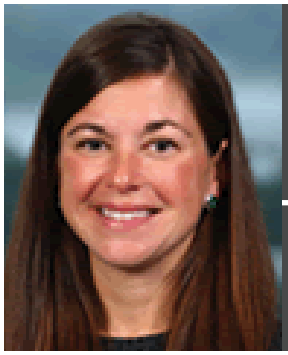

DEFENDING MANAGED CARE DECISIONS: UNDERSTANDING PATIENT DISPUTES OVER COVERAGE DENIALS

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Are We Out of the Woods Yet?: An ERISA Case Study of Wilderness Therapy

Belinda Jones

Recent disputes have arisen over insurance coverage of what is generally described as wilderness therapy. This therapy consists of treatment for behavioral health conditions using an outdoor-based model, with elements of nature, contact with horticulture and animals, and camping, similar to a NOLS or Outward Bound program. To set the stage, what often occurs is a parental decision to separate a "troubled" adolescent from the home and enroll him or her in a wilderness program. Often parents hire educational or healthcare consultants to assist in the process. In many circumstances, parents enroll first and then, with the assistance of the consultant or the program, seek insurance coverage later. This is critical because many programs last for months and come with a price tag of hundreds of thousands of dollars. As reported in a number of federal court cases in recent years, many insurance plans deny coverage for a myriad of reasons, including, but not limited to, specific exclusions under the plan, a determination that wilderness therapy is experimental, a finding that the adolescent does not meet the clinical criteria for the program, or because components of the program do not meet accreditation requirements.

Using the wilderness therapy case study, this article will discuss three strategic approaches throughout the stages of benefit disputes under the Employment Retirement Income Security Act ("ERISA").

[1] Pre-litigation: Best Defense is Offense

As litigators, the usual modus operandi is clean up duty. Like most litigation, this familiar premise exists in ERISA denial of benefits claims. Indeed, by the time a Complaint hits a litigator's desk, the playing field has been set by the terms of the insurance plan itself and the communications between the plaintiff beneficiary and the plan administrator, culminating in the denial of the claim. More often than not, the litigator had no role in drafting the plan language or the communications denying the requested benefit.

Whether representing insurers or administrators, or both, the best advice given to clients is to get advice, specifically on plan design and adverse benefit determination letters. For insurers, crafting plan language that defines plan administrators and fiduciaries and grants discretion to those defined roles is critical to the standard of review the court will apply to a claim for benefits. Alternatively, for third party administrators, understanding all defined roles and the discretion provided by the plan is necessary to evaluate litigation risk and exposure. The same holds true for adverse benefit determination letters. ERISA regulations govern the minimum requirements of adverse benefit determinations and a failure to satisfy those requirements could result in the court forgoing a deferential standard of review in favor of a de novo review.

In a claim for recovery of benefits under 29 U.S.C. § 1132(a)(1)(B), the language of the applicable insurance plan determines the standard of review. Following the Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), courts in ERISA claim

for benefits matters will apply one of two standards of review: abuse of discretion or de novo review. Under a de novo review, the court is at liberty to review the claim without any deference or presumption of reasonableness to the plan administrator's determination of benefits. Alternatively, an abuse of discretion standard of review is deferential to the plan administrator's determination. In this case, in order for a plaintiff to succeed, the court must find that the plan's ultimate decision was "arbitrary and capricious."

Pre-litigation drafting of the plan directly impacts which standard of review will apply. As the Supreme Court held in Firestone, the determining factor is whether the plan language "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[1] The type of language required to vest the necessary discretion with a plan fiduciary has been the subject of a number of federal district and appellate court decisions. One such example presented to a number of Circuits is whether plan language that requires a beneficiary to submit proof "satisfactory" to a plan fiduciary is enough to grant discretion to that plan fiduciary in determining benefits, thereby trigging the abuse of discretion standard. The answer is likely no in the Second, Third, Fourth, Seventh, and Ninth Circuits. In fact, the Third Circuit kindly has provided safe harbor language guaranteed to satisfy Firestone, "[i] f an administrator wishes to insulate its decision to deny benefits from de novo review, we suggest … the following 'safe harbor' language: 'Benefits under this plan will be paid only if the administrator decides in [its] discretion that the applicant is entitled to them.'"[2] Conversely, other Circuits, like the Tenth Circuit, have held that no magical language is required.[3]

The contents of adverse benefit determination letters also may impact the standard of review applied by the court. ERISA requires that beneficiaries be afforded a "full and fair review" of their claims for benefits. ERISA regulations, specifically 29 CFR § 2560.503-1, require that certain minimum contents are included in adverse benefit determination letters. Requirements vary depending on whether the communication is an initial adverse benefit determination (29 CFR § 2560.503-1(g)), or an administrative appeal of an initial adverse benefit determination (29 CFR § 2560.503-1(h)(2)). Additional requirements are placed on group health plans (29 CFR § 2560.503-1(h)(3)). The plan administrator's failure to strictly comply with these ERISA regulatory requirements could result, at least in the Second Circuit and perhaps some districts in the Eleventh Circuit, in a loss of the deferential abuse of discretion standard in favor of a de novo standard of review.[4] The majority of Circuits focus on the overall fairness of the review of the benefit determination and require only that plan administrators substantially comply with ERISA regulations.[5]

Applying these principles to wilderness therapy benefits, the gold standard is to understand the insurer's position of coverage of wilderness therapy and to draft plan language that unambiguously adopts that position. The insurer's position as to coverage must be communicated to any plan administrator and the plan administrator must then refer to specific plan provisions when communicating with beneficiaries.[6] Often times, third party administrators have internal policies and procedures related to levels of care. A collaborative approach ensures communications to beneficiaries are, first, supported by the plan language, and, second, clearly and consistently communicated to the beneficiary.

