The ERISA Edit: "Meaningful Dialogue" Standard Gains Traction

Employee Benefits Alert
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Fifth Circuit Adopts "Meaningful Dialogue" Requirement for Benefits Claim Review

In an opinion issued on September 19, 2024, the U.S. Court of Appeals for the Fifth Circuit found that United Healthcare Insurance Company (United) breached its obligations under ERISA by denying benefits for an adolescent's eating disorder treatment and failing to engage in a "meaningful dialogue" as part of the claim review process. *Dwyer v. United Healthcare Ins. Co.* , No. 23-50439 (5th Cir. Sept. 19, 2024). Reversing the decision of the district court following a bench trial, the Fifth Circuit joined the Tenth Circuit in adopting a "meaningful dialogue" standard for claims review and a heightened information burden for claim denial letters.

The plaintiff sought coverage of benefits for his daughter, E.D., for eating disorder treatment under an employee group health plan issued by United. In June 2015, after covering several months of full hospitalization benefits, United reduced coverage to partial hospitalization. A month later, United stepped down coverage to outpatient-only treatment despite the objections of the plaintiff and E.D.'s doctors. The plaintiff appealed unsuccessfully and ended up paying for the hospital care out of pocket. According to the decision, United also stopped treating the care provider as part of its "MultiPlan benefit" offering that allowed plan participants to take advantage of predetermined rates that the insurance company had negotiated with out-of-network providers, and the plaintiff appealed that decision as well. The opinion states that United acknowledged receiving the plaintiff's appeal on the MultiPlan issue but never responded to it.

The plaintiff sued United under ERISA for terminating coverage of his daughter's partial hospitalization benefits and failing to process all her claims at the MultiPlan rates. The district court conducted a 90-minute bench trial in 2019 and, close to four years later, found in United's favor on both claims. The Fifth Circuit reversed and remanded for calculation of damages.

According to the Fifth Circuit, review under ERISA requires the court to consider both substance (whether the terms of the plan entitled the participant to the claimed benefits) and procedure (whether the fiduciary offered the "full and fair review" mandated by ERISA § 503(2)). The court began its *de novo* substantive review by emphasizing that "[a]n ERISA plan must explain its decisions to deny benefits, and its denial must be based on concrete evidence." The opinion analyzes each sentence of United's benefits termination letter to explain why the company's assertions are not only "not supported by the underlying medical evidence," but "[i]n fact, they are *contradicted* by the record." The court concluded that substantively, under the terms of the plan, there was not enough evidence to support denial of the claim.

Turning to the procedural analysis, the court said that ERISA § 503(2) and the ERISA claims regulation require plan administrators to base their claims review on a "meaningful dialogue" with the beneficiary. The court quoted *Ian C. v. United Healthcare Ins. Co.* , 87 F.4th 1207, 1223 (10th Cir. 2023) as describing this "meaningful dialogue" as "an ongoing, good faith exchange of information to ensure that the terms of the plan are applied accurately and the benefits are dispensed fairly." It also stated that the claims regulation further compels such a dialogue when providing for "[t]he specific reason or reasons for the adverse determination," "the specific plan provisions on which the determination is based," and, where health benefits are denied based on a lack of "medical necessity," "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."

The court found that United had failed to engage in any dialogue with the plaintiff. It faulted United's benefits termination letter for not addressing applicable plan provisions or how the beneficiary's medical needs were evaluated under the terms of the plan. The Fifth Circuit's cited to four other cases rejecting the adequacy of "similar denial letters." *Ian C.*, 87 F.4th at 1223–24; *David P. v. United Healthcare Ins. Co.*, 77 F.4th 1293, 1311–13 (10th Cir. 2023); *D.K. v. United Behav. Health* , 67 F.4th 1224, 1243 (10th Cir.

2023); *Pac. Shores Hosp. v. United Behav. Health* , 764 F.3d 1030, 1044 (9th Cir. 2014).

The court declined to allow United to propose *post hoc* explanations for the benefits denial that were not included in its letter to the plaintiff. The court also rejected United's contention that by reversing its denial of benefits, the court would be giving undue preference to the patient's treating providers over its own paper reviewers. Acknowledging that ERISA does not require plan administrators to privilege treating physicians, the court said administrators may not arbitrarily ignore credible evidence and must address contrary medical opinions as part of the required "meaningful dialogue."

