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A New Approach to Abuse of Discretion Review

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The Ninth Circuit Court of Appeals recently applied a searching analysis under the abuse of discretion standard of review — one that takes into account all circumstances and will not uphold denial simply if there is a single reasonable basis to deny benefits — even where there was no finding that a conflict of interest existed. In *Pacific Shores Hospital v. United Behavioral Health,* the Ninth Circuit reversed a district court judgment and held that a health plan's third-party administrator ("TPA") abused its discretion by denying a participant's health benefit claim and relying on "a number of obvious mistakes" made by the TPA's physician reviewers during their review of the participant's medical history and condition.[1]

Factual Background

In *Pacific Shores,* an employee of Wells Fargo, called Jane Jones by the court, was covered under the Wells Fargo & Co. Health Plan (the "Plan"), a self-funded plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). United Behavioral Health ("UBH"), a TPA for the Plan, was responsible for reviewing Plan mental health and substance abuse claims including those for anorexia nervosa.

Jones was admitted to Pacific Shores Hospital ("PSH") for acute inpatient treatment for severe anorexia nervosa and major depression. Through an assignment of rights to payment under the Plan, PSH submitted a claim to UBH for the costs of treatment during Jones's inpatient stay, but UBH refused to pay for more than three weeks of acute inpatient treatment.

District Court Decision

PSH sued UBH and the Plan, seeking payment for the additional days of acute inpatient treatment. The district court held a bench trial on the administrative record and ruled in favor of UBH, concluding that Jones's administrative record provided a reasonable basis for UBH's denial of additional acute inpatient care.[2]

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1 *Pac. Shores Hosp. v. United Behavioral Health,* 12-55210, 2014 WL 4086784 (9th Cir. Aug. 20, 2014).

2 *Pac. Shores Hosp. v. United Behavioral Health,* CV 10-5828 PSG CWX, 2011 WL 6402435 (C.D. Cal. Dec. 19, 2011) rev'd, 12-55210, 2014 WL 4086784 (9th Cir. Aug. 20, 2014).

Ninth Circuit Decision

PSH appealed, and the Ninth Circuit reversed, holding that UBH abused its discretion in refusing to pay for additional days of inpatient treatment. On appeal, PSH asserted that although the Plan had granted the discretion to make claim determinations to the TPA, the court should adopt a less deferential standard of review of UBH's decision. PSH made three points in support of this argument, which provided the court with reasons to hold that even under an abuse of discretion standard of review, UBH's decision was not reasonable in consideration of all of the circumstances of the claim.

Missteps Throughout UBH's Benefits Denial

First, PSH contended that there were procedural irregularities in UBH's benefits denial, such that the court should review the denial *de novo*. The court disagreed, stating that it was "painfully apparent that UBH did not follow procedures appropriate to Jones's case." For instance, although UBH stated that Jones's case required medical evaluation due to its "medical and psychiatric complexity," UBH's decision was based almost entirely on telephone conversations and voicemail messages. The court also noted that no PSH hospital records or independent examination results were ever put into the administrative record. In addition, UBH's physician evaluations contained "obvious factual errors that could easily have been corrected" if UBH had consulted its administrative record or the PSH hospital records.

Second, PSH argued that the court should have considered materials outside Jones's administrative record to review UBH's denial. The district court had declined to consider documents outside the administrative record, which is typical in cases involving an abuse of discretion analysis. However, the Ninth Circuit explained that when the administrator's decision contains procedural irregularities, a court may review extrinsic evidence to assess the implications of the irregularities. The court noted that despite the "medical and psychiatric complexity" involved in Jones's case, the administrator issued its decision based solely on UBH's telephone conversations and conflicting information. The court concluded that expansion of the record at the district court level would be appropriate where the administrator makes a coverage determination based solely on an administrative record and where actual medical records would be helpful to assess the accuracy of the medical facts upon which the administrator makes its coverage determination. The court even stated that the "choice to conduct only a paper review raises questions about the thoroughness and accuracy of the benefits determination."

Finally, PSH argued that although UBH was a TPA, it was operating under a conflict of interest, and the court should have considered this conflict as one factor in deciding whether UBH abused its discretion. PSH further asserted that UBH had a "self-interest" in continuing its contractual relationship with Wells Fargo, and Wells Fargo had a self-interest, as a direct funder of the Plan, in minimizing benefit payments paid from the Plan by UBH.