[2] Defend Aggressively: Rule 12(b)(6) is Alive and Well in ERISA Benefit Litigation

The majority of claims for benefits are decided on cross-motions for summary judgment based exclusively on the administrative record. As a result, potential grounds for a motion to dismiss under Fed. R. Civ. P. 12(b)(6) are often overlooked. In fact, because the nature of the claim for a recovery of benefits requires that the existence and terms of the plans be sufficiently alleged in the Complaint, the summary plan description or plan document itself is fair game when considering whether a basis exists for a motion to dismiss. In every case, counsel should consider whether arguments can be made in support of dismissal. For example:

Named defendant is not a plan fiduciary and therefore not a proper party defendant. When third party administrators are named, consider whether the third party administrator makes final benefit determinations and/or processes claims.

The benefit sought is specifically excluded by the plan. Certain plans excluding wilderness therapy used the following language:

- "health resorts, spas, recreational programs,

1 Id. at 115.

2 Viera v. Life Ins. Co. of N. Am., 642 F. 3d 407 (3rd Cir. 2011).

3 Streeter v. Metro. Life Ins., 2006 WL 2944867 (D. Utah 2006).

4 Halo v. Yale Health Plan, 819 F.3d 42 (2d Cir. 2016); Johnston v. Aetna Life Ins. Co., 282 F. Supp. 3d 1303 (S.D. Fl. 2017).

5 L.M. v. Metro. Life Ins. Co., 2016 WL 8193159 (D. N.J. 2016); Lacy v. Fulbright & Jaworski LLP, 405 F. 3d 254 (5th Cir. 2005); Van Bael v. United HealthCare Servs., 2019 WL 142298 (E.D. La. 2019); Zack v. McLaren Health Advantage, Inc., 340 F. Supp. 3d 648 (E.D. Mich. 2018); Dardick v. Unum Life. Ins. Co. of Am., 739 Fed. App'x 481 (10th Cir. 2018); Joel S. v. Cigna, 356 F. Supp. 3d 1305 (D. Utah 2018); Jo H. v. Cigna, 2018 WL 4082275 (D. Utah 2018); Brian C. v. ValueOptions, 2017 WL 4564737 (D. Utah 2018).

6 Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc., 852 F.3d 105 (1st Cir. 2017).

camps, wilderness programs (therapeutic outdoor programs) outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs."[7]

- "Wilderness Programs, Boot Camps, and/or Outward Bound Programs: These programs may provide therapeutic alternatives for troubles [sic] and struggling youth, teens and adults, offering experiential learning and personal growth through outdoor and adventure-based programming. However, they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the care of the child or adolescent. These programs nearly universally do not meet standards for certification as psychiatric residential treatment programs or the quality of care standards for medically supervised care provided by licensed mental health professionals."[8]

Plaintiff failed to exhaust the administrative appeals afforded by the plan.

The claim is untimely and therefore barred by a contractual limitation period. Although there is no statute of limitations specified in ERISA, insurers may and often do state in the plan how quickly a lawsuit must be filed following the exhaustion of administrative appeals. One note of warning—certain district courts have held that defendants may not rely on the contractual limitation period unless the beneficiary was notified of the contractual limitation period during the administrative appeal.[9]

[3] Be Creative (To a Point): Doctoring with the Mind of a Lawyer

If there is no legal support for a motion to dismiss, the next step is to get your hands dirty and dive into the administrative record. If you ever wished you had gone to medical school, now is your opportunity. Appreciate that while ERISA defense lawyers are not doctors, neither are district court judges. What resonates with counsel may well be persuasive to the judge. Importantly, if the case is proceeding under an abuse of discretion standard, the task of defense counsel is to establish that the benefit determination was reasonable and supported by evidence in the administrative record. As previously discussed, the playing field is set and the pieces are in place. Armed with the plan language, the benefit determination correspondence, and the administrative record, the job of defense counsel is to put those pieces together in a narrative the court can understand. By way of example, consider a denial based on a failure to meet medical necessity criteria for residential wilderness therapy and a recommendation for a lower level of care such as outpatient therapy. Using the pieces in play:

Define the medical necessity standard using the plan language:

- A medically necessary service must "be of demonstrated value for treatment of the medical condition, consistent with diagnosis and no more than required to meet the basic health needs of the patient."

Define any additional clinical criteria applied at the discretion of the plan administrator:

- "The child/adolescent is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment."

