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IN THE UNITED STATES DISTRICT COURT
DISTRICT OF UTAH - CENTRAL DIVISION

ABILIO A. HERNANDEZ, individually and as guardian for EDUARDO HERNANDEZ, and the class of similarly situated individuals, Plaintiffs, vs. THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, Defendant.	**ORDER AND OPINION** Case No. 2:99-CV-898B Judge Dee V. Benson

I. Introduction

This matter comes before the Court on defendant Prudential Insurance Company of America's Motion for Judgment on the Pleadings and Supplemental Rule 12(c) Motion for Judgment on the Pleadings. Defendant requests that the Court dismiss the lawsuit brought by plaintiff Abilio A. Hernandez on the basis that plaintiff's claims fail as a matter of law. Specifically, defendant argues that it is not the proper defendant and that the statutes and regulation under which plaintiff sues do not provide for the discovery plaintiff seeks to conduct. Finally, defendant argues that plaintiff lacks standing to sue because he irrevocably assigned his rights to bring suit to a third party.

The Court has heard oral arguments on these motions. Having thoroughly reviewed the oral arguments, the briefs and relevant case law, the Court issues this Order and Opinion.

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II. DISCUSSION

Before raising any substantive defenses against defendant's motions, plaintiff argues that these motions are premature. According to plaintiff, defendant did not file an answer prior to submitting its motions as required by Federal Rule of Civil Procedure 12(c). The court record, however, clearly shows that defendant filed an answer before it brought these motions, and the motions are therefore properly before the Court.

A motion for judgment on the pleadings is treated the same as a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6). *See Mock v. T.G. & Y. Stores Co.*, 971 F.2d 522, 528 (10th Cir. 1992). It is appropriate to grant such a motion only if plaintiff can prove no set of facts that would entitle him to judgment even when accepting all well-pleaded allegations in the complaint and construing the facts and allegations in the light most favorable to plaintiff. *See LaFoy v. HMO Colorado*, 988 F.2d 97, 98 (10th Cir. 1993). The facts are set forth below pursuant to that standard.

A. Factual Background

In 1996, Abilio A. Hernandez resided in the State of California and worked as a psychiatrist and an employee of Abilio A. Hernandez M.D., Inc. ("Hernandez Corporation"). The Hernandez Corporation sponsored a group medical benefit plan for its employees and their dependents. Defendant Prudential was the insurer of the plan, which qualified as an employee welfare benefit plan under 29 U.S.C. § 1002(1) of the Employment Retirement Income Security Act ("ERISA"). The Hernandez Corporation purchased one of defendant's group plans, entitled "Prudential HealthCare PPO, Preferred Provider Organization, Small Group Plan, Plan F," and the corporation was named as the plan administrator. Nevertheless, the Hernandez Corporation did not have any control or discretion to review claims under the employee benefit plan. Rather,

defendant Prudential retained control and discretion to deny or grant claims for benefits and appeals under the plan.

Eduardo Hernandez is the child of Abilio and Sandra Hernandez. He resided at all relevant times with his parents in Huntington Beach, California, and was a beneficiary of the welfare benefit plan. On October 8, 1996, Eduardo was admitted for inpatient care at Brightway Adolescent Hospital ("Brightway"), located in St. George, Utah, where he received psychiatric treatment for a period of approximately two weeks. Defendant denied payment of the bills submitted by Brightway for Eduardo's treatment on the basis it was not "medically necessary." Defendant also denied plaintiff's subsequent appeal.

During the appeals process, plaintiff appointed Claims Management, Inc. ("CMI") as his agent. CMI has repeatedly asked defendant for documents containing the criteria relied on by defendant in its decision that the treatment was not medically necessary. CMI has also sought to obtain documents that disclose the identity and qualifications of the personnel who reviewed plaintiff's claim and has requested that defendant provide any written opinions or evaluations prepared by the reviewers. Defendant has not produced the requested documents. Plaintiff argues that defendant's refusal to provide the documents constitutes a violation of §§ 1024(b)(4) and 1133(2) of ERISA and federal regulation 29 C.F.R. § 2560.503-1. Plaintiff therefore seeks a declaratory judgment that he is entitled to discover these documents.

B. Prudential is a Proper Defendant Under ERISA

Defendant Prudential's central argument is that it is not the proper defendant because it is not the "plan administrator." Prudential points out that §§ 1024(b)(4) and 1133(2) and 29 C.F.R. § 2560.503-1(g)(1)(ii) refer only to the plan administrator. The relevant portions of the statutes and regulation are as follows: "The *administrator* shall, upon written request of any

participant or beneficiary, furnish a copy of . . . other instruments under which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Next, "*every employee benefit plan* shall . . . (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review . . . ." 29 U.S.C. § 1133(2). Lastly, "*[e]very plan* shall establish and maintain a procedure . . . under which a full and fair review of the claim and its denial may be obtained." 29 C.F.R. § 2560.503-1(g)(1)(ii). Because the Hernandez Corporation is the plan administrator, Prudential argues, it is not the proper defendant in this lawsuit and cannot be subject to any sanctions or remedies for violations of these statutes or regulation.[1] Summary judgment, according to defendant, is therefore proper.

