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Full Disclosure: Tenth Circuit Highlights ERISA's Document Disclosure Requirements

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Everyone likes to know the rules. And, in the case of the Employee Retirement Income Security Act of 1974 (ERISA), there are rules that require the disclosure of information at various points in time so that plan participants can understand their rights and the requirements for contesting events where benefit coverage may have been denied.

Specifically, ERISA requires the disclosure of the documents under which the plan is established or operated, as well as certain disclosures designed to provide useful information to participants and beneficiaries about plan provisions when a benefit claim is denied. When ERISA was first enacted, this probably seemed like a straightforward exercise. The plan and the summary plan description set forth the plan terms, and benefit claims were addressed by a plan administrator or committee. But as benefit plans became more complicated and expansive, so too did the required participant disclosures.[1]

The failure to comply with these requirements can have serious consequences for plans and their administrators. If plans fail to comply with these requirements, ERISA allows a participant or beneficiary to sue a plan administrator and allows courts to impose monetary penalties. In addition, depending on the plan terms, the failure to fully and

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fairly review a benefit claim – including providing adequate information regarding the claims review process – can reduce or eliminate the deference a court might otherwise afford a plan administrator's claim denial.

While the determination of whether to impose such penalties depends on the facts and circumstances of each case, a recent decision by the U.S. Court of Appeals for the Tenth Circuit serves as a useful reminder of some of the pitfalls of failing to comply with ERISA's disclosure requirements.

ERISA'S DISCLOSURE REQUIREMENTS

ERISA plan administrators must comply with both statutory and regulatory disclosure requirements.

Statutory Disclosure Requirements

Within ERISA, 29 U.S.C. § 1024(b) provides that annual reports and Summary Plan Descriptions (SPDs), which describe participants' rights, benefits, and responsibilities under the plan, must be made available to participants and beneficiaries within prescribed time frames. In general, plan administrators must provide documents within 30 days after a written request for such documents.[2]

Section 1024(b)(1) specifically sets forth that "a plan administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary[] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." The Supreme Court has explained that this provision furthers "ERISA's goal of enabling plan beneficiaries to learn their rights and obligations under the plan at any time."[3]

Failure to comply with the disclosure requirements of § 1024(b)(4) carries consequences for plan administrators. ERISA creates a private right of action for "a participant or beneficiary" if a plan administrator "fails or refuses to comply with a request for any information which such administrator is required . . . to furnish" under § 1024(b).[4] If the plan administrator does not comply with the request within 30 days, a court may award damages "up to $100 a day from the date of such failure or refusal" and order "such other relief as it deems proper."[5] The award of statutory penalties for failing to provide required information is "in the court's discretion."[6]

Regulatory Disclosure Requirements

As part of a plan administrator's obligation to "fully and fairly" consider a claim for benefits,[7] ERISA's implementing regulations[8] also provide

disclosure requirements with which plan administrators must comply. Those regulations set forth extensive "claims procedure" provisions that detail how such claims must be processed, along with the type of information that must be compiled and disclosed to a plan participant.[9] While the requirements vary to some extent depending on whether the benefit claim relates to, for example, a health plan or disability plan, claims procedures are not deemed to provide a participant "with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination" unless they:

(i) Provide claimants at least 60 days to appeal the determination;

(ii) Provide claimants the opportunity to submit documents and other information relating to the benefits claim;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to the claim; and

(iv) Provide for a review that takes into account all documents and other information submitted by the claimant relating to the claim.[10]

The regulations further provide that whether a "document, record, or other information is relevant to a claim" is to be determined by reference to paragraph (m)(8) of the same regulations.[11] That paragraph in turn sets forth that a document is "relevant" if it:

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination;

(iii) Demonstrates compliance with the required administrative processes and safeguards; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance concerning the denied treatment option or benefit.[12]

The breadth of these disclosure regulations emphasizes the obligations ERISA imposes on plans and their administrators. While there is obviously room for disagreement regarding how these regulations should be interpreted, the risks for a plan administrator in failing to discharge these disclosure obligations – from fines to a determination that a claims process was neither fair nor comprehensive – can carry substantial administrative costs and additional burdens that need to be carefully considered.

M. S. v. Premera Blue Cross

A recent Tenth Circuit decision, *M. S. v. Premera Blue Cross*, serves as a further reminder that courts are willing to impose monetary penalties when plans fail to comply with ERISA's disclosure requirements.

