert two causes of action. (ECF No. 39.) In the First Cause of Action, Plaintiffs assert an ERISA claim for recovery of benefits under 29 U.S.C. § 1132(a)(1)(B). (ECF No. 39.) The Second Cause of Action alleges a violation of the Mental Health Parity and Addiction Equity Act (the "Parity Act") under 29 U.S.C. §1132(a)(3). (ECF No. 39.) On February 18, 2021, both parties filed cross-motions for summary judgment, seeking summary judgment on both claims. (ECF No. 75, 77.) During the hearing on these motions, Plaintiffs abandoned their Parity Act claim.

DISCUSSION

Since Plaintiffs abandoned their Parity Act claim, the court focuses only on Plaintiffs' ERISA claim. Thus, this Order will proceed by discussing: (A) which standard of review applies in this instance; (B) the merits of Plaintiffs' ERISA claim; and (C) the appropriate relief that should be awarded.

A. Standard of Review

The Supreme Court has held that "a denial of benefits challenged under [ERISA] must be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibly for benefits or to construe the terms of the plan." *Firestone Tire and Rubber Co. v. Brunch*, 489 U.S. 101, 115 (1989). When a plan gives an administrator this discretion, a court applies a "deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious." *Weber v. GE Grp. Life Assurance Co.*, 541 F.3d 1002, 1010 (10th Cir. 2008) (citation and internal quotation marks omitted). A plan administrator may forfeit the deferential standard when it fails to follow certain ERISA procedures.

Plaintiffs claim that the deferential standard is forfeited "if [the claims administrator] fails to comply with ERISA's procedural requirements." (ECF No. 77 at 31.) The ERISA procedural standards are lengthy, and a full recitation of the procedures is not necessary here. Relevant to this action are ERISA's requirements that the plan administrator: (1) provide adequate notice, "setting forth the specific reasons for [a] denial"; (2) afford a "full and fair review. . . of the decision denying the claim"; (3) give "[t]he specific reason. . . for the adverse determination"; (4) "[r]eference the specific plan provisions upon which the determination is based"; and (5) in the context of denials for lack of medical necessity, explain "the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances." 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1.

Plaintiffs seem to argue that almost any failure to comply with these procedural requirements results in

de novo review of the claim unless the failure is a *de minimis* violation or done for good cause. Plaintiffs cite *Rasenack v. AIG Life Insurance Co.*, 585 F.3d 1311, 1361–17 (10th Cir. 2009), 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1)–(2), and *Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ.*, 819 F.3d 42 (2d Cir. 2016) to support this claim. The court is unpersuaded that any of these citations supports Plaintiffs' claim that the de novo standard should apply in this instance.

First, the claims administrator in *Rasenack* did indeed forfeit the deferential standard but not for generally failing to comply with ERISA's procedures. 585 F.3d at 1315–16. Rather, *Rasenack's* holding that the claim was subject to de novo review was based upon the administrator's failure to issue a claim determination within its self-imposed time limits. *Id.* Specifically, the court held that "where the plan and applicable regulations place temporal limits on the administrator's discretion and the administrator fails to render a final decision within those limits, the administrator's 'deemed denied' decision is by operation of law rather than the exercise of discretion, and thus falls outside the *Firestone* exception." *Id.* at 1316 (citing *Firestone Tire & Rubber Co.*, 489 U.S. at 115). Thus, the administrator's failure resulted in the claim being "deemed denied" due to procedural issues, not a substantive determination of the claim's merits. *Id.* That is not what happened here when Defendants stated that they reviewed the medical records and found a lack of medical necessity.

Second, and relatedly, 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1)–(2) does not provide that *any* ERISA procedural violation results in an administrator forfeiting the deferential standard. Subsection (F)

deals with when ERISA deems that the internal claims and appeals process is exhausted. Specifically, Subsection (F)(1) states that a claimant may seek relief under section 502(a) of ERISA for an administrator's failure to comply with all of the requirements of paragraph (b)(i). This challenge, however, must be "on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would *yield a decision on the merits of the claim*." *Id.* (emphasis added). Thus, it is only when the internal decision process does not yield a decision on the merits of the claim that an administrator's determination is done "without the exercise of discretion." *Id.* In this instance, UBH's decision was—at least for the final three reviews—based on the merits regarding the medical necessity of A.K.'s claim and, therefore, does not result in Defendants forfeiting the deferential standard.

Third, Plaintiffs cites the Second Circuit's opinion in *Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ.* to support their contention that the alleged ERISA procedural violations in this instance warrant de novo review. 819 F.3d 42 (2d Cir. 2016). This argument, urging courts in this district to adopt *Halo's* reasoning, has been frequently rejected by the Utah District Court judges—including this very court. *See Joel S. v. Cigna*, 356 F. Supp. 3d 1305, 1313 (D. Utah 2018); *James C. v. Aetna Health & Life Ins. Co.*, Case No. 218-cv-00717-DBB-CMR, 2020 WL 6382043, at *6 (D. Utah Oct. 30, 2020); *H. v. Cigna Behavioral Health*, Case No. 2:17-cv-110-TC, 2018 WL 4082275, at *8 n.3 (D. Utah August 27, 2018); *C. v. ValueOptions*, Case No. 1:16-cv-93-DAK, 2017 WL 4564737, at *4 (D. Utah October 11, 2017) (10th Cir. Nov. 9, 2017).

All these courts rejected the *Halo* framework and then looked to the Tenth Circuit precedent for determining the correct standard of review. The court finds Judge Barlow's opinion persuasive on the Tenth Circuit precedent for when the deferential standard is forfeited:

> Under Tenth Circuit precedent, de novo review is appropriate despite a plan's conferral of discretion on a plan administrator if: the administrator fails to exercise discretion within the required timeframe; the administrator fails to apply its expertise to a particular decision; the case involves serious procedural irregularities; the case involves procedural irregularities in the administrative review process; or where the plan members lack notice of the conferral of administrator discretion over the plan.

James C., 2020 WL 6382043, at *7 (footnotes and quotation marks omitted). None of those situations are present here. Accordingly, the court will apply the deferential arbitrary and capricious standard.

B. ERISA Claim

Now that the court has determined the standard of review, it must determine if Defendants' adverse benefits decisions were arbitrary and capricious under the terms of the Plan. Under this standard, the administrator's "decision will be upheld unless it is not grounded on any reasonable basis." *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (emphasis in original) (citation omitted). "This standard is a difficult one for a claimant to overcome." *Tracy O. v. Anthem Blue Cross Life & Health Ins.*, 807 F. App'x 845, 853–54 (10th Cir. 2020) (citation omitted). The

arbitrary and capricious review of an ERISA benefits decision looks to whether the decision: "(1) . . . was the result of a reasoned and principled process, (2) is consistent with any prior interpretations by the plan administrator, (3) is reasonable in light of any external standards, and (4) is consistent with the purposes of the plan." *Id.* at 854 (citations omitted). Additionally, failure to "consistently apply the terms of an ERISA plan" and inconsistent interpretations with the "plans unambiguous language" are considered arbitrary and capricious. *Id.* (citations omitted).

In this case, Plaintiffs raise three reasons why Defendants' determinations were arbitrary and capricious: (1) medical necessity was met under the terms of the Plan; (2) Defendants incorrectly disregarded A.K.'s treating physicians' opinions; and (3) Defendants did not articulate how they applied the terms of the Plan to A.K.'s medical history or current condition. The court will add another consideration, and discuss (4) the implications of UBH's inconsistent denial rationales. Plaintiffs certainly raised this fourth issue but the court wishes to address it separately. This court will discuss each issue in turn.