The court declined to rule on these three arguments for lowering the standard to *de novo*, concluding that even under the more deferential abuse of discretion standard of review (without any additional scrutiny because of a conflict of interest) and based on the record that UBH had before it, UBH had unreasonably and improperly denied benefits to Jones.

Court Breaks from "Any Reasonable Basis" Test Even in the Absence of a Conflict of Interest

The court revisited its previous holding in *Horan v. Kaiser Steel Retirement Plan* in 1991 that it would uphold a plan administrator's benefit claim decision if it were grounded in "any reasonable basis." This language in *Horan*, the court explained, could be read to mean that a court could make an "any reasonable basis" determination without looking at all the circumstances of the case. The court cited its 2011 decision in *Salomaa v. Honda Long Term Disability Plan* to confirm that this "unrealistic reading of the any-reasonable-basis test" is not good law when an administrator is operating under a structural conflict of interest. The court concluded that "[i]n 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."

In reviewing for abuse of discretion, the court explained, courts must consider "all of the relevant circumstances" for "any reasonable basis" supporting a plan administrator's decision. A plan administrator abuses its discretion if the administrator rendered its decision without any explanation, construed provisions of the plan in a way that conflicts with the plain language of the plan, failed to develop necessary facts for its determination, or relied on clearly erroneous findings of fact in making benefit determinations.

UBH Violated its Fiduciary Duty to Jones under ERISA

The court concluded that UBH fell short of fulfilling its fiduciary duty to Jones. As a claims administrator, UBH had a fiduciary responsibility under ERISA to discharge its duties with respect to a plan "solely in the interest of the participants and beneficiaries," [3] that is, "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." [4] 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." [5] By employing and relying on three physician evaluators who made critical factual errors supporting UBH's denial decision, UBH breached its duty and improperly denied benefits under the plan.

Future Direction of Claims Adjudicated Under the Abuse of Discretion Standard

In *Pacific Shores*, the Ninth Circuit applied to a situation involving no conflict of interest, the more searching review that it had previously reserved for conflict of interest cases decided under the abuse of discretion standard. The court emphasized that it will not uphold a claims decision simply because it is supported by "any reasonable basis," as the court had originally held in *Horan*

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3 29 U.S.C. § 1104(a)(1).

4 29 U.S.C. § 1104(a)(1)(A).

5 29 U.S.C. § 1104(a)(1)(B).

v. Kaiser Steel Retirement Plan. In addition, the Ninth Circuit suggested that the admission of extrinsic evidence — even where the abuse of discretion standard applies — may be appropriate in ERISA cases where the administrative record is not sufficient.

Two days after the Ninth Circuit decided *Pacific Shores,* the Sixth Circuit in *Butler v. United Healthcare of Tennessee, Inc.* took an approach similar to that of the Ninth Circuit in addressing a benefits denial.[6] In *Butler,* the court disagreed with United's argument that its denial of benefits could not have been an abuse of discretion because several physicians had stated that the medical care at issue was not medically necessary. The Sixth Circuit explained, "That reviewing physicians paid by or contracted with the insurer agree with its decision, though, does not prove that the insurer reached a reasoned decision supported by substantial evidence."[7] The court further noted that the reviewing physicians had not provided a fair opinion applying the standard for granting benefits to the facts of the case. Rather, the physicians had omitted the key fact of the insured's prior failed outpatient treatment and ignored United's guideline that allowed residential rehabilitation where outpatient treatment had not worked in the past. The court concluded:

"If a decision to deny benefits could never be arbitrary and capricious when backed by the insurer's reviewing physicians, court review would be for naught. The insurer would invariably prevail so long as the insurer had physicians on its staff willing to confirm its coverage rulings. That also does not make sense."[8]

Pacific Shores and *Butler* are recent decisions that suggest a movement in the Circuit Courts of Appeals towards a less deferential approach to analyzing ERISA benefit claims decisions even under the abuse of discretion standard of review. Thus, claims administrators may find it more difficult to have their claims decisions upheld in the future, despite the applicability of the abuse of discretion standard of review.

SEPTEMBER 2014

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6 *Butler v. United Healthcare of Tennessee, Inc.,* 13-6446, 2014 WL 4116478 (6th Cir. Aug. 22, 2014).

7 *Id.* at *5.

8 *Id.*