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Health insurer’s three-word denial brings cold shoulder from 2nd Circuit

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In *Halo v. Yale Health Plan*, 2016 WL 1426291 (2nd Cir., April 12, 2016), the 2nd U.S. Circuit Court of Appeals recently addressed whether an Employee Retirement Income Security Act-governed health insurance plan's failure to issue a benefit determination compliant with federal claims-processing regulations should be penalized and, if so, how.

The U.S. District Court had ruled that substantial compliance with the regulations was sufficient to preclude punishment. However, the federal court of appeals disagreed, holding, "[W]hen denying a claim for benefits, a plan's failure to comply with the Department of Labor's claims-procedure regulation, 29 C.F.R. Section 2560.503-1, will result in that claim being reviewed de novo in federal court, unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the regulation in the processing of a particular claim was inadvertent *and* harmless" (emphasis in original).

The appeals court also rejected the imposition of an additional monetary penalty for noncompliance with the regulations.

Plaintiff Tiffany Halo was a student at Yale University who was insured under the Yale Health Plan. Due to eye problems, she initially sought consultation and surgical treatment with doctors who were within the Yale plan's network. However, she required additional treatment, which she received from out-of-network providers.

Because a number of Halo's claims relating to that treatment were denied, Halo challenged the timing and content of the denials and ultimately filed suit pro se. Among her allegations, she asserted that one of the claim denials was tersely rejected as "Service not authorized."

No further explanation was provided despite the regulations' mandate that benefit claimants whose claims are denied be provided with the following:

- "The specific reason or reasons for the adverse determination."

- "Reference 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."
- "[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." 29 C.F.R. Sections 2560.503-1(g)(i)-(iv).

Disagreeing with Halo, the district court ruled the plan substantially complied with the regulations, concluding that "while YHP's communications of its claim denials were not ideal (and in some instances failed to comply with ERISA regulations), the substance and timing of its denials of Halo's claims were sufficient to indicate that YHP had exercised its discretion, such that [the district court] review[ed] its denials of Halo's claims under an arbitrary and capricious standard." Id. at 257.

The appeals court reversed.

After recounting the 1977 issuance of the initial claim regulations applicable to ERISA benefit claims by the U.S. Labor Department, and the comprehensive revision of the regulations in 2000, the court focused on the provision addressing the consequences of a benefit plan's "[f]ailure to establish and follow reasonable claims procedures." 29 C.F.R. Section 2560.503-1(l). Under that provision, noncompliance with the regulations constitutes a "deemed denial" of the claim.

The court deferred to the Labor Department's interpretation of the regulations under the authority of *Auer v. Robbins*, 519 U.S. 452, 461 (1997) and rejected the adequacy of substantial compliance since the regulations were described as minimum standards.

Hence, the court ruled that when a plan "fails to comply with [the regulations], the plan's decision denying a claim should not be entitled to deference in court."

Although the regulations themselves say nothing about the standard of review, the court cited rulings from three circuits supporting its conclusion that noncompliance with the regulations forfeits an entitlement to deference since it shows the absence of an exercise of discretion.

The court further justified its ruling by pointing out the rewards that follow from plans' compliance with the regulations - "the plans get the benefit of both an exhaustion requirement and a deferential standard of review when a claimant files suit in federal court - protections that will likely encourage employers to continue to voluntarily provide employee benefits."

Nor did the 2nd Circuit deem abrogation of deferential review "unnecessarily harsh," since, under the de novo standard, "plans will have to pay the claim only if it is a meritorious claim, which they are already contractually obligated to do. They will simply lose the benefit of the great deference afforded by the arbitrary and capricious standard."

However, the court concluded that discretionary authority would be preserved in situations where the plan 'has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulation in the processing of a particular claim was inadvertent *and* harmless" (emphasis in original). The court placed the burden on the plan, though, to show its deviation was both inadvertent and harmless.

The court also examined whether civil penalties are available when plans fail to comply with the regulations. The court determined there was no support for the imposition of penalties in either the statute or regulations and cited two appellate rulings for the proposition that no penalties are available to redress violations of the regulations or 29 U.S.C. Section 1133.

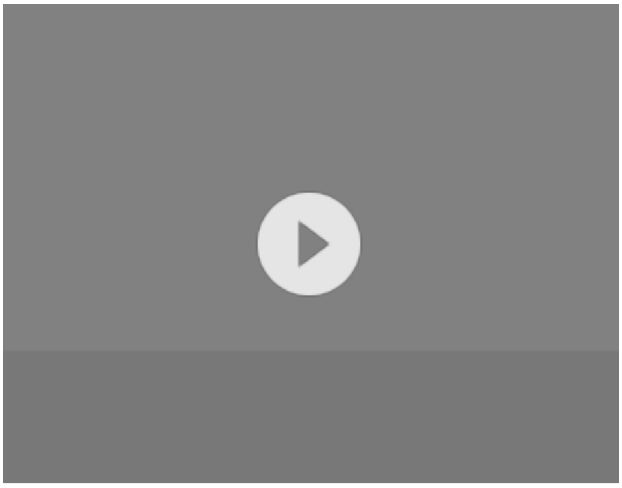
Although the court persuasively rejected the "substantial compliance" doctrine, this ruling will undoubtedly trigger further litigation as to the meaning of "inadvertent and harmless" noncompliance.

The court could also have gone much further because the harm here is one that is typical (and frustrating) in health care - summary denials lacking any explanation. In matters involving disability benefits, insurance companies and benefit plans adapted to the requirements of the 2000 regulations and now regularly engage in a claim and appeal process involving a meaningful exchange of information.

Not so with many health benefit denials. Obtaining a comprehensible explanation for a denial so that it can be effectively challenged is hard enough, but obtaining the so-called administrative record is often impossible.

It is hardly satisfying for a claimant to undergo a six-month runaround and then win a de novo review as the exclusive prize for the insurer's noncompliance.

Until Congress or the Labor Department really put some teeth into the regulations - or the courts develop a doctrine of default for flagrant noncompliance - nothing significant will ever be accomplished.



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