Tie the clinical decision as stated in the correspondence denying the benefit to the plan language and any clinical criteria:

- "You are a _____admitted to RTC for treatment of _____. Your medications were _____, you were in full compliance with your prescribed medication regime. You exhibited no behavior such as aggression or self-harm which required 24 hour monitoring. You were safe and appropriate for outpatient care (5 days per week for 5-7 hours per day) as of _____."

Scour the record for clinical notes supporting the benefit determination, keeping in mind that any clinical notes prior to admission suggesting an alternative level of care or success at a current level of care are ideal:

- When discussing placement, her clinician stated, "She is begging her parents to send her to an all-girls RTC with horses."
- Residential Progress Note: "Student seemed upbeat and excited and also nervous for the dance. Student went to the dance and seemed to have fun. Student ate dinner and attended the dance."
- Residential Progress Note: "Student seemed to

7 Vorpahl v. Harvard Pilgrim Health Ins. Co., 2018 WL 3518511, at *2 (D. Mass. 2018).

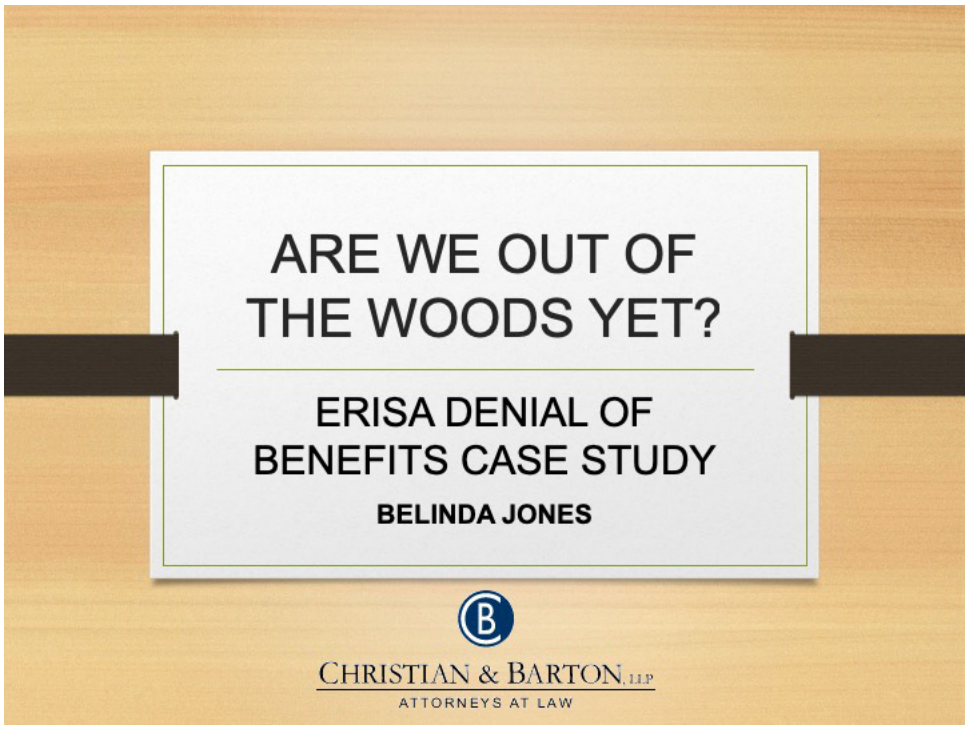
8 Welp v. Cigna Health & Life Ins. Co., 2017 WL 3263138, at *2 (S.D. Fl. 2017).

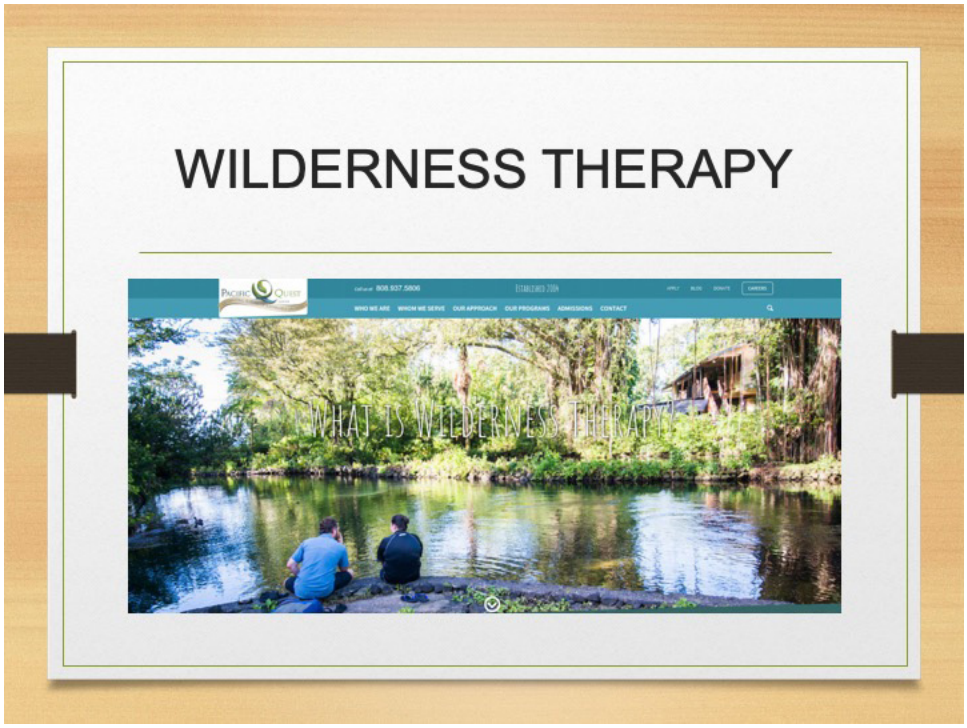
9 Stacy S. v. Boeing Co. Emp. Health Benefit Plan (Plan 626), 344 F. Supp. 3d 1324 (D. Utah 2018).