On the MultiPlan rate issue, the court also found in plaintiff's favor, stating that "United is limited to the arguments it made at the administrative level, which were none." The case was remanded to the district court to calculate compensatory damages, statutory penalties, attorneys' fees, and other relief.

A Right with No Remedy? DOJ Argues for Ability to Sue for Unpaid NSA Awards

The U.S. Department of Justice (DOJ) recently weighed in on a Fifth Circuit case to argue that the No Surprises Act (NSA) allows healthcare providers to sue insurers over non-payment of an independent dispute resolution (IDR) award. The government's *amicus* brief, filed on October 4, 2024, posits that the denial of an ability to sue would frustrate the very purpose of the law. The NSA, which went into effect in 2022, seeks to protect patients from unexpected out-of-network "surprise" medical bills and, to that end, created an IDR process to address disagreements between out-of-network healthcare providers and insurers over how much those providers should be paid for covered medical claims. However, courts are divided over whether the NSA permits providers and insurers to sue to enforce IDR awards.

At the trial level, in *Guardian Flight LLC v. Health Care Serv. Corp.* , No. 3:23-CV-1861, 2024 WL 2786913 (N.D. Tex. May 30, 2024), the District Court for the Northern District of Texas held that, while the NSA may create a right to recover IDR awards, the law did not create a private cause of action to enforce that right. The court refused to assume that Congress intended to create a procedural mechanism to transform IDR awards to judgments. Rejecting the plaintiffs' other two arguments based on findings of insufficient standing and lack of an independent cause of action for unjust enrichment under Texas law, the district court dismissed the case.

The plaintiffs, a pair of air ambulance companies, appealed to the Fifth Circuit in June 2024. In support of the plaintiff-appellants, the DOJ argues that the district court's blocking suit over non-payment made little sense. The government cited the text and history of the NSA and noted that it was modeled after arbitration between private parties, a foundational aspect of which is that an arbitration award is judicially enforceable. In its dismissal, the district court relied in part on the fact that the NSA does not include specific portions of the Federal Arbitration Act (FAA), but the DOJ's *amicus* brief pushes back by noting that the law cites other FAA provisions. For instance, the NSA incorporates FAA § 10(a), 9 U.S.C. § 10(a), which allows a court to vacate an IDR award upon a demonstration of fraud or similar misconduct. Notably, this amounts to the NSA's only provision addressing judicial review of IDR awards. No NSA provision relates to the enforcement of IDR awards.

Fundamentally, the DOJ argues that there is no adequate alternative means to enforce an IDR award. Civil monetary penalties may apply if a party fails to make timely payments, but the government asserts that such enforcement does not equate to ensuring IDR decisions are binding on the parties. In essence, the DOJ cannot match the district court's comfort with the conclusion that the NSA "provisions only suggest that Congress created a right, but there is nothing to suggest that Congress also intended to confer a corresponding remedy."

This case may be part of a developing circuit split. In September 2023, the District Court for the District of New Jersey, in *GPS of New Jersey M.D., P.C. A/S/O/ T.U. v. Horizon Blue Cross & Blue Shield*, No. 22-cv-06614 (D.N.J. Sept. 8, 2023), held that the NSA gave the court the authority to enforce the award. In that case, the provider sought to vacate an IDR award and the insurer responded with a cross-motion to confirm it; the court confirmed the insurer's award.

The DOJ also addresses the district court's decision that the plaintiffs lacked standing. The plaintiffs asserted the right to the benefits of some of the defendant's beneficiaries, but the district court held that the beneficiaries did not suffer a concrete injury from the failure to pay the IDR award. The court reasoned that the NSA made the beneficiaries no longer financially responsible for the billing, so they suffered no financial injury from the disputed and unpaid expense. In response, the DOJ notes that the NSA added surprise-billing provisions to ERISA, so the refusal to pay the IDR determinations amounts to a wrongful denial of plan benefits to the plan participants and, by extension, those suing based on the assignment of those benefits.
