The ERISA Edit: Tenth Circuit Issues Two ERISA Decisions

Employee Benefits Alert
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Tenth Circuit Declines to Consider New Standard of Review for Benefit Claims

On December 5, 2023, the U.S. Court of Appeals for the Tenth Circuit issued its decision in *Ian C. v. United Healthcare Ins. Co* ., No. 22-4082, --- F.4th ----, 2023 U.S. App. LEXIS 32051 (Dec. 5, 2023), overturning a district court's grant of summary judgment in favor of UnitedHealthcare Insurance Company (United). Whereas the district court had upheld United's denial of benefits to a minor for inpatient substance abuse treatment, the Tenth Circuit found that United acted arbitrarily and capriciously by failing to address an independent ground for coverage in its denial-of-coverage letters to the plan participant and therefore did not provide a "full and fair" review of the claim as required by ERISA § 503(2). In reaching its decision, the court applied a deferential arbitrary-and-capricious standard because the plaintiffs, who urged the court to adopt a *de novo* review standard, provided no reason "to stir the pot." In short, the court determined that United could not surmount arbitrary-and-capricious review, making it "fruitless" for the court to even consider proceeding *de novo*.

Plaintiff Ian C.'s minor son, A.C., was admitted to an inpatient wilderness program after habitual drug and alcohol abuse culminated in an overdose. A psychologist at the wilderness program diagnosed A.C. with mild-to-severe substance abuse disorders in addition to anxiety and depression and recommended that A.C. seek treatment at an inpatient residential facility with access to substance abuse treatment. Upon admission to the residential facility, A.C.'s treatment plan listed five diagnoses, which included anxiety and depressive disorders, parent-client relational problems, and cannabis and alcohol use disorders. United initially approved four days of coverage and subsequently approved coverage in short increments of either three or four days each. At the end of the fourth such increment, Ian C. requested approval for 30 days of coverage, which United declined.

When reviewing Ian C.'s request, United applied its level-of-care guidelines for Mental Health Residential Treatment Centers (Mental Health Guidelines) and concluded that the recommended treatment for A.C.'s general anxiety disorder was not "consistent with generally accepted standards of medical practice." A first-level reviewer upheld United's determination because A.C. had made progress with respect to his generalized anxiety disorder and was not experiencing acute withdrawal or post-withdrawal symptoms with respect to his substance abuse disorders. Ian C. appealed, arguing that the reviewer should have applied the level-of-care guidelines for Substance-Related Disorders (Substance Abuse Guidelines), not the Mental Health Guidelines, and provided additional documentation concerning A.C.'s substance abuse treatment and risk for relapse. Relying solely on the Mental Health Guidelines, the second-level reviewer also upheld United's denial, stating that A.C. was not a danger to himself or others and had a stable mood. That decision did not mention any of A.C.'s substance-abuse-related diagnoses.

On appeal, the parties disputed which standard of review should apply. United, supported by the U.S. Chamber of Commerce as *amicus curiae*, urged the Tenth Circuit to follow *Firestone Tire and Rubber Co. v. Bruch* , 489 U.S. 101, 115 (1989), and *Gilbertson v. Allied Signal, Inc*., 328 F.3d 625, 635 (10th Cir. 2003), and apply an arbitrary-and-capricious standard of review because (1) the plaintiffs' benefits plan gave the plan administrator discretionary authority to determine eligibility for benefits and to interpret plan terms and (2) United allegedly committed no procedural errors constituting a failure to substantially comply with required claim procedures. In *Gilbertson*, the Tenth Circuit stated that in the context of an ongoing, good faith exchange of information between a plan administrator and a claimant, inconsequential violations of the deadlines or other procedural irregularities would not entitle a claimant to a less deferential *de novo* review. The plaintiffs argued that a *de novo* standard was appropriate because, they claimed, United failed to substantially comply with ERISA's procedural requirements by not reviewing A.C.'s substance abuse as an independent ground for coverage, thereby depriving him of a "full and fair review," as required by the U.S. Department of Labor's (DOL) claims regulations. The plaintiffs further urged the Tenth Circuit to adopt a *de novo* standard "for all cases in which administrators fail to 'strictly adhere[]' to ERISA regulations" to address United's failure to comply with DOL's claims regulations, arguing that 2002 and 2011 amendments to those regulations require as much.

The Tenth Circuit, disagreed, concluding that the plaintiffs' argument

> assumes the [DOL's] ERISA regulations can, or should, dictate our judicial standards of review. That is a flawed premise. Congress delegated authority to the Secretary of Labor to enact procedural regulations to enforce ERISA's policies, but that authorizing legislation never mentioned judicial standards of review. . . . Congress intentionally left ERISA's standard of review open to the judiciary's interpretation, which the Supreme Court duly applied in *Firestone*.