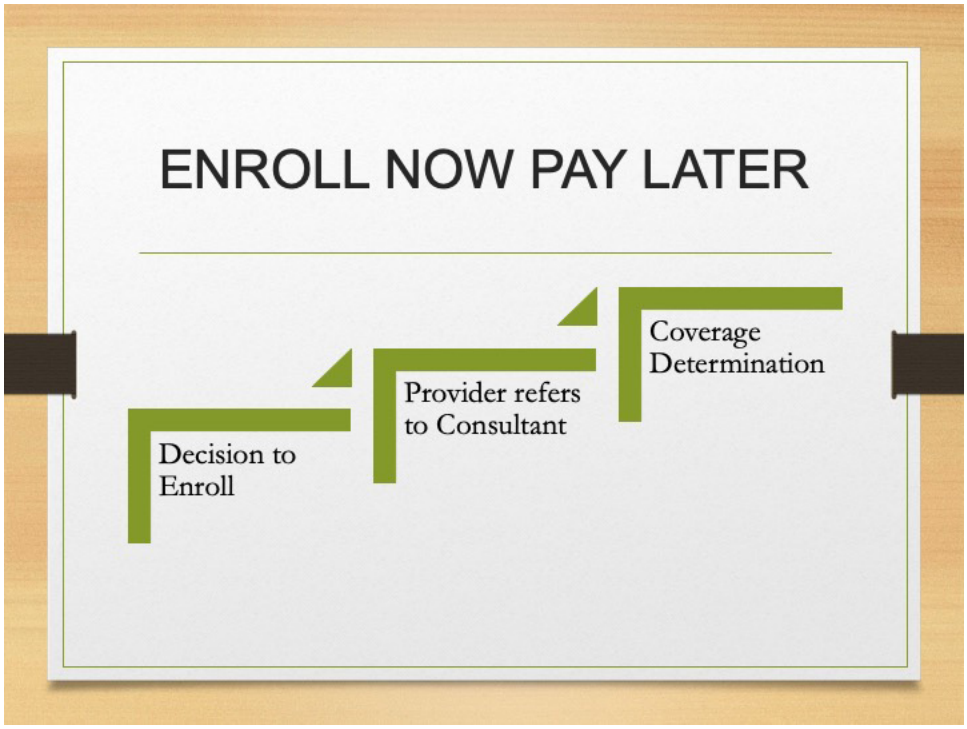
keep peers accountable to their chores. Student seemed to enjoy movie night, as well as going outside to watch fireworks with the community."

Conclude the narrative by focusing on the standard of review and the reasonableness of the decision.

While the insignia of M.D. over J.D. has its moments and creativity is one key to a successful defense, remember that some cases should be settled. Reviewing clinicians at times get it wrong. Judges are patients themselves and have loved ones that have needed clinical care. If, after reviewing the administrative record, your tally sheet contains more facts that make you flinch than not, take off your stethoscope, pick up the phone, and call your client. The ultimate exposure for your client is not just the benefit amount, but more likely than not plaintiff's costs and attorneys' fees.




WILDERNESS THERAPY
WHAT IS WILDERNESS THERAPY


ENROLL NOW PAY LATER
Decision to Enroll
Provider refers to Consultant
Coverage Determination

THREE STRATEGIC APPROACHES

- BEST OFFENSE IS DEFENSE
- DEFEND AGGRESSIVELY
- BE CREATIVE (TO A POINT)

