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.

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

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

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

Juliana Morrill and Timothy Bunch contracted with Claims Management, Inc ("CMI") to pursue their claims with the Board. By letters dated March 25, 1997, and April 25, 1997, CMI indicated to

the Board that it was Morrill's authorized representative and requested the medical reviewer's rationale for determining that Erica Reed's hospitalization at Brightway was not medically necessary and the utilization review criteria used by the Plan for making determinations of medical necessity. See Olson Decl, Exh K. CMI was never provided with the documents it requested and on May 23, 1997, the Board denied Reed's appeal. See Olson Decl, Exh J.

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

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

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

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

ERISA provides that "[t]he 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." 29 USC § 1024(b)(4). A request for

documents pursuant to section 1024(b)(4) must "give[] the administrator clear notice of what information the beneficiary desires." Andersen v Flexel, Inc, 47 F3d 243, 248 (7th Cir 1995). If the request is from a third party, the third party must provide written authorization from the beneficiary or participant to request the documents. See id at 249.

The first two requirements are clearly satisfied here. Defendants concede that CMI was authorized to act on behalf of Morrill and Bunch. See Def's Mem in Support of SJ at 6. Indeed, as noted above, the letters by which CMI made the requests for information indicate that written authorizations executed by Morrill and Bunch were provided to the Plan. Nor are the letters unclear about what information CMI was seeking. The parties only dispute is over whether the documents CMI requested are "other instruments under which the plan is established or operated," within the meaning of section 1024(b)(4).

The Ninth Circuit addressed the meaning of that phrase in Hughes Salaried Retirees Action Committee v Administrator of the Hughes Non-Bargaining Retirement Plan, 72 F3d 686 (1995). The Hughes court held that "other instruments under which the plan is established or operated," did not include a list of the names and addresses of other plan participants because the scope of that phrase is limited to documents similar in nature to those documents specifically listed in section 1024(b). "The relevant documents are those documents that provide individual participants with information about the plan and benefits." Id at 690. The Second circuit reached a similar conclusion in Board of Trustees of the

CWA/ITU Negotiated Pension Plan v Weinstein, 107 F3d 139 (2d Cir 1997). Interpreting the same phrase according to its plain meaning, the Weinstein court concluded that the word "instruments" refers to "formal legal documents that govern or confine a plan's operations, rather than the routine documents with which or by means of which a plan conducts its operations." Id at 142; see also Faircloth v Lundy Packaging Company, 91 F3d 648, 654 (4th Cir 1996) (concluding that "'other instruments under which the plan is established or operated.' * * * encompasses only formal or legal documents under which a plan is set up or managed.") The Weinstein court also mined the legislative history of section 1024(b) and articulated Congress' goals in enacting that section as "providing plan participants with more significant information about (1) the plans, (2) their rights and benefits, (3) how those rights could be lost, and (4) transactions by plan fiduciaries * * * ." Weinstein, 107 F3d at 144.

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

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

Herman v Nationsbank Trust Company, 126 F3d 1354, 1363 (11th Cir 1997); see also Anweiler v American Electric Power Service Corporation, 3 F3d 986, 993 (7th cir 1992) (deferring to Secretary

of Labor's interpretation of ERISA as contained in amicus curiae brief filed with the court). Department of Labor Advisory Opinion Letter 96-14a indicates that

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

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

The court finds the Secretary's interpretation of the statute to be reasonable. The utilization review criteria are arguably an instrument as the Second and Fourth circuits understand the term because they govern how the plan operates and are not "routine documents" such as the actuarial valuation reports addressed in Weinstein or the list of participants' addresses 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

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

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

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

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

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

See DOL Brief at 9-12.

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

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

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

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

issue here come within the scope of ERISA's disclosure provisions. Nor is there any other evidence pointing toward bad faith on defendants' part. The only injury or prejudice plaintiffs cite is their inability to obtain the requested documents and make use of them during the administrative review process. While this harm is not trivial, it is inherent in every case in which the court finds that a document should have been disclosed during the administrative review process, but was not. In close cases, it is not unreasonable for the plan administrator to seek a court determination whether it was required to disclose the documents. Accordingly, the court will exercise its discretion not to award sanctions in this case.

