Legal Alert

A Cautionary Tale: Self-Funded Plan Administrators Must Meaningfully and Effectively Communicate With Plan Participants and Their Providers on Appeal

Sponsors of self-funded ERISA plans have fiduciary obligations to plan participants, which include the obligation to provide a full and fair review of claims, and effectively and meaningfully communicate or engage with plan participants regarding claim denials. One district court recently clarified that this obligation may include the need for the plan administrator, which is usually the plan sponsor, to engage in a dialogue with healthcare providers who are providing healthcare services to plan participants when there is a dispute over denied claims.

In *K.D. v. Anthem Blue Cross and Blue Shield, Group Health Plan of United Technologies Corporation*, the plaintiff sued the plan administrator and Blue Cross and Blue Shield, the group health plan's third-party administrator (TPA), in the United States District Court for the District of Utah due to the plan's denial of continued inpatient mental health treatment and transitional care for alleged lack of medical necessity. Plaintiff further alleged a violation of the Mental Health Parity and Addiction Act of 2008 (MHPAEA). This alert will focus on the ERISA claims review and appeals process and not the MHPAEA claims in the lawsuit.

As described in the district court opinion, the terms of the plan sponsor's medical plan generally required a medical necessity determination for continued inpatient/residential mental health treatment for plan participants, and provided that medically necessary services are those that are necessary for the participant and that are "rendered in the least intensive setting that is appropriate for the delivery of health care." Once residential treatment is determined to be medically necessary, then there is a predetermined length of stay, and such benefits are then subject to concurrent review which may result in approval for additional care above and beyond those originally approved by the plan.

The District Court Magistrate reviewed the TPA's own internal clinical guidelines and policies and procedures, which provide that mental health residential treatment is appropriate when the patient's behavioral health condition is such that the patient demonstrates they are a danger to themselves or others, or it "causes a serious dysfunction in daily living." If such conditions are present, then the guidelines provide that continued residential care should be approved if the condition is likely to deteriorate without continued treatment at the same level of care or if continued care at the current level is necessary. The clinical guidelines also provide that treatment should be available when "necessary, appropriate, and not feasible at a lower level of care." If a claim is denied, there are two levels of appeal that the plan participant must undergo before filing a lawsuit.

As set forth in the district court's opinion, the plan participant had a history of mental illness, and the TPA initially determined that residential treatment was medically necessary. The participant underwent residential treatment in a program that could last from nine to 12 months, though not all of it was intended to be residential, as the participant would step down from residential into transitional living. Ultimately, the participant's discharge from treatment was contingent upon, and determined by, their progress on goals, participation and clinical recommendations. The participant was initially approved for seven days of residential treatment and then an additional nine days. At that time, the TPA requested additional information from the provider via a peer-to-peer discussion, which the provider did not attend. Thus, the TPA independently reviewed the medical information and denied the claim for additional residential treatment based on a lack of medical necessity. Transitional living treatment claims were also denied for failing to obtain precertification.

After appealing the determinations, the participant sued for violation of ERISA and the MHPAEA. In asserting their claim for ERISA violations, the plaintiff alleged that the plan's denial of their claims was arbitrary. The defendants alleged that while they were obligated to consider the letters and other records submitted as part of the claims appeal process, there was no obligation to "affirmatively respond" to them. The District Court magistrate disagreed and applied other, contrary caselaw that requires a plan administrator to "engage with and address" the opinions of the treating providers. As such, the District Court found that the TPA or plan administrator should have provided an explanation for rejecting healthcare provider opinions. As an example, the court suggested the claims administrator (the TPA) should have addressed why they did not find the treating providers' opinions to be persuasive and provided factual support. The court reasoned that the plan and TPA had a fiduciary duty to plan beneficiaries to communicate the bases for their decisions, which includes addressing the provider opinions and communicate "effectively and meaningfully" with participants regarding the factual bases for denying coverage.

Ultimately the case was remanded back to the plan administrator for a new determination and the plaintiffs could seek recovery of their attorneys' fees.

This case serves as a cautionary tale for plan sponsors to ensure they, or their claims administrators, are actively engaging with plan participants and/or their providers and meaningfully responding to their concerns when claims are denied. While it is unclear whether the participant will ultimately be entitled to the benefits sought under the plan, addressing why the claims administrator denied the claims and providing factual support for their rationale could have saved the claims administrator and/or plan administrator costs and legal fees.