Plaintiff acknowledges that the United States Court of Appeals for the Tenth Circuit has held that no claim for penalties may be assessed under § 1132(c) against anyone other than the plan administrator for violations of § 1024(b)(4). However, plaintiff argues that the Court has power to grant injunctive or declaratory relief against Prudential as an agent for the plan administrator and a fiduciary under 29 U.S.C. § 1002(21)(A).

1. Prudential is a Fiduciary

In addition to those persons and entities expressly named as fiduciaries in a plan, ERISA treats a person or entity as "a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . ." 29 U.S.C. §

[1] Defendant stated during oral arguments that plaintiff Abilio Hernandez should sue Abilio A. Hernandez M.D., Inc. because it is the named plan administrator. The Court pointed out to defendant that this would lead to an absurdity, as plaintiff would basically have to sue himself to obtain the information he seeks from defendant. Defendant agreed that this would be the result in the present case, but argued that it is the result the law demands.

1002(21)(A). Moreover, ERISA regulations state that an insurance company may be the "appropriate named fiduciary" if it is identified in the plan as the entity that will review and make decisions on claims. *See* 29 C.F.R. § 2560.503-1(g)(2). Thus, although defendant is not a named fiduciary in the employee welfare benefit plan at issue, the Court may find that defendant was an ERISA fiduciary if defendant had authority and discretion to grant or deny claims and to review appeals of denied claims. *See Reich v. Stangl,* 73 F.3d 1027, 1029 (10th Cir. 1996).

In the present case, while the Hernandez Corporation was the named plan administrator, it is clear that defendant had the authority and discretion to decide claims, and the Hernandez Corporation retained no authority under the plan to review, and could in no way impact, defendant's decisions. Instead, defendant was the sole arbiter of claims submitted under the plan, and defendant alone would review any subsequent appeals. On page two of the plan description, defendant wrote "Thank you for selecting Prudential HealthCare's Preferred Provider Organization (PPO), as your health plan . . . ." The plan description frequently referred to defendant Prudential in its capacity to decide claims submitted under the plan. The most important portions of the plan description, for purposes of the present case, provide that "a medical emergency is generally defined as a sudden and unforeseeable sickness or injury . . . [that could] cause serious harm . . . as determined by Prudential HealthCare," and if treatment is to be continued beyond the initial 48 hour emergency period, the party must "[c]ontact Prudential HealthCare within 48 hours of all emergencies resulting in . . . hospitalization."

Eduardo's treatment lasted approximately two weeks. Defendant decided to pay for the treatment during the first 48 hours of Eduardo's hospitalization at Brightway Hospital. However, it denied payment for treatment beyond 48 hours because defendant decided the treatment was not a medical necessity. Defendant denied plaintiff's subsequent appeal. The

Hernandez Corporation, as plan administrator, was not authorized to review defendant's decisions.

All correspondence by plaintiff and his agents, including CMI, was directed to defendant, and defendant alone responded to the various parties. Defendant always issued its correspondence on official Prudential letterhead, and defendant's "Explanation of Benefits" documents all stated that "If you wish a review of how this claim was processed or if you have any questions, please contact: Prudential Insurance Company." At no point did defendant or the other entities involved turn to the Hernandez Corporation. The corporation never got involved in or reviewed defendant's administration of the claim.

Accordingly, viewing the evidence in the light most favorable to non-movant, the Court finds that defendant was a fiduciary for purposes of §§ 1024(b)(4) and 1133(2) and 29 C.F.R. § 2560.503-1. As a fiduciary, defendant was obliged to furnish complete and accurate information under ERISA upon plaintiff's written request, and failure to comply is a breach of that obligation. *See Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1301 (3d Cir. 1993).

C. The Requested Documents Are Covered by ERISA

Defendant argues that even if the Court finds that it is subject to §§ 1024(b)(4) and 1133(2) and 29 C.F.R. § 2560.503-1, the documents requested by plaintiff are not discoverable under those sections. In response, plaintiff states that his request for documents under §§ 1024(b)(4) and 1133(2) must be separated. Plaintiff concedes that only documents containing mental health care review criteria fall under § 1024(b)(4), whereas a reviewer's identity, credentials and rationale are discoverable under § 1133(2) and the accompanying regulation § 2560.503-1.