DENIAL OF BENEFITS LITIGATION

PRE-LITIGATION: BEST OFFENSE IS DEFENSE

- Plan language
- Communication of benefit denial
- Administrative record

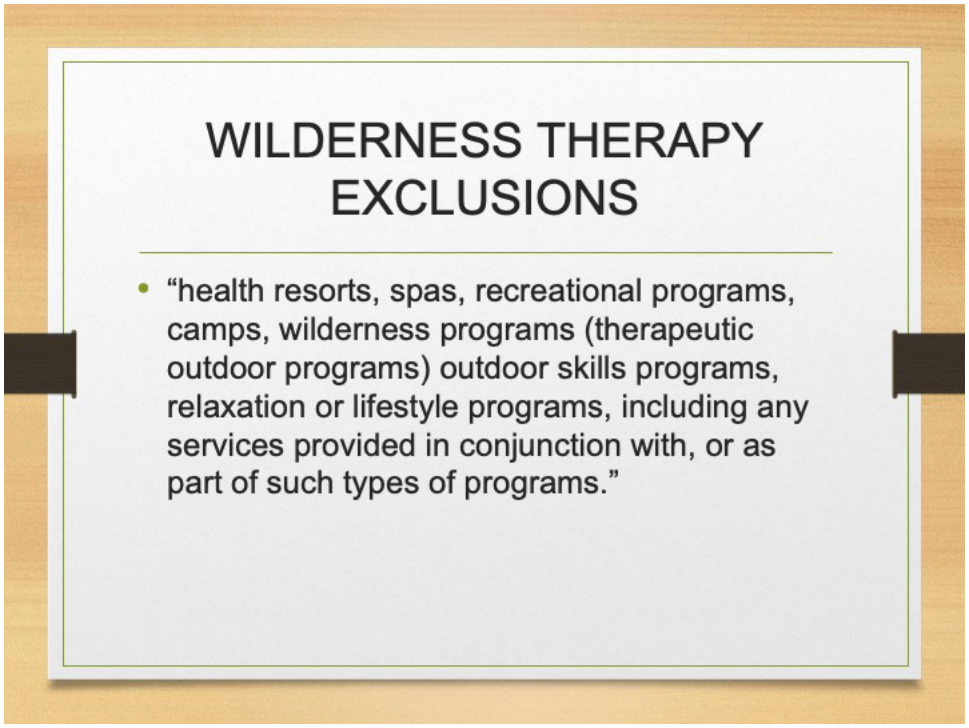

PLAN LANGUAGE
Determines Standard of Review
Abuse of Discretion
De Novo
Defines Covered Benefits

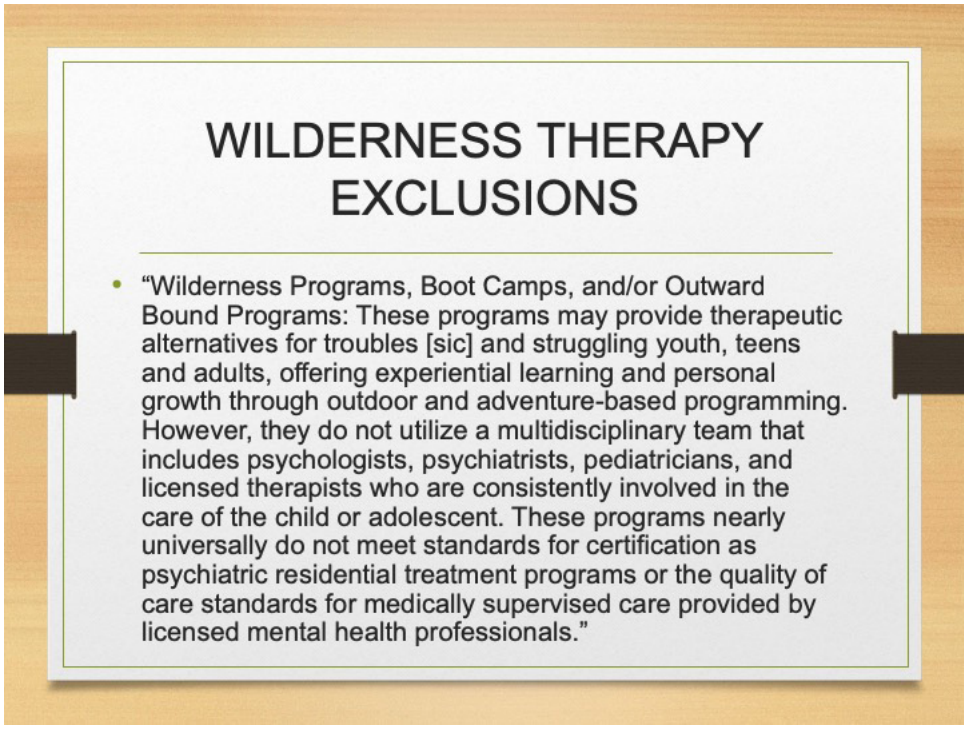

COMMUNICATION OF BENEFIT DENIAL
ERISA Regulations
Standard of Review
Coverage Determination
Consistency
Supported by Plan and Record

DEFEND AGGRESSIVELY

RULE 12(b)(6)

- Not a proper party defendant
- Benefit is excluded by the Plan
- Failure to exhaust administrative remedies
- Contractual limitation period