Plaintiffs also seek substantive review of the administrator's decision to deny benefits. The conclusions reached above, however, demonstrate that the administrative process leading to this determination was inadequate in that it failed to provide either Morrill or Bunch with a full and fair review of their claims as required by section 1133(2). "Normally, where the plan administrator has failed to comply with ERISA's procedural guidelines and the plaintiff/participant has preserved his objection to the plan administrator's noncompliance, the proper course of action for the court is remand to the plan administrator for a 'full and fair review.'" Weaver v Phoenix Home Life Mutual Insurance Company, 990 F2d 154, 159 (4th Cir 1993); see also Wolfe v J C Penney Co, 710 F2d 388, 393 (7th Cir 1983) (remanding to plan administrator for violation of section 1133(2)); Jenkinson v Chevron Corporation, 634 F Supp 375, 380 (ND Cal 1986) (remand

proper relief for violation of claims procedure). Because plaintiffs did not have access to the utilization review criteria, the medical reviewer's rationale or the medical reviewer's credentials, they were not able to present their best arguments to the administrator. In Bunch's case, the Board, through its own fault, failed to provide any review of the initial denial of benefits.

The court will therefore remand this action to the plan administrator with instructions to provide plaintiffs with the documents they have requested and conduct its review of the benefits denials anew. The parties should use this remand as an opportunity to present to the administrator the arguments made to the court in this motion.

Plaintiff also moves for attorney fees pursuant to 29 USC § 1132(g)(1), which provides that, "[i]n any action under this subchapter * * * by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." Plaintiff has prevailed on its claims for disclosure of documents pursuant to section 1024(b) and section 1133(2). Both of these sections are part of the subchapter referred to in section 1132(g)(1) and the court may therefore award fees to plaintiffs.

The Ninth Circuit has instructed that "a prevailing ERISA employee plaintiff should ordinarily receive attorney's fees from the defendant." Smith v CMTA-IAM Pension Trust, 746 F2d 587, 590 (9th Cir 1984); see also Mc Connel v MEBA Medical and Benefits Plan, 778 F2d 521, 525-26 (9th Cir 1985). In Hummel v SE Rykoff &

Co, 634 F2d 446, 453 (9th Cir 1980), the Ninth Circuit held that district courts should consider the following factors in exercising their discretion under section 1132(g):

> (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Although the court concluded above that there was no evidence that the Board's refusal to provide the requested documents was made in bad faith, the Board's unwillingness to review its denial of Bunch's claim does appear to be culpable. The Board provides no satisfactory explanation for its unwillingness to provide such review and to the extent that the instant case was required by that refusal, the Board should bear the cost of bringing the action. An award of costs against the Board would therefore satisfy the third Hummel factor as well, by deterring the Board from failing to honor proper petitions for review and encouraging it to err on the side of disclosure when considering requests for documentation by plan beneficiaries.

As to the parties ability to pay, the Ninth Circuit instructs that "[g]enerally, when an employee participant brings suit under ERISA, whether it is against the trustees or the employer, the resources available to the pensioner are limited," and that "[b]ased on this factor alone, absent special circumstances, a prevailing ERISA employee plaintiff should ordinarily receive attorney's fees from the defendant." Smith, 746

F2d at 590. Nothing in the parties' submissions distinguishes this action from what the Ninth Circuit has described as the usual case in which fees should be awarded.

The legal questions presented by this action are not only significant to all beneficiaries of the Operating Engineers Health & Welfare Trust Fund who might, in the future, undergo the denial review process, they are significant to ERISA law generally, as demonstrated by Secretary of Labor's interest in the matter. Accordingly, the fourth-listed factor also supports an award of fees here.

Finally, although the Board's contentions were not frivolous, the weight of authority regarding documents available to beneficiaries supported the plaintiff's position in this action. The fifth and final factor therefore supports an award of fees. Accordingly, plaintiffs shall recover their reasonable attorney fees and costs from defendant.

For the foregoing reasons, defendants' motion for summary judgment (Doc 21) is DENIED. Plaintiff's motion for summary judgment (Doc 26) is GRANTED in part and DENIED in part. Defendants are ordered to produce the documents sought by plaintiffs in this action, but the court will exercise its discretion not to award statutory penalties for defendant's refusal to provide them initially. The action is remanded to the administrator for a full and fair review of plaintiff's benefit denials as required by 29 USC § 1133 and the regulations promulgated thereunder. Plaintiffs shall recover their reasonable attorney fees and costs from the defendant. If the parties are

unable to stipulate to the amount of fees and costs, any motions filed with the court shall comply with Civil LR 54-5.

IT IS SO ORDERED.

VAUGHN R. WALKER
United States District Judge