1. Medically Necessary

The court divides Plaintiffs' medically necessary arguments into two categories: (i) the "why now" factors and (ii) the "Custodial Care" portions of the Plan and how the reviewers interpreted those terms. Additionally, the court will not redefine the relevant terms of the Plan here, as those are detailed above. *See* BACKGROUND, *supra*.

i. The "Why Now" Factors

Plaintiffs take aim at the third and fourth letters' reasoning that coverage would be denied because the

"why now" reasons for admission had been addressed. According to Plaintiffs, the "why now" factors had not been addressed because the purpose of admission was not to ensure that A.K. stopped self-harming behavior while at Discovery, but rather to provide long-term care until she had developed the tools to break the cycle of relapsing into self-harming behavior upon leaving inpatient care. The final three reviews stated that this admission goal had been satisfied because she had improved or had not shown self-harming behavior.

The court finds that, under the deferential standard, the final three reviewers did not abuse their discretion because the evidence could reasonably be interpreted to show that A.K. could have been discharged to a lower level of care because her most pressing admission factors had allegedly subsided. Indeed, the evidence can support a finding that during her first 90 days at Discovery that A.K. had improved in important ways. The court notes, however, that this is a particularly hard issue: at some point during long-term residential treatment, a patient must be discharged to a lower level of care to see if the treatment helped stop self-harming behavior. There is no sure way to tell if discharge would be appropriate after three months, or six months, or a year. The court cannot properly say that the final three reviewers arbitrarily or capriciously found that A.K.'s three months of treatment had met the "why now" factors and that a lower level of care would be appropriate.

For the foregoing reasons, the court finds that the final three reviewers did not abuse their discretion in interpreting the "why now" factors as used in their denial rationales.

ii. Custodial Care

Plaintiffs argue that the third and fourth denial letters arbitrarily concluded that because the "why now" factors of A.K.'s admission had been addressed that her care became "Custodial." Plaintiffs state this is an incorrect conclusion because the care A.K. received at Discovery does not meet the Plan's definition of "Custodial Care." As noted above, the Plan defines "Custodial Care" as:

> Treatment or service prescribed by a medical professional, that could be rendered safely and reasonably by a person not medically skilled, or that is designed mainly to help the patient with daily living activities. These activities are the following:
>
> (g) Personal care such as help in: walking, getting in and out of bed, bathing, eating by spoon, tube or gastronomy, exercising and dress;
>
> (h) Homemaking, such as preparing meals or special diets;
>
> (i) Moving the patient
>
> (j) Acting as a companion or sitter;
>
> (k) Supervising medication that can usually be self-administered; or
>
> (l) Treatment or services that any person may be able to perform with minimal instruction including, but not limited to, recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

(Rec. 19.) According to Plaintiffs, the mere fact that A.K. was no longer exhibiting self-injurious behavior does not demonstrate that her care, for example, "could be rendered . . . by a person not medically skilled" or was "designed to mainly help the patient with daily living activities." (Rec. 19.) Defendants do not rebut this argument in any of their summary judgment papers. Without the help of Defendants' briefing, the court is persuaded by Plaintiffs' arguments.

The treatment and care that A.K. received at Discovery continued to include physician visits, counseling, therapy, medication changes, etc. Those are not services that can be rendered by a medically unskilled person. Additionally, A.K.'s care had nothing to do with her assisting her with daily activities. There is no evidence that A.K. was being assisted with any of the things listed in (m)–(r) above or that anything that is remotely like those services. Therefore, the care A.K. received at Discovery was not Custodial Care as defined by the Plan. In short, under the Plan, treatment does not automatically become Custodial Care just because it is not medically necessary. Such an interpretation of the Plan's terms is erroneous and a denial based thereon is arbitrary.

For the foregoing reasons, the court concludes that Defendants abused their discretion in finding that A.K.'s care had become "Custodial" under the Plan.

2. A.K.'s Treating Professionals' Opinions

"Nothing in [ERISA] itself . . . suggests that plan administrators must accord special deference to the opinions of treating physicians. Nor does [ERISA] impose a heightened burden of explanation on administrators when they reject a treating physician's opinion." *Black & Decker Disability Plan v. Nord,* 538 U.S. 822,

831 (2003). However, "[p]lan administrators . . . may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* at 834. The Tenth Circuit phrases this rule as a "narrow principle that fiduciaries cannot shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory." *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807 (10th Cir. 2004)

> If benefits are denied . . . the reason for the denial must be stated in reasonably clear language, . . . [and] if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.

Id.

Plaintiffs claim that Defendants' decisions were arbitrary because Defendants disregarded and failed to engage with the opinions of A.K.'s treating professionals. The court finds that the claims administrators clearly reviewed the treating professionals' opinions. For example, Defendants third denial letter states that the administrator reviewed: (1) a "[l]etter from K.K. detailing the reasons she believed the decision was in error"; (2) "correspondence from K.K. with exhibits"; (3) the IPRO letter; (4) "Note from Kimberly Weater"; (5) letter from Andrew Dieterich MD; (6) "Letter from Tim Lowe PhD and Ryan Williams MD of Discovery Ranch"; and (7) "Attending Physician Progress notes." (Rec. 2004.) The fourth denial letter is less detailed but still states that the administrator reviewed the

medical record, case management notes, and appeal letter—presumably from K.K., including attachments. (Rec. 2052–54.) Lastly, the fifth, external determination states that it was based upon a review of the appeal information, denial letters, correspondence between K.K. and UBH, submitted medical information, submitted criteria, and the Summary Plan Description. Again, these files likely included A.K.'s treating professionals' opinions. (Rec. 2606.) Thus, the evidence shows the claims administrators did not disregard the treating professionals' opinions. Whether Defendants engaged with those opinions is an entirely different matter.

In this instance, the evidence shows the administrators did not engage with A.K.'s treating physicians' opinions. As noted above, A.K. received extensive out- and in-patient treatment in the 20 months leading up to her admission to Discovery. None of that treatment was sufficient to keep A.K. from reverting to self-harming behavior. During that time, several physicians recommended that A.K. receive long-term care. All of A.K.'s medical history and her treating professionals' opinions stand in stark contrast to the denial letters' scant reasoning. For example, the *only* reference to all of A.K.'s treatment and professionals' opinions is a passing reference stating that the purpose of the treatment was to "consolidate" A.K.'s "gains." This language comes directly from Dr. Riedel's September 10th letter to the IPRO. That is it. There is no more acknowledgement of A.K.'s serious mental health history. Indeed, this strikes the court as an instance where Defendants "shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the [Plaintiffs'] theory of entitlement." *Gaither*, 394 F.3d at 807.

Thus, the court finds that Defendants abused their discretion by not fairly engaging with A.K.'s treating professionals' opinions.

3. Applying the Terms of the Plan to A.K.'s Medical History

Plaintiffs argue that Defendants abused their discretion by failing to apply the specific terms of the Plan to any specific portion of A.K.'s medical records. The law is not very clear on what level of specificity is required from claims administrators in applying a plan's terms to the medical records. Plaintiffs relied upon Judge Parrish's reasoning from *Raymond M.*, wherein claims denials were deemed arbitrary and capricious because the letters "contain[ed] neither citations to the medical record nor references to the report by [the plaintiff's] doctors" and were merely "conclusory statements without factual support." 463 F. Supp. 3d at 1282.[1]

In *Raymond M.*, Judge Parrish draws the standard of review from *McMillan v. AT&T Umbrella Benefit Plan No. 1*, 746 F. App'x 697 (10th Cir. 2018).[2] In *McMillan*, the Tenth Circuit took issue with a plan administrator's denial of short-term disability benefits. *Id.* at 705–06. The court stated that the problem with the denials was "the lack of *any* analysis, let alone a

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[1] This case is currently on appeal to the Tenth Circuit. *Raymond M. v. Beacon Health Options,* Appeal No. 21-4041(Mar. 30, 2021).