WILDERNESS THERAPY EXCLUSIONS
• "health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs) outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs."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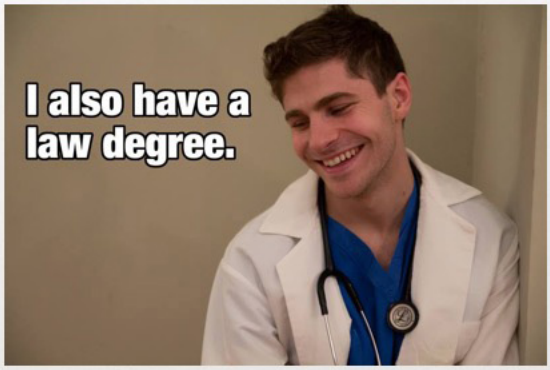
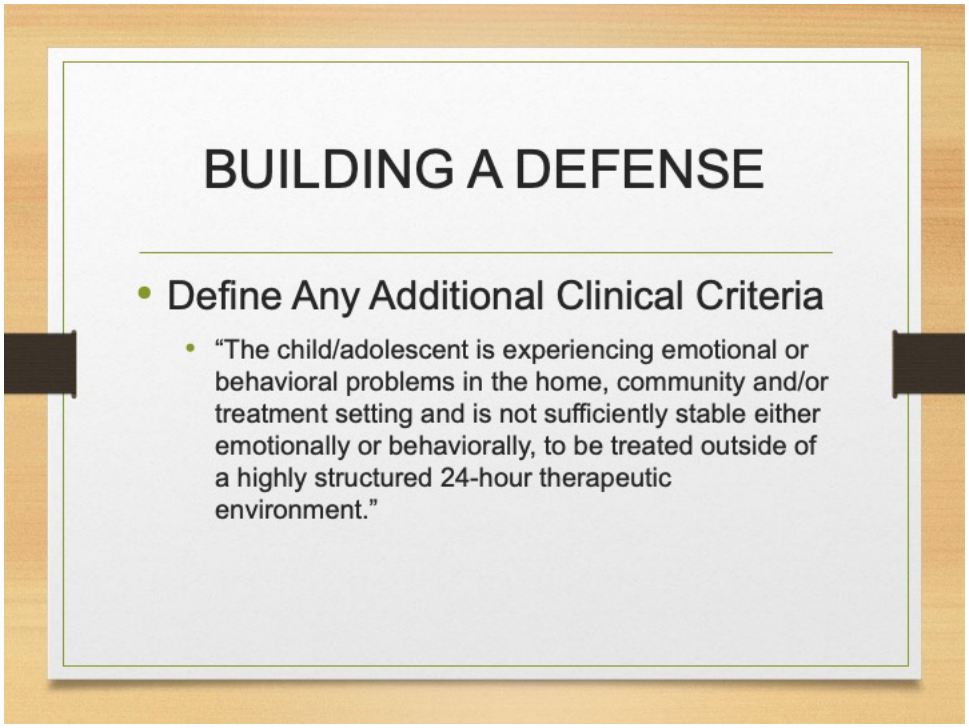
• "Wilderness Programs, Boot Camps, and/or Outward Bound Programs: These programs may provide therapeutic alternatives for troubles [sic] and struggling youth, teens and adults, offering experiential learning and personal growth through outdoor and adventure-based programming. However, they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the care of the child or adolescent. These programs nearly universally do not meet standards for certification as psychiatric residential treatment programs or the quality of care standards for medically supervised care provided by licensed mental health professionals."

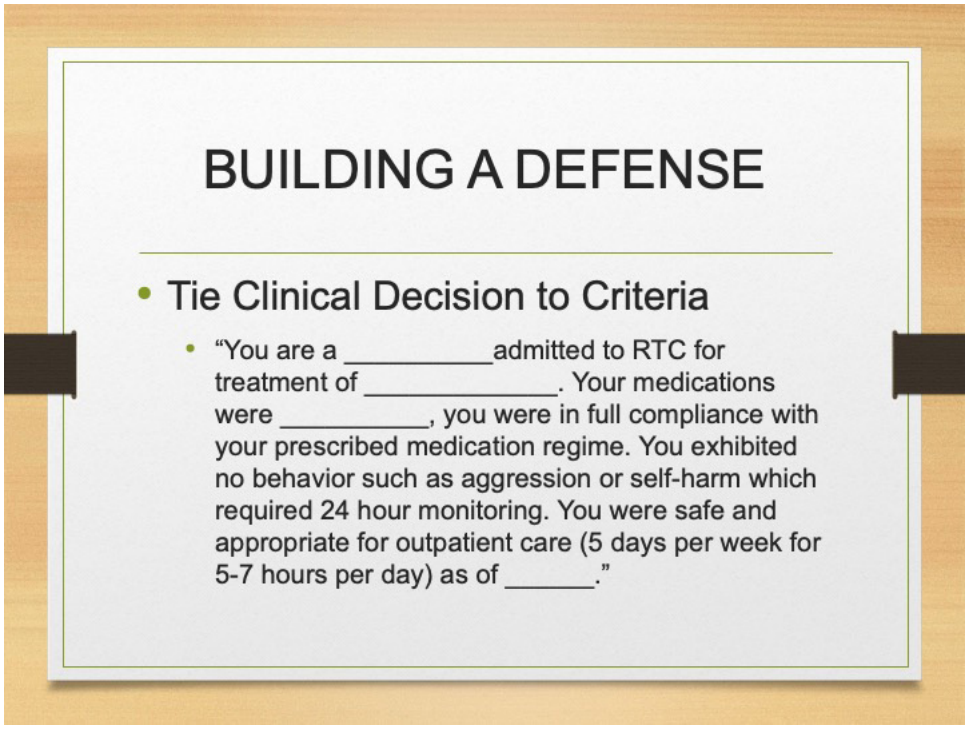
BE CREATIVE (TO A POINT)

