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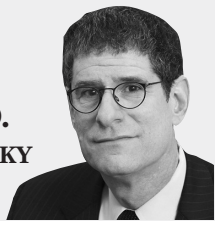
Appearance of reasonableness is not enough

WORKPLACE ISSUES



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It has become common in the U.S. health-care system for insurance companies to require pre-approval of hospitalization requests. Such determinations are intended to contain costs and avoid the tremendous expenses of in-patient hospital care when less intensive care would suffice.

However, in some circumstances, an insurer's refusal to approve hospitalization expenses could potentially mean the difference between life and death — if the patient lacks the financial means to pay out of pocket for a hospitalization recommended by the treating doctor, yet refused by the health insurer. Such situations often arise in the context of treatment of severe eating disorders where insurers may be reluctant to approve hospital admissions.

One such case is the recently issued decision from the 9th U.S. Circuit Court of Appeals in *Pacific Shores Hospital v. United Behavioral Health,* 2014 WL 4086784 (9th Cir., Aug. 20). This decision, rendered under the ERISA law, overturned the refusal of United Behavioral Health to certify inpatient hospitalization for a patient suffering from a severe eating disorder who was deemed at high risk of suicide.

The insurer denied reimbursement and upheld its decision following the patient's appeal. The hospital admitted her anyway and brought this claim for reimbursement of treatment after receiving an assignment from the patient.

After reviewing the chronology and the evidence, the court was extremely critical of the plan's reliance on its file-review consulting doctors who did not even examine the underlying medical records and thus made critical errors in their analysis.

Although the benefit plan language triggered a deferential standard of judicial review, the key part of the ruling was the 9th Circuit's discussion of the scope of such a review. The 9th Circuit had previously ruled in *Horan v. Kaiser Steel Retirement Plan,* 947 F.2d 1412, 1417 (9th Cir. 1991), that it would uphold a decision that was grounded in "any reasonable basis." Following the Supreme Court's ruling in *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105 (2008), the court found that test was no longer appropriate. The court explained that following Glenn, "we have recognized that this unrealistic reading of the any-reasonable-basis test is not good law when ... an administrator operates under a structural conflict of interest." *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 674 (9th Cir. 2011).

Here, though, the 9th Circuit went even further and renounced the "any reasonable basis" standard even without a conflict. Hence, the court held, "In all abuse-of-discretion review, whether or not an administrator's conflict of interest is a factor, a reviewing court should consider 'all the circumstances before it' ... in assessing a denial of benefits under an ERISA plan."

Applying that standard to the facts presented, the court added that consideration had to be given to a plan administrator's fiduciary responsibility:

"[A plan administrator's] fiduciary responsibility under ERISA is simply stated. The statute provides that fiduciaries shall discharge their duties with respect to a plan 'solely in the interest of the participants and beneficiaries,' [29 U.S.C.] Section 1104(a)(1), that is, 'for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan,' Section 1104(a)(1)(A).

"*Pegram v. Herdrich*, 530 U.S. 211, 223–24 (2000). Fiduciaries must discharge their duties 'with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.'" Id. at 224 n.6 (quoting 29 U.S.C. Section 1104(a)(1)(B)).

The court determined that "UBH fell far short of fulfilling its fiduciary duty." The claims personnel and medical consultants who advised them were found to have "made a number of critical factual errors," which were compounded into what the court characterized as "a striking lack of care." The court also was persuaded by the fact that "the errors are not randomly distributed. All of the errors support denial of payment; none supports payment." Thus, the court concluded, "The unhappy fact is that UBH acted as a fiduciary in name only, abusing the discretion with which it had been entrusted."

The *Glenn* ruling imposed a fiduciary obligation on ERISA plan administrators to apply "higher-than-marketplace quality standards." That ruling further imposed on courts adjudicating ERISA cases the same standard imposed on courts in adjudicating administrative agency decisions — a responsibility to assure the "reasonableness and fairness" of decisions regardless of the deference owed to the agency (citing *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 490, 71 S.Ct. 456, 95 L.Ed. 456 (1951)).

Until this ruling, though, no lower court had so firmly tied deficient claim assessment into a breach of fiduciary duty as the Supreme Court has required. Fortunately for the claimant in this case, she was hospitalized anyway and survived. But someone else less fortunate would likely have died after receiving a comparably irresponsible and grossly deficient assessment of the need for hospitalization. The 9th Circuit has finally put some strength into the Supreme Court's admonition about how courts are to view ERISA claim decisions — and the world should take notice.

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