[2] Judge Parrish also relies on *Kerry W. v. Anthem Blue Cross & Blue Shield*, 444 F. Supp. 3d 1305, 1313 (D. Utah 2020). That case similarly draws its standard from *McMillan v. AT&T Umbrella Benefit Plan No.* 1, 746 F. App'x 697 (10th Cir. 2018). Thus, the court does not discuss *Kerry W* since the standard is what is at issue here.

reasoned analysis. For example, the reviews by [the claims administrators] contain[ed] nothing more than conclusory statements that [the plaintiff] could travel without any discussion whatsoever." *Id.* at 706 (emphasis in original). Indeed, a review of the facts in that case indicates that the reviewers did not do *any* analysis about the patient's ability to travel. *Id.* at 699–705. Thus, *McMillan* concluded that when a claims administrator makes a health conclusion it must provide reasoning and citation to the record. *Id.*

Extrapolating from *McMillan*, Judge Parrish concluded that the denial letters in *Raymond M.* similarly failed to fulfill their obligation to conduct a fair review of the claims. *Raymond M.*, 463 F. Supp. 3d at 1282. For example, the most detailed of denial letters from *Raymond M.* states:

> You are a 17 year old female admitted to the mental health residential treatment service level of care on 12/21/2015. On admission, you were withdrawn and not fully cooperative with the treatment programming. You were treated with individual, group, family, horse, and milieu therapies. You successfully ventured away from the facility several times without incident and had not engaged in any self-harming behaviors. You were not psychotic or aggressive and you have a supportive family. As of 01/19/2016 it was not medically necessary for your symptoms to be treated with residential treatment service monitoring and they could have been safely addressed in a less restrictive level of care such as in outpatient treatment with individual treatment, family work and medication management.

Id. at 1264. It is this denial letter that prompted Judge Parrish to hold that the "denial letters contain[ed] neither citations to the medical record nor references to the reports . . . concerning the state of [the patient's] condition." *Id.* at 1282. Thus, Judge Parrish concluded the denial was arbitrary. *Id.*

Here, the denial letters similarly do not contain any specific citation to the medical record whatsoever. Instead, the denial letters simply contain general statements about A.K.'s condition on admission and minimal statements about her treatment while at Discovery. As noted, there is no specific reference to any of her medical history or professionals' opinions prior to her admission to Discovery. For example, the letters generally state: (1) that when A.K. was admitted she was diagnosed as having "Dysthymia, in partial remission, Major Depressive Disorder in remission but having an Anxiety Disorder and what is termed a rule out for Group B Traits (meaning personality issues)"; (2) A.K.'s diagnoses upon admission "did not change" during her first three months; (3) A.K.'s "medication changes were minimal"; (4) "[t]here was no evidence of self-injurious behavior"; (5) A.K.'s "goals of admission"—to consolidate her gains and control self-injurious behavior—appeared to have been met; (6) because her goals had been met care became custodial; and (7) the Plan's guidelines for Residential Treatment required "evidence of active treatment, including that the psychiatrist see the patient twice a week, whereas [A.K.] was seen once a month." (Rec. 2052–54.) Of these seven statements, only two make a general reference to A.K.'s condition: that her diagnoses "did not change" and there was no evidence of self-injurious behavior. Neither of these statements are supported by citations to the record or explained in the context of A.K.'s prior, extensive mental health medical history. Additionally, the letters

do not explain or cite to any evidence to support its conclusion that A.K.s goals of admission had been met and that she would not return to self-harming behavior upon discharge. Without any support, the court finds that these conclusory statements result in an arbitrary denial of A.K.'s treatment.

At the hearing, Defendants urged the court to look at the claims administrators' notes and not just the denial letters sent to Plaintiffs. Defendants claim that these notes are more substantive and explain in more detail A.K.'s medical history and the reason why coverage for Discovery was no longer medically necessary. Plaintiffs' counsel argues that it would be improper for the court to consider these documents as they were not provided to Plaintiffs. The court agrees with Plaintiffs.

The court was unable to find any Tenth Circuit case law that speaks to this issue. The First Circuit has, however, discussed "whether a plan administrator may defend a denial of benefits on the basis of a different reason than that articulated to the claimant during the internal review process." *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 115 (1st Cir. 2004). In deciding this issue, the *Glista* court declined to adopt a "hard-and-fast rule" on this issue, instead opting to take this on a case-by-case basis. *Id.* In finding that the administrator could not rely on reasons that had not been articulated to the claimant, the *Glista* court considered the following: (1) would "traditional insurance law place[] the burden on the insurer to prove that the applicability" of a similar benefits exclusion rationale; (2) did the plan "expressly provide that participants 'must receive a written explanation of the reasons for the denial'"; (3) did the administrator give an "explanation for why it did not explain earlier" its

unstated reason for denying the claim; and (4) did the facts of the situation require that the controversy be resolved quickly? *Id.* at 131

The court finds *Glista* persuasive and will rely on its reasoning. Here, the court must hold Defendants to their denial rationales articulated in the denial letters because two of the *Glista* considerations are satisfied. First, the Plan requires "written notification from the applicable Claims Administrator" that would include: "(a) The specific reason or reasons for the denial; [and] (b) specific reference to any pertinent Plan provisions on which the denial was based[.]" (Rec. 129–30.) In fact, if a denial was "based on Medical Necessity," the notification must provide "an explanation of the scientific or clinical judgment of the determination, applying the terms of the Plan to the Participant's circumstances." (Rec. 129–30.) As explained above, that did not happen here. Second, Defendants have not given any reason why they did not include their full reasoning for the denial in the letters sent to Plaintiffs. Without any reason justifying their failure to explain their internal reasoning for denying A.K.'s claims, Defendants cannot now rely on those rationales.

Even were the court to consider those additional materials, the court is unpersuaded that the internal documents make any difference. The internal documents behind the third denial letter are, in fact, more detailed. (Rec. 1544–46.) This document details A.K.'s medical history quite thoroughly, noting her in-patient admissions, partial hospitalizations, residential treatment center stays, emergency room visits, out-patient treatment, and her history of regressing after discharge. (Rec. 1545.) The problem with these records—besides the fact that they were not communicated to Plaintiffs—is that they undermine the denial letters'

conclusions and assertions. For example, the internal document states "[t]he chart [from Discovery] is absent of treatment plan updates that review her progress in attaining her objectives. Updated goals or objectives are never stated. Of significance is *the absence of notes* relating to her progress in controlling suicidal threats, runaway behavior and self-injurious behavior." (Rec. 1545 (emphasis added).) In the third denial letter, however, Defendants assert that "[t]he treatment record indicates no evidence of ongoing self-injurious behavior." (Rec. 2004.) This is misleading because it suggests that A.K. had not had self-injurious or suicidal thoughts when the record actually indicates that there was simply an absence of notes on that subject. A lack of notes about self-injurious behavior does not mean A.K. was not struggling with such thoughts or behavior. As the aphorism goes, absence of evidence is not evidence of absence. Additionally, the third denial letter expressly states that "[t]throughout the treatment, the attending psychiatrist did not change [A.K.'s] diagnoses." (Rec. 2004.) That statement is directly contrary to Defendants internal documents noting that "[t]he Master Treatment Plan changed the diagnosis to Major Depressive Disorder, recurrent and severe, Reactive Attachment Disorder and Anxiety Disorder NOS." (Rec. 1545.) Similar problems are present in the fourth denial letters' internal supporting notes. (*Compare* Rec. 2575–76 *with* Rec. 2052–53.) Thus, the internal documents that were not shared with Plaintiffs actually work to show that the denial letters' rationales were unsupported by the record, including Defendants own notes.

For the foregoing reasons, the court concludes that the denials were arbitrary because they lacked "any analysis, let alone a reasoned analysis," consisting

of "nothing more than conclusory statements." *See McMillan*, 746 Fed. App'x at 706 (emphasis omitted).