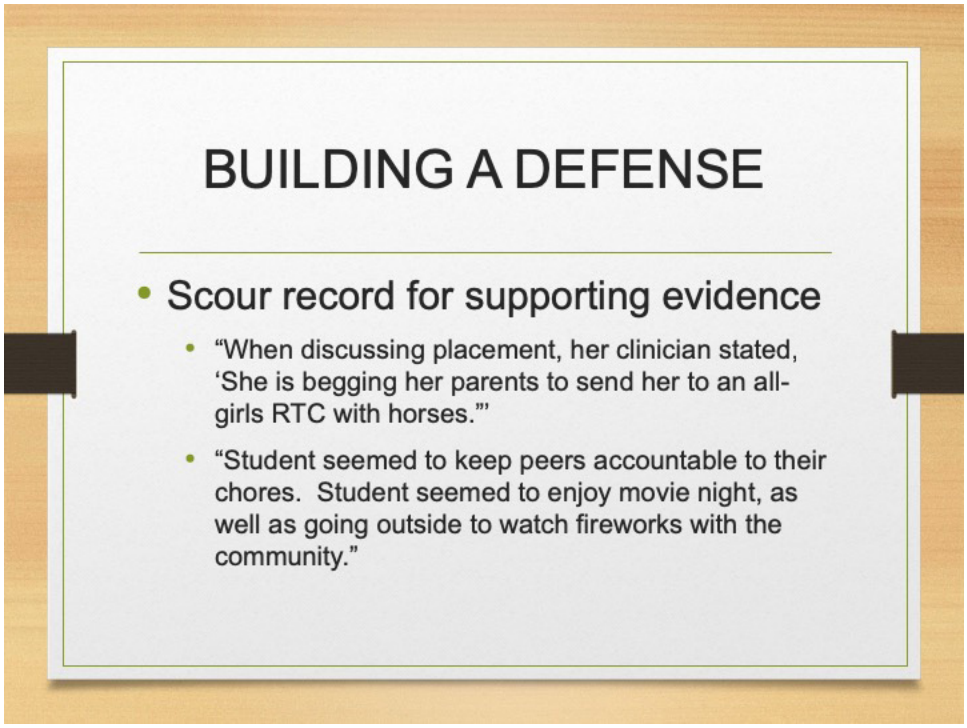


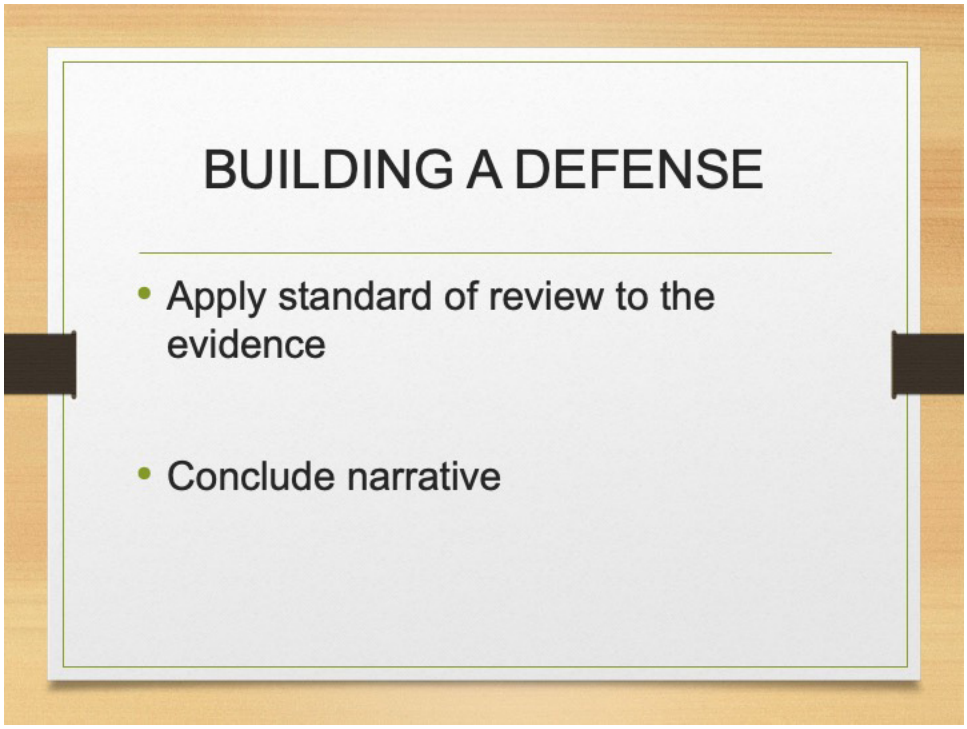
BUILDING A DEFENSE

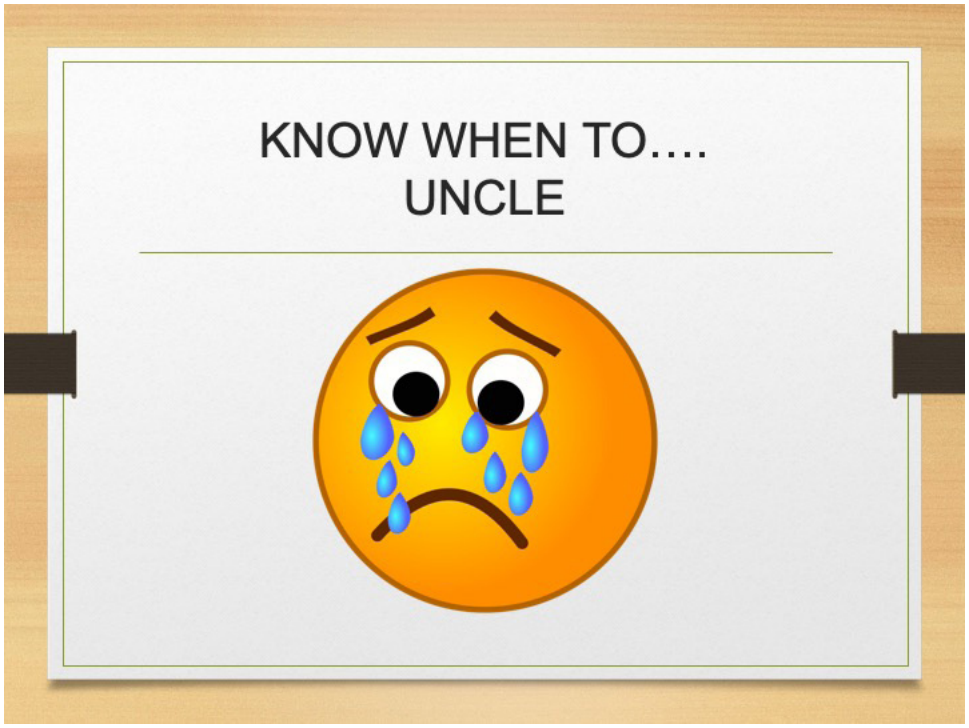
- Define Medical Necessity
  - A medically necessary service must "be of demonstrated value for treatment of the medical condition, consistent with diagnosis and no more than required to meet the basic health needs of the patient."

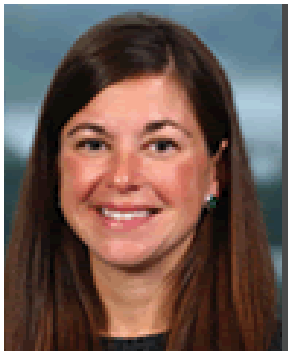

BUILDING A DEFENSE
Define Any Additional Clinical Criteria
"The child/adolescent is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment."


BUILDING A DEFENSE
Tie Clinical Decision to Criteria
"You are a _____admitted to RTC for treatment of _____. Your medications were _____, you were in full compliance with your prescribed medication regime. You exhibited no behavior such as aggression or self-harm which required 24 hour monitoring. You were safe and appropriate for outpatient care (5 days per week for 5-7 hours per day) as of _____."


BUILDING A DEFENSE
Scour record for supporting evidence
"When discussing placement, her clinician stated, 'She is begging her parents to send her to an all-girls RTC with horses.'"
"Student seemed to keep peers accountable to their chores. Student seemed to enjoy movie night, as well as going outside to watch fireworks with the community."


BUILDING A DEFENSE
Apply standard of review to the evidence
Conclude narrative


KNOW WHEN TO....
UNCLE



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Belinda Jones is a partner in the firm's Intellectual Property, Health Care and Litigation departments. She represents clients in intellectual property matters before the United States Patent and Trademark Office, federal courts and the Trademark Trial and Appeal Board. Mrs. Jones' commercial litigation practice focuses on health care matters, transportation and financial services disputes. She regularly practices before state and federal courts and has arbitrated commercial matters before FINRA Dispute Resolution and the American Arbitration Association.

