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**RICHARD W. WIEKING
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NORTHERN DISTRICT OF CALIFORNIA**

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

TEEN HELP, INC, et al,)
)
) Plaintiff,)
)
) v.)
)
) OPERATING ENGINEERS HEALTH AND)
) WELFARE TRUST FUND, et al,)
)
) Defendants.)

No. C 98-2084 VRW
ORDER.

United States District Court
For the Northern District of California

This action stems from the decision of defendant Board of Trustees of the Operating Engineers Health & Welfare Trust Fund ("the Board") to deny claims for payment for services provided to Erica Reed and Sandra Bunch by plaintiff Teen Help, Inc dba Brightway Adolescent Hospital ("Brightway"). Plaintiffs seek recovery of benefits pursuant to the Employee Retirement Income Security Act ("ERISA"), 28 USC § 1132(a)(1)(B) and statutory penalties pursuant to 29 USC § 1132(c)(1) for defendants' failure to produce documents in violation of 29 USC § 1024(b)(4) and 29 USC § 1133(2). Before the court are the parties' cross-motions for summary judgment.

Juliana Morrill was a beneficiary of the Operating

1 Engineers Health & Welfare Trust Fund. See Def's Mem at 2. Her
2 daughter, Erica Reed, received treatment at Brightway for
3 adjustment reaction with disturbance of mood and conduct, mixed
4 psychoactive substance abuse, parent-child conflict, dysthymia
5 (mental depression, despondency), amphetamine abuse and cannabis
6 abuse. Reed was admitted to Brightway on October 31, 1995, and
7 treated there through November 20, 1995. See Compl 11-12. Timothy
8 Bunch was also a beneficiary under the Fund. See Daf's Mem at 2.
9 His daughter, Sandra Bunch, received treatment at Brightway for
10 dysthymic disorder, major depression, single episode, moderate,
11 parent-child relational problem, cannabis abuse and polysubstance
12 abuse. Bunch was admitted to Brightway January 9, 1995, and
13 treated there through January 30, 1995.

14 The Board contracted with Health Care Evaluation, Inc
15 ("HCE") and Cost Care to perform reviews of the medical necessity of
16 Bunch's hospitalization. Cost Care concluded that Bunch's
17 hospitalization was not medically necessary; HCE concluded that
18 only three days of the hospitalization were medically necessary.
19 See Declaration of Susan J. Olson ("Olson Decl") ¶¶17, 19, Exhs E,
20 H. Accordingly, the Board denied Bunch's claim for hospitalization
21 between January 13, 1995, and January 30, 1995. Cost Care
22 conducted the review of Reed's claim and concluded that the
23 hospitalization was not medically necessary. See id ¶17, Exn F.
24 Accordingly, the Board denied the entirety of Reed's claim.

25 Juliana Morrill and Timothy Bunch contracted with Claims
26 Management, Inc ("CMI") to pursue their claims with the Board. By
27 letters dated March 25, 1997, and April 25, 1997, CMI indicated to
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1 the Board that it was Morrill's authorized representative and
2 requested the medical reviewer's rationale for determining that
3 Erica Reed's hospitalization at Brightway was not medically
4 necessary and the utilization review criteria used by the Plan for
5 making determinations of medical necessity. See Olson Decl, Exh K.
6 CMI was never provided with the documents it requested and on May
7 23, 1997, the Board denied Reed's appeal. See Olson Decl, Exh J.

8 The Board contends that Timothy Bunch never pursued an
9 appeal of the denial of his claim as required by the terms of the
10 plan. Accordingly, the Board contends that Bunch's claim must be
11 denied for failure to exhaust administrative remedies, citing Amato
12 v. Bernard, 618 F2d 559 (9th Cir 1980). The summary plan
13 description provides that a beneficiary whose claim has been denied
14 or his duly authorized representative must submit a petition for
15 appeal in writing with 60 days after the petitioner received notice
16 of the denial. See Olson Decl ¶15, Exh C at 57-58. Defendants do
17 not indicate the date that the notice of denial was sent to Bunch
18 or CMI, nor does that notice appear in the record. A letter from
19 CMI to the Board dated September 23, 1996, does appear in the
20 record. See Olson Decl, Exh D. That letter indicates that the
21 notice of denial was dated July 24, 1996. After complaining that
22 the notice of denial was not sent to CMI and criticizing the denial
23 of benefits, the September 23 letter states:

24 We ask that the Board review this matter in its entirety.
25 If denial is maintained we ask that you forward to this
26 office a copy of the clinical criteria which was used by
27 [HCE] and also provide for us Dr. Kellars' rationale for
28 not certifying the continued confinement past January 12,
 1995 as medically necessary.