4. Inconsistent Denial Letters

As noted above, one of the factors that a court must consider in ERISA benefits decision is the consistency of the denial reason between the administrators. *See Tracy O.*, 807 F. App'x at 853–54. Plaintiffs argue that the first two denial letters are wildly inconsistent with the last three denials. Defendants attempt to distance themselves from the first two letters by: (1) claiming that those letters did not constitute a medical necessity review; (2) asserting that the last three denials were consistent; and (3) arguing that the first two denials were based upon different versions of the Plan. The court will address each argument in turn.

First, the court is concerned at Defendants argument that the first two reviewers did not conduct a medical necessity review. This argument is unsupported by the evidence. This is manifest by looking at the first two denial letters and the supporting internal documents. The first two denial letters clearly state that the reviewers looked at the medical records:

> Based upon current clinical [sic] member appears to require Mental Health Residential Treatment Center long term level of care.
>
> * * *
>
> Based upon current medical records, the member appears to require Mental Health Residential long term level of care.

(Rec. 442, 1904.). The plain language indicates that the claims administrator reviewed the records and that A.K. appeared to require additional long-term care. Indeed, Defendants have not pointed to any portion of

the Plan or the record that demonstrates there was any meaningful difference in the reviews' underlying the denial letters. The internal document supporting the second denial letter states that A.K. "does meet [the criteria] for continued [mental health Residential Treatment level of care]; but long term residential care as defined below is not a covered service." (Rec 1872.) Therefore, the first and second denial letters stand in direct opposition to the final three letters. These conflicting reasons alone are enough for the court to find that the Defendants' denials were arbitrary.

Second, the final external denial letter's rationale is different from the third and fourth denial letters, contrary to Defendants' assertions. While it is true that all three of the final reviewers found that medical necessity was not met, their reasoning for why it was not met differed. Specifically, the external review focused mainly on the Plan's requirement that treatment be the "most appropriate, safest, and most effective level of care." (Rec. 2606.) The external reviewer's opinion was, in short, that A.K.'s "remainder in a residential setting" was not "the safest and most effective level of care" because her conditions "could have been managed at a therapeutic school with intensive outpatient behavioral supports." (Rec. 2606.) This reasoning is different than the third and fourth reviewers' assertions that A.K.'s care had "become custodial." (Rec. 2004, 2053.) As noted above, A.K.'s care did not meet the Plan's definition of custodial care. This custodial care error is only further illustrated by the external reviewer not making that same misinterpretation.

Third, Defendants did not show that the outdated version of the Plan would require a different type of claims review process. In fact, it appears from the

record that the only difference in the plan was that the exclusion for residential treatment care had been deleted. Thus, Defendants' assertion that it should not be held to account for an interpretation based on an old version of the Plan is not well taken because the Plan was—in all relevant and important ways—the same as the Plan upon which the final three reviews were based.

For the foregoing reasons, the court finds that the Defendants' shifting and inconsistent denial rationale is arbitrary and capricious.

C. Appropriate Relief

"[W]hen a reviewing court concludes that a plan administrator has acted arbitrarily and capriciously in handling a claim for benefits, it can either remand the case to the administrator for a renewed evaluation of the claimant's case, or it can award a retroactive reinstatement of benefits." *DeGrado v. Jefferson Pilot Fin. Ins. Co.*, 451 F.3d 1161, 1175 (10th Cir. 2006) (citations and internal quotation marks omitted). "The remedy when an ERISA administrator fails to make adequate findings or to explain adequately the grounds of her decision is to remand the case to the administrator for further findings or explanation." *Id.* at 1288 (citation omitted). On the other hand, remand is unnecessary only when "the evidence clearly shows that the administrator's actions were arbitrary and capricious, or the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground." *Id.* (citations and quotation marks omitted).

In this instance, the court finds that Defendants' denials were, in part, arbitrary and remand is not required. Although Defendants "fail[ed] to make ade-

quate findings or to explain adequately the grounds of [their] decision"—which would require remand—that is not the basis for the court's decision to decline to remand this case. *Id.* Instead, the court basis its decision on the fact that Defendants' denials were arbitrary and capricious. The denials were arbitrary because Defendants gave inconsistent denial rationales and erroneously interpretated and applied the Plans' terms. These two types of denials fall into the category of denials for which remand is not necessary according to *Caldwell*. Accordingly, the court will not remand these claims to Defendants and instead orders Defendants to pay for A.K.'s treatment at Discovery.

CONCLUSION

For the foregoing reasons the court GRANTS IN PART AND DENIES IN PART Plaintiffs Motion for Summary Judgment. (ECF No. 77.) Plaintiffs' Motion is GRANTED as to their First Cause of Action for ERISA violations. The court DENIES Plaintiffs' Motion on their Second Cause of Action for Parity Act violations. (ECF No. 77.) This means that the court similarly GRANTS IN PART AND DENIES IN PART Defendants' Motion for Summary Judgment. (ECF No. 75.) Defendants' Motion is DENIED as to Plaintiffs' First Cause of Action for ERISA violations and GRANTED as to Plaintiffs' Second Cause of Action for violations of the Parity Act. Since Defendants' denials were arbitrary and capricious, the court will not remand the claims to Defendants and instead orders Defendants to pay for A.K.'s treatment at Discovery.

DATED this 22nd day of June, 2021.

BY THE COURT:
/s/ Dale A. Kimball
DALE A. KIMBALL
United States District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH

[Filed June 22, 2021]

Case No. 2:17-CV-01328-DAK

D.K. and A.K.,
Plaintiffs,
vs.
UNITED BEHAVIORAL HEALTH AND ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR ACTIVE MANAGEMENT EMPLOYEES,
Defendants.

Judge Dale A. Kimball

JUDGMENT

This matter is before the court on the parties' Cross-Motions for Summary Judgment (ECF No. 75, 77.) In the court's Memorandum Decision and Order, dated June 23, 2021, the court awarded Plaintiffs summary judgment on their ERISA claim and denied their claim under the Mental Health Parity and Addiction Equity Act (29 U.S.C. § 1132(a)(3)). Accordingly, Defendants are ordered to pay for A.K.'s treatment at Discovery and Plaintiffs' Mental Health Parity and Addiction Equity Act claim is denied and dismissed with prejudice. This action is closed.

DATED this 22nd day of June, 2021.

BY THE COURT:
/s/ Dale A. Kimball
DALE A. KIMBALL
United States District Judge

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH

[Filed September 7, 2021]

Case No. 2:17-CV-01328-DAK

D.K. and A.K.,

Plaintiffs,

vs.

UNITED BEHAVIORAL HEALTH and
ALCATEL-LUCENT MEDICAL EXPENSE PLAN FOR
ACTIVE MANAGEMENT EMPLOYEES,

Defendants.

Judge Dale A. Kimball

MEMORANDUM DECISION AND
ORDER GRANTING IN PART BENEFIT AWARD,
PREJUDGMENT INTEREST,
ATTORNEY FEES, AND COSTS

This matter is before the court on Plaintiff's Motion for entering Judgment for Benefit Award and awarding Prejudgment Interest, Attorney Fees, and Costs, pursuant to the court's Memorandum Decision and Order in this case (ECF No. 96) and based on 29 U.S.C. §1132(g)(1), F.R.Civ.P. 54(d), DUCivR 54, and DUCivR 7-1. The court does not believe that a hearing will significantly aid in its determination of this motion. The court, therefore, renders the following Memorandum

Decision and Order based on the materials submitted by the parties.

DISCUSSION

In the court's Memorandum Decision and order dated June 22, 2021, the court granted the Plaintiffs' Motion for Summary Judgment as to their first cause of action brought under 29 U.S.C. §1132(a)(1)(B) alleging wrongful denial of ERISA benefits. In light of this decision, Plaintiffs seek the amount of the benefits at issue, an award of prejudgment interest on those benefits, an award of attorney fees under 29 U.S.C. §1132(g)(1), and reimbursement of their allowable costs under 28 U.S.C. §§1920 and 1924 in the amount of $400 as the filing fee for this case.