In this case, plaintiffs M.S. and L.S. sought insurance coverage for their child, C.S., for mental health treatments. M.S. was employed by Microsoft and enrolled in the company's health benefits plan. The plan provided coverage for "medically necessary" treatments, including medically necessary treatments for mental health.[13] Under the plan, Microsoft was the administrator and Premera Blue Cross (Premera) was the claims administrator, which was responsible for claims-processing. If Premera denied a claim, a plan participant could appeal for an internal review of the decision. If the internal review was denied, a participant could request an external review by an independent review organization. These internal and external review processes were prerequisites to seeking judicial review.[14]

In the effort to obtain mental health treatment for C.S., his parents enrolled him in the Daniels Academy, a residential treatment center in Utah. His parents then submitted a claim to Premera, seeking coverage under the plan for C.S.'s treatment. In denying the claim, Premera concluded C.S.'s treatment was not "medically necessary" and identified the sources it relied on in making its decision, which included the plan, C.S.'s medical records, and the "McKesson InterQual Criteria, BH: Child and Adolescent Psychiatry InterQual 2017" (InterQual Criteria).[15] Premera's review found that the intensity of C.S.'s symptoms did not meet the InterQual Criteria for a residential treatment center.

Believing their child's treatment was medically necessary, the parents pursued both the internal and external administrative appeals of Premera's denial. During both phases, they requested a copy of all the documents Premera used to evaluate C.S.'s claim, including any administrative services agreements and any mental health and substance use disorder treatment criteria. The parents specifically requested criteria used to evaluate claims for treatments at skilled nursing facilities. In response to the request for documents, Premera produced copies of the plan and the InterQual Criteria, but did not provide any administrative services agreements, nor copies of the skilled nursing facility criteria. Both internal and external administrative appeals were denied.

After exhausting their administrative remedies, the family sued in federal district court, alleging that Premera and Microsoft violated the Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act),[16] by impermissibly applying disparate treatment limitations to claims for mental health care, and violated ERISA by improperly denying benefits and failing to produce certain documents.[17]

Resolving cross-motions for summary judgment, the district court granted summary judgment to the defendants on the denial of benefits claim while finding in favor of for the plaintiffs on the ERISA disclosure claim and the Parity Act claims.[18] For the ERISA disclosure claim, which was based on 29 U.S.C. § 1024, the court determined that defendants failed to satisfy their required disclosure obligations by failing to produce the skilled nursing criteria until discovery and never producing the administrative services agreement between Microsoft and Premera.[19] For this violation, the district court imposed a statutory penalty of $100 per day, under 29 U.S.C. § 1132(c), resulting in a total penalty of $123,100.[20]

The defendants appealed the summary judgment rulings on the Parity Act and ERISA disclosure claims. The family did not appeal the adverse ruling on their benefit denial claim.

On appeal, the Tenth Circuit dispensed with the Parity Act claim on jurisdictional grounds. Because the plaintiffs still would have suffered the alleged injury – the denial of benefits – even if defendants had not violated the Parity Act, the plaintiffs failed to demonstrate that the denial of benefits was "fairly traceable to the challenged action of" the defendants.[21] The plaintiffs also asserted that the Parity Act was violated and that they were injured because the defendants were required to provide notice of the plan's terms and claim review procedures but failed to do so. The court was unpersuaded and concluded that, without more, there was not an injury in fact and jurisdiction was improper.

On the plaintiffs' ERISA disclosure claim, the appellate court considered whether the administrative services agreement (ASA) between Premera and Microsoft and "the InterQual Criteria for medical/surgical benefits including skilled nursing and inpatient rehabilitation facilities" (the Skilled Nursing InterQual Criteria, which helps clinicians determine the most appropriate level of care for a patient), were outside of the statutory scope of 29 U.S.C. § 1024(b)(4).[22]

The meaning of this portion of § 1024(b)(4) was an issue of first impression in the circuit. At issue specifically was interpretation of the phrase "contract . . . under which the plan is established or operated."[23] The appellate court first analyzed whether the ASA ought to be considered a "contract" as described by the statute. The panel described the ASA as an agreement between Premera and Microsoft for Premera to act as the claims administrator for the plan.[24] Relying on this description, the court determined the ASA fell squarely within the commonly understood definition of "contract" at the time of ERISA's enactment.

Next, the court considered whether the ASA was a contract "under which the plan is established or operated."[25] The court applied the dictionary definitions of "established" and "operated." The panel determined that the document created the system requiring plan beneficiaries to submit benefits claims to Premera (rather than Microsoft directly), thus "establish[ing]" the plan for beneficiaries.[26] Also, the plan "operate[d]"

according to the terms of Premera's administration, as delegated by Microsoft to Premera in the ASA.[27] Because the ASA settled the relationship between Microsoft, Premera, and the plan, the ASA fell within the plain meaning of § 1024(b)(4)'s disclosure requirements. Further, even though there were other plan documents available to the plaintiffs that contained the relevant information found in the ASA, the Tenth Circuit determined that nothing in § 1024(b)(4) conditions the disclosure requirement on plan participants being parties to the contract or obviates the disclosure requirement if the information provided in the contract is available elsewhere.