1 Id. The letter also indicates that a written authorization for
2 CMI to act as Timothy Bunch's representative was sent to the Board.
3 Defendants do not explain why they believe that this letter fails
4 to meet the requirements for a petition for appeal as set forth in
5 the summary plan description. It appears timely and makes
6 sufficiently clear the petitioner's desire to appeal his denial of
7 benefits. In light of this letter and the total absence of any
8 attempt by defendants to indicate why it was not adequate as a
9 petition for appeal, the court finds that Bunch did petition the
10 Board for review and that the Board's failure to conduct such a
11 review violated Bunch's right to a full and fair review of a denial
12 of his claim. See 29 USC § 1133(2).

13 CMI also wrote letters to the Board on June 13, 1996, and
14 July 12, 1996. See *id.*, Exh L. Along with the September 23 letter,
15 these letters requested the medical reviewer's rationale for
16 determining that Sandra Bunch's hospitalization at Brightway
17 between January 13, 1995, and January 31, 1995, was not medically
18 necessary, the utilization review criteria used by the Board for
19 making determinations of medical necessity and the medical
20 reviewer's credentials. The plan never provided these documents
21 to CMI.

22 ERISA provides that "[t]he administrator shall, upon
23 written request of any participant or beneficiary, furnish a copy
24 of the latest updated summary plan description, [] and the latest
25 annual report, any terminal report, the bargaining agreement, trust
26 agreement, contract, or other instruments under which the plan is
27 established or operated." 29 USC § 1024(b)(4). A request for
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1 CWA/ITU Negotiated Pension Plan v Weinstein, 107 F3d 139 (2d Cir
2 1997). Interpreting the same phrase according to its plain
3 meaning, the Weinstein court concluded that the word "instruments"
4 refers to "formal legal documents that govern or confine a plan's
5 operations, rather than the routine documents with which or by
6 means of which a plan conducts its operations." Id at 142; see
7 also Faircloth v Lundy Packaging Company, 91 F3d 648, 654 (4th Cir
8 1996) (concluding that "other instruments under which the plan is
9 established or operated." * * * encompasses only formal or legal
10 documents under which a plan is set up or managed.") The Weinstein
11 court also mined the legislative history of section 1024(b) and
12 articulated Congress' goals in enacting that section as "providing
13 plan participants with more significant information about (1) the
14 plans, (2) their rights and benefits, (3) how those rights could be
15 lost, and (4) transactions by plan fiduciaries * * * ." Weinstein,
16 107 F3d at 144.

17 The court is also guided by the opinion of the Secretary
18 of Labor, who has filed a brief as amicus curiae in this action and
19 written an advisory opinion letter addressing this issue.

20 The Secretary of the Department of Labor is charged with
21 enforcing ERISA and its fiduciary duties, and she has the
22 authority to render authoritative interpretations of the
23 Act. See 29 USC § 1132(a)(2). Unless Congress, in
24 enacting ERISA, demonstrated clearly its intent with
25 regard to the questions before us, we must defer to the
26 Secretary's official interpretations of ERISA if they are
27 reasonable.

24 Herman v Nationsbank Trust Company, 126 F3d 1354, 1363 (11th Cir
25 1997); see also Anweiler v American Electric Power Service
26 Corporation, 3 F3d 986, 993 (7th cir 1992) (deferring to Secretary
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1 of Labor's interpretation of ERISA as contained in amicus curiae
2 brief filed with the court). Department of Labor Advisory Opinion
3 Letter 96-14a indicates that

4 it is the view of the Department of Labor that, for
5 purposes of [section 1024(b)(2) and (4)], any document or
6 instrument that specifies procedures, formulas,
7 methodologies, or schedules to be applied in determining
8 or calculating a participant's or beneficiary's benefit
9 entitlement under an employee benefit plan would
10 constitute an instrument under which the plan is
11 established or operated, regardless of whether such
12 information is contained in a document designated as the
13 "plan document."

14 In her amicus curiae brief, the Secretary argues that the
15 utilization review criteria documents requested by CMI "by
16 definition are used to determine the benefits a [sic] participants
17 are entitled to and under what circumstances the benefits are
18 provided. The criteria are the types of 'rules, practices and
19 procedures' which define how the plan is operated." Brief of the
20 Secretary of the United States Department of Labor as Amicus Curiae
21 ("DOL Brief") at 9.