The award of the benefits at issue in this case, sought by Plaintiffs, is not disputed by Defendants. The agreed upon amount of these benefits has been presented to the court by both Plaintiffs and Defendants as $88,505. In accordance with the court's Memorandum Decision (ECF No. 96), the $88,505 is recoverable by Plaintiffs.

Plaintiffs additionally seek prejudgment interest on the recoverable benefits at issue, as well as attorney fees and costs. Defendants object to both requests. The court addresses these disputes as follows.

A. Prejudgment Interest on Benefits

It is well-established in the 10th Circuit that "[a]n award of prejudgment interest in an ERISA case is . . . within the district court's discretion." *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 816 (10th Cir. 2010). Plaintiffs and Defendants agree on this point. In this case, the court chooses to use its

discretion to grant prejudgment interest to Plaintiffs. The court does so in order to make Plaintiffs whole for the loss of income from monies that Plaintiffs were forced to expend that the Defendants should have paid in the first place.

Plaintiffs argue that the proper percentage per annum for prejudgment interest in ERISA cases is 10% under the Utah law on prejudgment interest rates for written contracts, U.C.A. § 15-1-1(2). Plaintiffs assert that the 10% per annum rate is appropriate compensation, as well as a small measure of equitable disgorgement from the benefit plan to reflect that Defendants wrongfully retained the benefit of funds that Defendants should not have retained. Defendants disagree. Defendants assert that, if prejudgment interest is awarded, the percentage per annum should reflect what Plaintiffs would have made had they kept their funds in the financial markets during the time period at issue. However, Plaintiffs have demonstrated that there is a pattern in Utah district court ERISA cases where benefits were wrongfully denied to award, under U.C.A. § 15-1-1(2), 10% prejudgment interest per annum (ECF No. 100, fn. 9). The court finds this persuasive. The court awards to Plaintiffs prejudgment interest on the wrongfully denied benefits at the rate of 10% per annum, beginning on February 9, 2014 when coverage was first denied.

B. Attorney Fees and Costs

Under ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(a), the court may "in its discretion" allow "a reasonable attorney's fee and costs of action to either party." In *Hardt v. Reliance Standard Life Ins. Co*., 560 U.S. 242, 254 (2010), the Supreme Court clarifies that there are limits to the court's discretion. The statute's language means that a litigant need not be the prevailing party

to reasonably obtain an award of attorney fees, but merely must have achieved "some degree of success on the merits." *Id*. at 252, 255. A reversal of a denied claim is sufficient success to justify an award of fees. *Id*. at 255-256.

In *Hardt*, the Supreme Court also discusses the application of the well-accepted "five-factor" test from *DeBoard v. Sunshine Mining & Refining Co*., 208 F.3d 1228, 1244 (10th Cir. 2000), that has been used to determine whether or not an award of fees in ERISA cases is appropriate. *Hardt* states: "Because these five factors bear no obvious relation to §1132(g)(1)'s text or to our fee-shifting jurisprudence, they are *not required* for channeling a court's discretion when awarding fees under this section. 560 U.S. at 254-255 (emphasis added). Therefore, the court does not need to use the "five-factor" test from *DeBoard* to determine whether attorney fees are appropriate in this case. The court instead relies on *Hardt* to decide that Plaintiffs' success on the merits of the first action, which constituted a reversal of denied benefits, is sufficient to qualify for an award of attorney fees and costs.

The court's decision would not be different if the "five-factor" test were applied in this case. The five factors that *DeBoard* states a court should consider, when deciding whether to exercise its discretion to award fees in ERISA cases, are as follows:

1. the degree of the offending party's culpability or bad faith;
2. the degree of the ability of the offending party to satisfy an award of attorney's fees;
3. whether or not an award of attorney's fees against the offending party would

deter other persons acting under similar circumstances;

4. the amount of the benefit conferred on members of the plan as a whole; and
5. the relative merits of the parties' positions. 208 F.3d 1228, 1244 (10th Cir. 2000).

In this case, the first factor is satisfied by Defendants' culpability from their abuse of discretion in denying D.K's claim. The second factor is satisfied by Defendants' substantial ability to pay – a fact that is acknowledged by both Plaintiffs and Defendants. The third factor is satisfied because the court believes that awarding attorney fees and costs will deter insurers and other benefit plans from violating ERISA and the terms of employee benefit plans under similar circumstances. While the fourth factor is not strong in this case, an award of attorney fees and costs would still have a beneficial effect in this area of law. Therefore, the members of the plan as a whole would be benefited, and the factor is satisfied. Finally, the fifth factor is satisfied because D.K. prevailed in his goal of reversing the denial of his claim by the Defendants.

The court is awarding attorney fees and costs to Plaintiffs. Pursuant to the provisions of 28 U.S.C. §§1920 and 1924, the $400 filing fee is recoverable as costs in this case. The court awards Plaintiffs this $400 filing fee.

To determine the amount of attorney fees to award, the court uses the "hybrid lodestar" method – the method that the Supreme Court has decided is appropriate to determine attorney fees in ERISA cases. *Hensley v. Eckerhart*, 461 U.S. 424, 433 (1983). The hybrid lodestar method requires that the court

multiply the "number of hours reasonably expended on the litigation by a reasonable hourly rate." *Id*. The court then reviews the billing records and excludes any amounts it determines are "excessive, redundant, or otherwise unnecessary." *Id*. at 434. The court now applies the hybrid lodestar method for calculating attorney fees in this case as follows.

1. Reasonable Hourly Rates

The party seeking an award of attorney fees bears the burden of producing "satisfactory evidence . . . that the requested rates are in line with those prevailing in the community for similar services by lawyers of reasonably comparable skill, experience and reputation. *Blum v. Stenson*, 465 U.S. 886, 896, n. 11 (1984). Plaintiffs' requested rate for Brian King is $600 per hour – an amount that Plaintiffs assert is his customary rate for his services in ERISA cases. Plaintiffs' requested rate for Sam Hall, the assisting associate attorney, is $250 per hour. Defendants have no issue with Sam Hall's requested rate, but object to Brian King's requested rate because they believe it is unreasonable and out-of-line with rates for similar services in Salt Lake City. Defendants request that Mr. King's rate be reduced to $450 per hour – a rate that is consistent with prevailing hourly rates for partners in the relevant community of Salt Lake City.

Plaintiffs assert that the court should look to national rates to establish a standard rate for specialties that draw on federal statutes or bodies of law, such as ERISA. Plaintiffs rely heavily on a number of cases from other circuits and district courts across the nation holding that a national rate is appropriate for ERISA cases (ECF No. 100, at 8). Defendants counter that courts in this district have rejected this national rate argument, and therefore the court should use the

prevailing market rate for partners in Salt Lake City instead (ECF No. 106, at 10).

The court agrees with Defendants. This district generally uses a relevant market analysis when determining attorney fees in ERISA cases. See *James C. v. Aetna Health & Life Ins. Co*., No. 2:18-c-v-00717, 2021 U.S. Dist. LEXIS 4216, at *3 (D. Utah Jan. 8, 2021); *Carlile*, 2019 U.S. Dist. LEXIS 228481, at *1; *Foust*, 2019 U.S. Dist. LEXIS 202915, at *4. Earlier this year, a court in this district found that $450 was a reasonable hourly rate for Mr. King. *James C*., 2021 U.S. Dist. LEXIS 4216, at *3. This court agrees.

Given Mr. King's experience and the complexity of ERISA cases, $450 per hour is a reasonable rate for Mr. King.