The Tenth Circuit then considered the district court's holding that the Skilled Nursing InterQual Criteria were "plainly within the scope of 29 U.S.C. § 1024(b)(4) as 'instruments under which the Plan [was] . . . operated.'"[28] Again, utilizing dictionary definitions, the appellate court panel concluded that "instruments" in § 1024(b)(4) meant legal documents. Then, relying on statutory construction, the Tenth Circuit determined that the Skilled Nursing InterQual Criteria used by defendants were not legal documents of the type in listed in § 1024(b)(4). The list included "'annual report[s], . . . terminal report[s], . . . bargaining agreement[s], trust agreement[s], [and] contract[s]' as documents an administrator must disclose."[29] The defendants used the Skilled Nursing InterQual Criteria to evaluate the nature of the benefits claims; the criteria did not, as a legal document would, establish legal rights or duties.

In its summary judgment order, the district court reasoned the Skilled Nursing InterQual Criteria were "plainly within the scope of 29 U.S.C. § 1024(b)(4)" by relying on the language of federal regulation 29 C.F.R. § 2590.712(d)(3).[30] The Tenth Circuit found this unpersuasive, as reliance on the regulation was improper because § 1024(b)(4) was unambiguous. Accordingly, the panel reversed the district court's ruling in this respect.

To conclude its opinion, the Tenth Circuit noted that the defendants did not meaningfully oppose the district court's award of attorneys' fees. Thus, the panel affirmed the district court's imposition of a $123,100 penalty, plus the award of nearly $70,000 in attorneys' fees and costs.

TAKEAWAYS

To avoid potential pitfalls, plan administrators should be thoughtful and intentional about maintaining and organizing documents that may fall under § 1024. That will likely include documents beyond those that first come to mind, such as summary plan descriptions or disclosures. When participants request documents, whether by name or general description, administrators will then be well-positioned to timely meet their obligations. Plan sponsors should also conduct a thorough internal review of their administrative and compliance procedures to identify and optimize anything that might prevent administrators from readily complying with participant requests. A bit of forethought and planning ahead

can help ensure that participant requests for documents under ERISA are promptly and thoroughly addressed by service providers to avoid costly penalties and litigation fees.

Further, as noted above, in considering such requests, especially when the relevance of certain documents is not undisputedly clear, plans need to weigh the burden of disclosing the information against the risk, as in the case discussed above, that a court will later determine that the information fell within ERISA's disclosure obligations. A plan can opt to disclose certain information without waiving its position as to whether the document falls withing ERISA's disclosure obligations. But as ERISA plans become more complicated both in design and administration, plans and their administrators need to carefully evaluate their disclosure obligations and make sure they have a process for how such requests are evaluated and addressed. Prudent plan administration demands nothing less.

Notes

1. United States Government Accountability Office, "Private Pensions, Clarity of Required Reports and Disclosures Could Be Improved, report GAO-14-92," (Nov. 2013), available at https://www.gao.gov/assets/gao-14-92.pdf.

2. 29 U.S.C. § 1132(c)(1).

3. Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 74 (1995).

4. 29 U.S.C. § 1132(a)(1)(A), (c)(1)(B).

5. 29 U.S.C. § 1132(c)(1)).

6. Id.

7. 29 U.S.C. § 1133.

8. 29 C.F.R. Part 2520.

9. 29 C.F.R. § 2560.503-1.

10. 29 C.F.R. § 2560-503-1(h)(2).

11. 29 C.F.R. § 2560.503-1(h)(2)(iii).

12. 29 C.F.R. § 2560-503-1(m)(8).

13. M. S. v. Premera Blue Cross, 118 F.4th 1248, 1254 (10th Cir. 2024).

14. Id.

15. Id. at 1255. "The InterQual Criteria are a set of guidelines for evaluating the 'medical appropriateness of healthcare services.' . . . [t]he criteria are 'derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from [an] independent panel of clinical experts.'" Id. at n. 3.

16. 29 U.S.C. § 1185a.

17. M. S. v. Premera Blue Cross, supra n.13 at 1256.

18. M. S. v. Premera Blue Cross, 553 F. Supp. 3d 1000, 1041-42 (D. Utah 2021), aff'd in part, vacated in part, rev'd in part, 118 F.4th 1248 (10th Cir. 2024).

19. Id. at 1040.

20. Id. at 1041.

21. M. S., 118 F.4th at 1263.

22. Id. at 1265.

23. Id. at 1266.

24. Id.

25. Id. at 1267.

26. Id.

27. Id.

28. Id. at 1269.

29. Id. at 1270.

30. M. S. v. Premera Blue Cross, 553 F. Supp. 3d at 1034.