22 The court finds the Secretary's interpretation of the
23 statute to be reasonable. The utilization review criteria are
24 arguably an instrument as the Second and Fourth circuits understand
25 the term because they govern how the plan operates and are not
26 "routine documents" such as the actuarial valuation reports
27 addressed in Weinstein or the list of participants' addresses
28 sought by the plaintiffs in Hughes. Requiring the Plan to disclose
the utilization review criteria is also consistent with the Ninth
Circuit's interpretation in Hughes because the criteria "provide
individual participants with information about the plan and

1 benefits." Hughes, 72 F3d at 690. The Secretary's interpretation
2 is also consistent with Congress' objective that "the individual
3 participant know[] exactly where he stands with respect to the
4 plan--what benefits he may be entitled to * * * ." S Rep No 127,
5 93rd Cong, 2nd Sess 28 (1973), reprinted in 1974 USCCAN 4838, 4863;
6 see also Weinstein, 107 F3d at 144 (articulating Congress' purpose
7 in passing section 1024(b)(4)). Accordingly, the court finds that
8 the utilization review criteria are "other instruments under which
9 the plan is established or operated," and are required to be
10 disclosed by the plan administrator.

11 The court cannot conclude, however, that either the
12 medical reviewer's credentials or the medical reviewer's rationale
13 for denying coverage are "other instruments under which the plan is
14 established or operated" that must be disclosed pursuant to section
15 1024(b)(4). These documents are routine documents that do not
16 affect a beneficiary's rights under the plan, do not govern how the
17 plan operates and are not similar in nature to any of the
18 instruments specifically referred to in section 1024(b)(4).

19 Plaintiffs argue, however, that they are entitled to
20 these latter documents pursuant to 29 USC § 1133, which provides
21 that "[i]n accordance with regulations of the Secretary, every
22 employee benefit plan shall-- * * * afford a reasonable opportunity
23 to any participant whose claim for benefits has been denied for a
24 full and fair review by the appropriate named fiduciary of the
25 decision denying the claim." Acting pursuant to this provision,
26 the Secretary of Labor promulgated regulations defining what
27 constitutes a "full and fair review." These regulations provide

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1 that the plan's review procedure must allow "a claimant or his duly
2 authorized representative [to] * * * [r]eview pertinent documents."
3 29 CFR § 2560.503-1 (g)(ii); see also Ellis v Metropolitan Life
4 Insurance Company, 126 F3d 228, 237 (4th Cir 1997) ("The
5 opportunity to review the pertinent documents is critical to a full
6 and fair review, for by that mechanism the claimant has access to
7 the evidence upon which the decision-maker relied in denying the
8 claim and thus the opportunity to challenge its accuracy and
9 reliability.")

10 The question is whether the medical reviewer's rationale
11 for denying coverage and the medical reviewer's credentials are
12 "pertinent documents." The court concludes that they are. A
13 claimant cannot reasonably be expected to contest a benefit denial
14 without the administrator's rationale for denying the claim in the
15 first instance. Without the medical reviewer's rationale, the
16 claimant is left to shoot at a cloaked target and cannot deploy her
17 arguments and evidence in a fashion that will meaningfully address
18 the administrator's concerns. The claimant should also be able to
19 make arguments directed to the weight that the administrator ought
20 to give to the reviewing physician's opinion vis-a-vis the opinion
21 of a treating physician. This requires that the claimant have
22 access to the medical reviewer's credentials. The claimants in
23 this case also require access to the utilization review criteria
24 discussed above in order to argue that their hospitalization was
25 medically necessary. Section 1133(2) is therefore an alternate
26 ground upon which the Board was required to provide the utilization
27 review criteria, a position that the Secretary of Labor endorses.

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1 See DOL Brief at 9-12.

2 Plaintiffs request the court to impose a monetary
3 sanction upon the plan administrator for its failure to provide the
4 requested documents. ERISA provides that:

5 Any administrator * * * who fails or refuses to comply
6 with a request for any information which such
7 administrator is required by this subchapter to furnish
8 to a participant or beneficiary * * * may in the court's
9 discretion be personally liable to such participant or
10 beneficiary in the amount of up to \$100 a day from the
11 date of such failure or refusal, and the court may in its
12 discretion order such other relief as it deems proper.

13 29 USC § 1132(c)(1). Both of the statutory provisions that
14 obligate the Board to disclose the requested documents, section
15 1133(2) and section 1024(b)(4), are part of same subchapter of
16 ERISA as section 1132(c)(1). Failure to comply with requests for
17 information pursuant to those provisions therefore subjects the
18 Board to the penalties described in section 1132(c)(1). "The
19 purpose of [section 1132(c)(1)] is not to compensate participants
20 for injuries, but to punish noncompliance with ERISA." Faircloth,
21 91 F3d at 658. Although neither prejudice nor injury are
22 prerequisites to an award of sanctions pursuant to section
23 1132(c)(1), these are factors the court may consider in deciding
24 whether to exercise its discretion to award a penalty. See
25 Moorhart v. Bell, 21 F3d 1499, 1506 (10th Cir 1994). The court may
26 also consider evidence that the plan acted in bad faith. See *id.*

27 Although the court is persuaded that the Board should
28 have disclosed the documents, the court cannot conclude that
29 defendants' position was so unreasonable as to reflect bad faith.
30 There is no authority directly addressing whether the documents at