2. Number of Hours Reasonably Expended on the Litigation

Plaintiffs have submitted time sheets with the number of hours billed for Mr. King and Mr. Hall in the King Declaration and the Hall Declaration (ECF No. 100; Exs. C-D). Defendants have no qualm with Mr. Hall's time sheet, but argue that the hours billed by Mr. King for drafting are excessive because the documents are similar to those he creates in other cases. The court finds this unpersuasive. Upon reviewing the time sheet submitted by Mr. King, the court finds the that his time entries for this case are reasonable. Therefore, Mr. King's 80.4 billed hours and Mr. Hall's 35.1 billed hours are reasonable.

3. Appropriate Lodestar

Based on the analysis above, the court uses the hybrid lodestar method to calculate the following lodestar amount for this matter. Brian King: 80.4

hours at $450 per hour = $36,180. Sam Hall: 35.1 hours at $250 per hour = $8,775. Therefore, the court finds a total lodestar amount for attorney fees of $44,955.

Conclusion

Based on the above reasoning, Plaintiff's Motion is GRANTED IN PART and DENIED IN PART. The court reduces Plaintiffs' requested award for attorney fees and ORDERS Defendants to pay Plaintiffs $88,505 in recoverable benefits, 10% per annum in prejudgment interest, $44,955 in attorney fees, and $400 in costs.

DATED this 7th day of September, 2021.

BY THE COURT:

/s/ Dale A. Kimball
DALE A. KIMBALL
United States District Judge

APPENDIX G

United States Code Annotated
Title 29. Labor
Chapter 18. Employee Retirement Income Security Program (Refs & Annos)
Subchapter I. Protection of Employee Benefit Rights (Refs & Annos)
Subtitle B. Regulatory Provisions
Part 5. Administration and Enforcement

29 U.S.C.A. § 1133

§ 1133. Claims procedure

Currentness

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

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

APPENDIX H

Code of Federal Regulations
Title 29. Labor
Subtitle B. Regulations Relating to Labor
Chapter XXV. Employee Benefits Security Administration, Department of Labor (Refs & Annos)
Subchapter G. Administration and Enforcement Under the Employee Retirement Income Security Act of 1974
Part 2560. Rules and Regulations for Administration and Enforcement (Refs & Annos)

29 C.F.R. § 2560.503–1

§ 2560.503–1 Claims procedure.

Effective: July 27, 2020

Currentness

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims proce-

dures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102–3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(7) In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary

arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination—

(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of

this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of

time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible,

taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii) (A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15–day period, of the circumstances requiring the extension of time and the

date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30–day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45–day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30–day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30–day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in

accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv), or with the standards imposed by 29 CFR 2520.104b–31 (for pension benefit plans). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan—

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(vii) In the case of an adverse benefit determination with respect to disability benefits—

(A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(D) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

(viii) In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (o) of this section).

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations—

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the

claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section, the claims procedures—

(i) Provide that before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this

section to give the claimant a reasonable opportunity to respond prior to that date; and

(ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date.

(i) Timing of notification of benefit determination on review—

(1) In general.

(i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60–day period. In no event shall such extension exceed a period of 60

days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but

not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims.

(A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the

need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims.

(i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1)(i) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed

within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii) (B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the

notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv), or with the standards imposed by 29 CFR 2520.104b–31 (for pension benefit plans). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) 1 The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4)(i) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and,

(ii) In the case of a plan providing disability benefits, in addition to the information described in paragraph (j)(4)(i) of this section, the statement of the claimant's right to bring an action under section 502(a) of the Act shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

(5) In the case of a group health plan—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement

that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(6) In the case of an adverse benefit decision with respect to disability benefits—

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(B) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a

statement that such explanation will be provided free of change upon request; and

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(7) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (o) of this section).

(k) Preemption of State law.

(1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of

the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures.

(1) In general. Except as provided in paragraph (l)(2) of this section, in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) Plans providing disability benefits.

(i) In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, except as provided in paragraph (l)(2)(ii) of this section. Accordingly, the claimant is entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) Notwithstanding paragraph (l)(2)(i) of this section, the administrative remedies available under a plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which

the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means:

(i) Any of the following: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and

(ii) In the case of a plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b–1(b) as appropriate with respect to

material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Standards for culturally and linguistically appropriate notices. A plan is considered to provide relevant notices in a "culturally and linguistically appropriate manner" if the plan meets all the requirements of paragraph (o)(1) of this section with respect to the applicable non–English languages described in paragraph (o)(2) of this section.

(1) Requirements.

(i) The plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non–English language and providing assistance with filing claims and appeals in any applicable non–English language;

(ii) The plan must provide, upon request, a notice in any applicable non–English language; and

(iii) The plan must include in the English versions of all notices, a statement prominently displayed in any applicable non– English language clearly indicating how to access the language services provided by the plan.

(2) Applicable non–English language. With respect to an address in any United States county to which a notice is sent, a non–English language is an applicable non–English language if ten percent or more of the population residing in the county is literate only in the same non–English language, as determined in guidance published by the Secretary.

(p) Applicability dates and temporarily applicable provisions.

(1) Except as provided in paragraphs (p)(2), (p)(3) and (p)(4) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.

(3) Paragraphs (b)(7), (g)(1)(vii) and (viii), (j)(4)(ii), (j)(6) and (7), (l)(2), (m)(4)(ii), and (o) of this section shall apply to claims for disability benefits filed under a plan after April 1, 2018, in addition to the other paragraphs in this rule applicable to such claims.

(4) With respect to claims for disability benefits filed under a plan from January 18, 2017 through April 1, 2018, this paragraph (p)(4) shall apply instead of paragraphs (g)(1)(vii), (g)(1)(viii), (h)(4), (j)(6) and (j)(7).

(i) In the case of a notification of benefit determination and a notification of benefit determination on review by a plan providing disability benefits, the notification shall set forth, in a manner calculated to be understood by the claimant—

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule,

guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(ii) The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3) (i) through (v) of this section.

APPENDIX I

Code of Federal Regulations
Title 29. Labor
Subtitle B. Regulations Relating to Labor
Chapter XXV. Employee Benefits Security Administration, Department of Labor (Refs & Annos)
Subchapter L. Group Health Plans (Refs & Annos)
Part 2590. Rules and Regulations for Group Health Plans (Refs & Annos)
Subpart C. Other Requirements (Refs & Annos)

29 C.F.R. § 2590.715–2719

§ 2590.715–2719 Internal claims and appeals and external review processes.

Effective: October 7, 2021
Currentness

(a) Scope and definitions—

(1) Scope—

(i) In general. This section sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers. Paragraph (b) of this section provides requirements for internal claims and appeals processes. Paragraph (c) of this section sets forth rules governing the applicability of State external review processes. Paragraph (d) of this section sets forth a Federal external review process for plans and issuers not subject to an applicable State external review process. Paragraph (e) of this section prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority

of the Secretary to deem certain external review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of this section.

(ii) Application to grandfathered health plans and health insurance coverage. The provisions of this section generally do not apply to coverage offered by health insurance issuers and group health plans that are grandfathered health plans, as defined under § 2590.715–1251. However, the external review process requirements under paragraphs (c) and (d) of this section, and related notice requirements under paragraph (e) of this section, apply to grandfathered health plans or coverage with respect to adverse benefit determinations involving items and services within the scope of the requirements for out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services under ERISA sections 716 and 717 and §§ 2590.716–4 through 2590.716–5 and 2590.717–1.

(2) Definitions. For purposes of this section, the following definitions apply—

(i) Adverse benefit determination. An adverse benefit determination means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in § 2590.715–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) Appeal (or internal appeal). An appeal or internal appeal means review by a plan or issuer

of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) Claimant. Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

(iv) External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) Final external review decision. A final external review decision means a determination by an independent review organization at the conclusion of an external review.