Although the court held that the "default arbitrary-and-capricious review standard should remain" in cases raising substantial compliance issues, the court noted that it would withhold such deference when "administrators fail to show a 'valid exercise' of their discretion." This aspect of the court's decision provides some insight on the division between the circuit courts concerning the appropriate standard of review and highlights the Tenth Circuit's perspective as compared with the Second Circuit's "strict adherence" standard set forth in *Halo v. Yale Health Plan* , 819 F.3d 42, 58 (2d Cir. 2016), where that court allowed *de novo* review unless the plan establishes that non-compliance was "inadvertent *and* harmless."

Here, even under the deferential standard, United failed to consider an independent ground for coverage, and the Tenth Circuit found that "United was not justified in shutting its eyes to the possibility that A.C. was entitled to benefits based on his substance abuse," especially when the record was "replete with evidence" of A.C.'s substance abuse. The "complete erasure of A.C.'s substance abuse, after Ian C. specifically raised it as an independent ground for coverage in his appeal, was arbitrary and capricious." According to the Tenth Circuit, "[i]f an administrator's decision ignores an independent ground for coverage and there is scant evidence to refute the claimant's theory, then the decision fails arbitrary-and-capricious review." The court reversed the summary judgment in favor of United and remanded the case back to the district court for further consideration consistent with its opinion.

Tenth Circuit Denies Re-Hearing in Oklahoma PBM Preemption Appeal

On December 12, 2023, the Tenth Circuit denied the Oklahoma insurance commissioner's request for *en banc* rehearing of the court's August 2023 decision, which found that parts of the state's Patient's Right to Pharmacy Choice Act regulating pharmacy benefit managers and their networks are preempted under ERISA. Oklahoma still has the option of seeking further review of that decision by filing a petition for a writ of *certiorari* with the Supreme Court.

Supreme Court Grants Review of Restrictions on Access to Mifepristone

As we reported earlier this year, the Supreme Court granted motions filed by the U.S. Food and Drug Administration (FDA) and Danco Laboratories, LLC to pause an April 7, 2023, order entered by the U.S. District Court for the Northern District of Texas enjoining the FDA's 2000 approval of the abortion medication mifepristone. The Supreme Court's order stayed the lower court's decision, which would have effectively banned mifepristone, "pending disposition of [an] appeal in the U.S. Court of Appeals for the Fifth Circuit and disposition of a petition for a writ of *certiorari*, if such a writ is timely sought." The Fifth Circuit's decision, issued on August 16, 2023, would keep mifepristone on the market, but it would block actions taken by the FDA in 2016 to expand access to the drug. On December 13, 2023, the Supreme Court granted *certiorari* in the case and will now have the final say, for now at least, on the availability of and access to the medication.

Two DOL Rules Expected Soon

The Office of Management and Budget (OMB) has completed its review of two DOL rules, signaling that the agency may be poised to release them in the coming weeks. One involves a notice of proposed rulemaking on association health plans. DOL

previously stated that this rulemaking will explore whether to withdraw, or withdraw and replace, its regulation at 29 CFR 2510.3-5, which was published as a final rule in 2018 and established an alternative set of criteria for determining when an employer association may act indirectly in the interest of an employer under ERISA § 3(5) (defining "employer") for purposes of establishing a multiple employer group health plan. The U.S. District Court for the District of Columbia vacated portions of the final rule in 2019 in *New York v. United States Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019). The new rulemaking is expected to set forth new criteria for a group or association of employers to be able to sponsor a multiple employer group health plan.

The second is a final rule that would amend the procedures governing requests for prohibited transaction exemptions from DOL. DOL has represented that the proposed rule, published in March 2022, seeks to:

- Clarify the types of information and documentation required for a complete application
- Revise the definitions of a qualified independent fiduciary and qualified independent appraiser in order to ensure their independence
- Clarify the content of specific reports and documents applicants must submit in order to ensure that DOL receives sufficient information to make the requisite findings under ERISA § 408(a) to issue an exemption
- Update various timing requirements to ensure clarity in the application review process
- Clarify items that are included in the administrative record for an application and when the administrative record is available for public inspection
- Expand opportunities for applicants to submit information to DOL electronically

DOL conducted hearings on its proposal in 2022 and extended the comment period for this rule several times. The regulated community voiced numerous objections to the proposed exemption procedure changes, arguing that the proposal imposes significant new requirements and will make it much harder for parties to obtain exemptions.