Mrs. Jones is a member of the firm's Executive Committee and the Associate Training and Evaluation Committee, and she is an active member of the Virginia Bar Association and the Bar Association of the City of Richmond.

Practice Areas

- Intellectual Property Litigation
- Health Care Litigation
- Trials/Appeals/Alternative Dispute Resolution
- Products Liability and Torts
- Non-Competition and Trade Secrets
- Financial Services Litigation

Representative Litigation

- Representation of a national mental health care management company in commercial and contract disputes, and benefit claims under ERISA.
- Representation of hospital providers in commercial contract negotiations and disputes.
- Representation of insurers in plan design and benefit claims.
- Representation of various providers in Virginia Medicaid appeals.
- Representation of railroad in various commercial disputes including breach of contract and antitrust claims.
- Representation of international accounting firm in business tort action.
- Representation of regional airport authority in constitutional challenge and other tort actions.
- Representation of citizens group in water rate litigation.
- Representation of insurers in commercial and coverage disputes.
- Representation of an avionics manufacturer in the Eastern District of Virginia.
- Representation of a third party administrator of substance abuse testing programs.

Recognition

- Virginia Rising Stars - Civil Litigation Defense, 2013-2017; Intellectual Property Litigation, 2012

Education

- Georgia State University, J.D., 2004 - Magna Cum Laude
- University of Virginia, B.A., Government, 1999