(vii) Independent review organization (or IRO). An independent review organization (or IRO) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) NAIC Uniform Model Act. The NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) Internal claims and appeals process—

(1) In general. A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) Requirements for group health plans and group health insurance issuers. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) Minimum internal claims and appeals standards. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in

29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) Additional standards. In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) Clarification of meaning of adverse benefit determination. For purposes of this paragraph (b)(2), an "adverse benefit determination" includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of § 2590.715–2712.)

(B) Expedited notification of benefit determinations involving urgent care. The requirements of 29 CFR 2560.503–1(f)(2)(i) (which generally provide, among other things, in the case of urgent care claims for notification of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503–1(m)(1), as determined by the

attending provider, and the plan or issuer shall defer to such determination of the attending provider.

(C) Full and fair review. A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503–1(h)(2)—

(1) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(2) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date. Notwithstanding the rules of 29 CFR 2560.503–1(i), if the new or additional evidence is received so late that

it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan administrator shall notify the claimant of the plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(D) Avoiding conflicts of interest. In addition to the requirements of 29 CFR 2560.503–1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(E) Notice. A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503–1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(1) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

(3) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(4) The plan and issuer must provide a description of available internal appeals and

external review processes, including information regarding how to initiate an appeal.

(5) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) Deemed exhaustion of internal claims and appeals processes.

(1) In the case of a plan or issuer that fails to strictly adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), except as provided in paragraph (b)(2)(ii)(F)(2) of this section. Accordingly the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(2) Notwithstanding paragraph (b)(2)(ii)(F)(1) of this section, the internal claims and

appeals process of this paragraph (b) will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this paragraph (b) to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under paragraph (b)(2)(ii)(F)(1) of this section on the basis that the plan met the standards for the exception under this paragraph (b)(2)(ii)(F)(2), the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

(iii) Requirement to provide continued coverage pending the outcome of an appeal. A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503–1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(c) State standards for external review—

(1) In general.

(i) If a State external review process that applies to and is binding on a health insurance issuer offering group health insurance coverage includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the group health plan is not required to comply with either this paragraph (c) or the Federal external review process of paragraph (d) of this section.

(ii) To the extent that a group health plan provides benefits other than through health insurance coverage (that is, the plan is self-insured) and is subject to a State external review process that applies to and is binding on the plan (for example, is not preempted by ERISA) and the State external review process includes at a

minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section. Where a self-insured plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process for plans that are not subject to the applicable State laws, the plan may choose to comply with either the applicable State external review process or the Federal external review process of paragraph (d) of this section.

(iii) If a plan or issuer is not required under paragraph (c)(1)(i) or (c)(1)(ii) of this section to comply with the requirements of this paragraph (c), then the plan or issuer must comply with the Federal external review process of paragraph (d) of this section, except to the extent, in the case of a plan, the plan is not required under paragraph (c)(1)(i) of this section to comply with paragraph (d) of this section.

(2) Minimum standards for State external review processes. An applicable State external review process must meet all the minimum consumer protections in this paragraph (c)(2). The Department of Health and Human Services will determine whether State external review processes meet these requirements.

(i) The State process must provide for the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting,

level of care, or effectiveness of a covered benefit, as well as a consideration of whether a plan or issuer is complying with the surprise billing and cost-sharing protections under ERISA sections 716 and 717 and §§ 2590.716–4 through 2590.716–5 and 2590.717–1.

(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement; the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section), or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, a State external review process that expressly authorizes, as of November 18, 2015, a nominal filing fee may continue to permit such fees. For this purpose, to be considered nominal, a filing fee must not exceed $25; it must be refunded to the claimant if the adverse benefit determination (or final internal

adverse benefit determination) is reversed through external review; it must be waived if payment of the fee would impose an undue financial hardship; and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a $500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a

health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review, and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant except to the extent the other remedies are available under State or Federal law,

and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the issuer (or, if applicable, the plan) and the claimant of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO,

the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) Transition period for external review processes.

(i) Through December 31, 2017, an applicable State external review process applicable to a health insurance issuer or group health plan is considered to meet the requirements of PHS Act section 2719(b). Accordingly, through December

31, 2017, an applicable State external review process will be considered binding on the issuer or plan (in lieu of the requirements of the Federal external review process). If there is no applicable State external review process, the issuer or plan is required to comply with the requirements of the Federal external review process in paragraph (d) of this section.

(ii) An applicable State external review process must apply for final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2018. The Federal external review process will apply to such internal adverse benefit determinations unless the Department of Health and Human Services determines that a State law meets all the minimum standards of paragraph (c)(2) of this section. Through December 31, 2017, a State external review process applicable to a health insurance issuer or group health plan may be considered to meet the minimum standards of paragraph (c)(2) of this section, if it meets the temporary standards established by the Secretary in guidance for a process similar to the NAIC Uniform Model Act.

(d) Federal external review process. A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group

health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage. A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d). In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied when a Multi State Plan or MSP complies with standards established by the Office of Personnel Management.

(1) Scope—

(i) In general. The Federal external review process established pursuant to this paragraph (d) applies to the following:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is experimental or investigational; its determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of ERISA section 712 and § 2590.712, which generally require, among other things, parity in the application of medical management techniques), as determined by the

external reviewer. (A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan or health insurance coverage is not eligible for the Federal external review process under this paragraph (d));

(B) An adverse benefit determination that involves consideration of whether a plan or issuer is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717 and §§ 2590.716–4 through 2590.716–5 and 2590.717–1; and

(C) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(ii) Examples. The rules of paragraph (d)(1)(i) of this section are illustrated by the following examples:

Example 1. (i) Facts. A group health plan provides coverage for 30 physical therapy visits generally. After the 30th visit, coverage is provided only if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Individual A seeks coverage for a 31st physical therapy visit. A's health care provider submits a treatment plan for approval, but it is not approved by the plan, so coverage for the 31st visit is not preauthorized. With respect to the 31st visit, A receives a notice of final internal adverse benefit determination stating that the maximum visit limit is exceeded.

(ii) Conclusion. In this Example 1, the plan's denial of benefits is based on medical necessity and involves

medical judgment. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(3) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

Example 2. (i) Facts. A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual B seeks coverage for a specialized medical procedure from an out-of-network provider because B believes that the procedure cannot be effectively provided in network. B receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(ii) Conclusion. In this Example 2, the plan's denial of benefits is based on whether a service can effectively be provided in network and, therefore, involves medical judgment. Accordingly, the claim is eligible for external review under paragraph (d) (1)(i) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(3) of this section because the plan does provide benefits for services on an out-of-network basis if the services cannot

effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

Example 3. (i) Facts. A group health plan generally provides benefits for services in an emergency department of a hospital or independent freestanding emergency department. Individual C receives pre-stabilization emergency treatment in an out-of-network emergency department of a hospital. The group health plan determines that protections for emergency services under § 2590.716–4 do not apply because the treatment did not involve "emergency services" within the meaning of § 2590.716– 4(c)(2)(i). C receives an adverse benefit determination and the plan imposes cost-sharing requirements that are greater than the requirements that would apply if the same services were provided in an in-network emergency department.

(ii) Conclusion. In this Example 3, the plan's determination that treatment received by C did not include emergency services involves medical judgment and consideration of whether the plan complied with § 2590.716–4. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

Example 4. (i) Facts. A group health plan generally provides benefits for anesthesiology services. Individual D undergoes a surgery at an in-network health care facility and during the course of the surgery, receives anesthesiology services from an out-of-network provider.

The plan decides the claim for these services without regard to the protections related to items and services furnished by out-of-network providers at in-network facilities under § 2590.716–5. As a result, D receives an adverse benefit determination for the services and is subject to cost-sharing liability that is greater than it would be if cost sharing had been calculated in a manner consistent with the requirements of § 2590.716–5.

