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Health Plan Hit with Big Penalty for Failing to Provide Plan-Related Documents

A federal judge ruled that a group health plan violated ERISA by failing to provide plan-related documents to a plan participant who requested them following the denial of a claim and a subsequent appeal for mental health residential treatment for the plan participant's teenage son, who was a covered beneficiary under the health plan.

Following the unsuccessful appeal of the son's denied claim, the plan participant requested that the health plan provide copies of "all documents under which the plan is operated," including: "(1) all governing plan documents; (2) the summary plan description (SPD); (3) any insurance policies in place for benefits [plaintiffs] are seeking;

(4) any administrative services agreements (ASAs) that exist; and (5) any mental health and substance abuse disorder treatment criteria (including [pediatric] skilled nursing facility and inpatient rehabilitation criteria) utilized to evaluate the claim."

ERISA's disclosure provision requires a plan administrator to provide a plan participant with copies of certain documents if the participant requests them in writing, including "the latest updated SPD, the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract or other instruments under which the plan is established or operated."

In response to the plan participant's request, the health plan provided copies of the SPD and the health plan's criteria for evaluating pediatric psychiatric care in a residential treatment facility. But it took over a year and a half to provide copies of the criteria used to evaluate pediatric care at skilled nursing and inpatient rehabilitation facilities. And the health plan never produced any ASAs. The plan participant sued, alleging, among other things, that the health plan's failure to provide the requested documents violated ERISA's disclosure provision. The health plan contended that the ASA did not fall within the scope of the disclosure provision, and because the criteria for evaluating care was never used in making the claims determination, it was not required to be disclosed.

With respect to the ASA, the court noted that, when the administration of a plan is divided between a plan administrator and a claims administrator, as it was in this case, the ASA is an "instrument under which the plan is operated" and must be disclosed. And although the criteria document was not used in making the claims determination, the court rejected the health plan's argument that it was not required to be disclosed, reasoning that ERISA's disclosure provision is broad and reaches beyond the

information needed to process claims. Consequently, the court found that the health plan violated ERISA's disclosure provision.

In calculating the penalty, the court noted that the health plan had acted in bad faith throughout the litigation and, therefore, the penalty imposed should be meaningful. Accordingly, the court imposed a penalty of $100 per day for 1,231 days of noncompliance, bringing the total penalty to $123,100.

Full text of M. S. v. Premera Blue Cross, 2:19-cv-00199 (D. Utah Aug. 10, 2021)(Casetext.com)

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