(ii) Conclusion. In this Example 4, whether the plan was required to decide the claim in a manner consistent with the requirements of § 2590.716–5 involves considering whether the plan complied with § 2590.716–5, as well as medical judgment, because it requires consideration of the health care setting and level of care. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

Example 5. (i) Facts. A group health plan generally provides benefits for services in an emergency department of a hospital or independent freestanding emergency department. Individual E receives emergency services in an out-of-network emergency department of a hospital, including certain post-stabilization services. The plan processes the claim for the post-stabilization services as not being for emergency services under § 2590.716–4(c)(2)(ii) based on representations made by the treating provider that E was in a condition to receive notice from the provider about cost-sharing and surprise billing protections for these services and subsequently gave informed consent to waive those protections. E receives an adverse benefit determination and is subject to cost-sharing requirements that are greater than the cost-sharing requirements that

would apply if the services were processed in a manner consistent with § 2590.716–4.

(ii) Conclusion. In this Example 5, whether E was in a condition to receive notice about the availability of cost-sharing and surprise billing protections and give informed consent to waive those protections involves medical judgment and consideration of whether the plan complied with the requirements under § 2590.716–4(c)(2)(ii). Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

Example 6. (i) Facts. Individual F gives birth to a baby at an in-network hospital. The baby is born prematurely and receives certain neonatology services from a nonparticipating provider during the same visit as the birth. F was given notice about cost-sharing and surprise billing protections for these services, and subsequently gave informed consent to waive those protections. The claim for the neonatology services is coded as a claim for routine post-natal services and the plan decides the claim without regard to the requirements under § 2590.716–5(a) and the fact that those protections may not be waived for neonatology services under § 2590.716–5(b).

Example 7. (i) Facts. A group health plan generally provides benefits to cover knee replacement surgery. Individual G receives a knee replacement surgery at an in-network facility and, after receiving proper notice about the availability of cost-sharing and surprise billing protections, provides informed consent to waive those protections. However, during the surgery, certain anesthesiology services are provided by an out-of-network nurse anesthetist. The claim for these anesthesiology services is decided by the plan without regard to the requirements under § 2590.716–

5(a) or to the fact that those protections may not be waived for ancillary services such as anesthesiology services provided by an out-of-network provider at an in-network facility under § 2590.716–5(b). G receives an adverse benefit determination and is subject to cost-sharing requirements that are greater than the cost-sharing requirements that would apply if the services were provided in a manner consistent with § 2590.716– 5(a) and (b).

(ii) Conclusion. In this Example 7, consideration of whether the plan complied with the requirements in § 2590.716–5(a) and (b) is necessary to determine whether cost-sharing requirements were applied appropriately. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

(2) External review process standards. The Federal external review process established pursuant to this paragraph (d) is considered similar to the process set forth in the NAIC Uniform Model Act and, therefore satisfies the requirements of paragraph (d)(2)) if such process provides the following.

(i) Request for external review. A group health plan or health insurance issuer must allow a claimant to file a request for an external review with the plan or issuer if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by

March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(ii) Preliminary review—

(A) In general. Within five business days following the date of receipt of the external review request, the group health plan or health insurance issuer must complete a preliminary review of the request to determine whether:

(1) The claimant is or was covered under the plan or coverage at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan or coverage at the time the health care item or service was provided;

(2) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan or health insurance coverage (e.g., worker classification or similar determination);

(3) The claimant has exhausted the plan's or issuer's internal appeal process unless the claimant is not required to exhaust the internal appeals process under paragraph (b)(1) of this section; and

(4) The claimant has provided all the information and forms required to process an external review.

(B) Within one business day after completion of the preliminary review, the plan or issuer must

issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(iii) Referral to Independent Review Organization—

(A) In general. The group health plan or health insurance issuer must assign an IRO that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO referral process must provide for the following:

(1) The plan or issuer must ensure that the IRO process is not biased and ensures independence;

(2) The plan or issuer must contract with at least three (3) IROs for assignments under the plan or coverage and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection); and

(3) The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(4) The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

(B) IRO contracts. A group health plan or health insurance issuer must include the following standards in the contract between the plan or issuer and the IRO:

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan or coverage.

(2) The assigned IRO will timely notify a claimant in writing whether the request is eligible for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days following the date of receipt of the notice, additional information. This additional information must be considered by the IRO when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(3) Within five business days after the date of assignment of the IRO, the plan or issuer must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan or issuer to timely provide the documents and information must not delay the conduct of the external review. If the plan or issuer fails to timely provide the documents and information, the assigned IRO may terminate the external review and make

a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

(4) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan or issuer. Upon receipt of any such information, the plan or issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan or issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan or issuer.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process applicable under paragraph (b). In addition to the documents and information

provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(iv) The terms of the claimant's plan or coverage to ensure that the IRO's decision is not contrary to the terms of the plan or coverage, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the plan or issuer, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and

(vii) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and

the clinical reviewer or reviewers consider such information or documents appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and the plan or issuer.

(7) The assigned IRO's written notice of the final external review decision must contain the following:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the plan's or issuer's denial);

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-

based standards that were relied on in making its decision;

(v) A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or health insurance issuer or to the claimant, or to the extent the health plan or health insurance issuer voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, issuer, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(iv) Reversal of plan's or issuer's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, the

plan or issuer immediately must provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

(3) Expedited external review. A group health plan or health insurance issuer must comply with the following standards with respect to an expedited external review:

(i) Request for external review. A group health plan or health insurance issuer must allow a claimant to make a request for an expedited external review with the plan or issuer at the time the claimant receives:

(A) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under paragraph (b) of this section would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(B) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility.

(ii) Preliminary review. Immediately upon receipt of the request for expedited external review, the plan or issuer must determine whether the request meets the reviewability requirements set forth in paragraph (d) (2)(ii) of this section for standard external review. The plan or issuer must immediately send a notice that meets the requirements set forth in paragraph (d)(2)(ii)(B) for standard review to the claimant of its eligibility determination.

(iii) Referral to independent review organization.

(A) Upon a determination that a request is eligible for expedited external review following the preliminary review, the plan or issuer will assign an IRO pursuant to the requirements set forth in paragraph (d)(2)(iii) of this section for standard review. The plan or issuer must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

(B) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process.

(iv) Notice of final external review decision. The plan's or issuer's contract with the assigned IRO

must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph (d)(2)(iii)(B) of this section, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan or issuer.

(4) Alternative, Federally-administered external review process. Insured coverage not subject to an applicable State external review process under paragraph (c) of this section may elect to use either the Federal external review process, as set forth under paragraph (d) of this section or the Federally-administered external review process, as set forth by HHS in guidance. In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied.

(e) Form and manner of notice—

(1) In general. For purposes of this section, a group health plan and a health insurance issuer offering group health insurance coverage are considered to provide relevant notices in a culturally and linguistically appropriate manner if the plan or issuer meets all the requirements of paragraph (e)(2) of this section with respect to the applicable non–English languages described in paragraph (e)(3) of this section.

(2) Requirements.

(i) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non–English language and providing assistance with filing claims and appeals (including external review) in any applicable non–English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non–English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non–English language clearly indicating how to access the language services provided by the plan or issuer.

(3) Applicable non–English language. With respect to an address in any United States county to which a notice is sent, a non–English language is an applicable non–English language if ten percent or more of the population residing in the county is literate only in the same non–English language, as determined in guidance published by the Secretary.

(f) Secretarial authority. The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under paragraph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) Applicability date. The provisions of this section generally are applicable to group health plans and

health insurance issuers for plan years beginning on or after January 1, 2017. The external review scope provision at paragraph (d)(1)(i)(B) of this section is applicable for plan years beginning on or after January 1, 2022. The external review provisions described in paragraphs (c) and (d) of this section are applicable to grandfathered health plans, with respect to the types of claims specified under paragraph (a)(1)(ii) of this section, for plan years beginning on or after January 1, 2022.