1. Mental Health Care Review Criteria are "Other Documents" under § 1024(b)(4)

The pertinent portion of § 1024(b)(4) says that a plan administrator must upon request provide a copy of "other instruments under which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Defendant argues that the medical review criteria do not establish or operate the Hernandez Corporation employee benefit plan and are therefore not "other instruments" under § 1024(b)(4). Accordingly, defendant contends it is not required to provide these documents to plaintiff.

The Tenth Circuit Court of Appeals has not addressed whether § 1024(b)(4) grants a beneficiary the right to obtain documents containing the criteria used to determine the medical necessity of psychiatric treatment, the identity and qualifications of the persons who review the beneficiary's claims and any written rationale or opinion drafted by the reviewers. As argued by defendant, the circuit courts that have confronted this issue have held that § 1024(b)(4) applies only to legal or formal documents under which a benefit plan is set up or managed. Thus, the statute does not apply to ministerial day-to-day documents used to process claims under the plan. Defendant argues that the documents sought by plaintiff are such ministerial day-to-day documents used for the processing of claims and therefore do not fall under § 1024(b)(4).

The case most analogous to the present law suit is *Teen Help, Inc. v. Operating Engineers Health and Welfare Trust Fund,* No. C 98-2084, 1999 WL 1069756, at *1 (N. D. Cal. Aug. 24, 1999), and is directly on point. As in the present case, plaintiffs in *Teen Help, Inc.* had been given mental health treatment at Brightway Hospital, and Brightway's claim for the treatment was denied. CMI became involved on plaintiff's behalf during the review process of the denial. Identical to the present action, CMI unsuccessfully requested from defendant the utilization review criteria for mental health treatment used to deny the claim and the medical

reviewer's rationale and credentials. *See id.* at *1 and *4. Plaintiff in *Teen Help, Inc.* sought penalties under 29 U.S.C. § 1132(a)(1), arguing that defendant's failure to produce documents regarding criteria, identity, credentials and rationale was a violation of 29 U.S.C. §§ 1024(b)(4) and 1133(2).

The issue in *Teen Help, Inc.* was "whether the documents CMI requested are 'other instruments under which the plan is established or operated,' within the meaning of section 1024(b)(4)." *Id.* To answer this issue, the district court relied on the rulings by several Courts of Appeals and an opinion by the United States Secretary of Labor. The court noted that it owed deference to the official interpretations of ERISA by the Secretary, provided they were reasonable. *See id.* at *3. Quoting Labor Advisory Opinion Letter 96-14a, the court said:

> it is the view of the Department of Labor that, for purposes of [§ 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."

Id. The *Teen Help, Inc.* court ruled that the utilization review criteria determined what benefits the beneficiary was entitled to and under what circumstances benefits would be provided and therefore managed and operated the plan and its assets. Consequently, the court held that the utilization review criteria were "other instruments" under § 1024(b)(4) and should have been provided by defendant.

The *Teen Help, Inc.* court's findings are supported by *Lee v. The Dayton Powever and Light Co.*, 604 F.Supp. 987 (S.D. Ohio 1985). In *Lee*, after a claim of underpayments of long-term disability benefits had been denied, plaintiff unsuccessfully sought to obtain from defendant a manual used to calculate the retirement benefits. The benefits coordinator in *Lee*

refused to provide the administration manual because § 1024(b)(4) in his opinion did not require such disclosure. The Court stated that "an administration manual containing charts essential to the calculation of retirement benefits appears to this Court to constitute an 'instrument[s] [sic] under which the plan is established or operated.'" *Id.* at 1002.

Most of the circuit court cases cited by defendant are not factually similar to the present case. The case that most strongly supports defendant's position is *Doe v. Travelers Ins. Co.*, 167 F.3d 53 (1st Cir. 1999). The *Doe* court reviewed a district court's decision to hold a defendant liable for over $150,000.00 in fees and costs for, *inter alia*, failing to disclose mental health guidelines under § 1024(b)(4). The circuit court stated that it did not "think" these mental health guidelines were "other instruments" under § 1024(b). *See id.* at 60. The court rested its decision in large part on the fact that defendant was not bound to use the medical review criteria when determining whether the treatment was medically necessary. Although the *Doe* court stated that non-mandatory medical review criteria need not be disclosed under § 1024(b)(4), the court also noted that the section could be construed to include even non-binding mental health review criteria. *See id.*

Plaintiff distinguishes *Doe* from the present case, arguing that defendant was required to use the mental health review criteria under the plan. Through a sworn affidavit by Mary Covington, President of CMI, plaintiff maintains that defendant Prudential is accredited by the Utilization Review Accreditation Commission ("URAC"), which is a national accreditation commission that establishes standards for conducting utilization review. Ms. Covington states that, as an accredited member of URAC, defendant must use explicit written clinical review criteria when evaluating the medical necessity of treatments under claims submitted by all of defendant's insureds, including those submitted by beneficiaries of the Hernandez Corporation's

employee benefit plan.[2]

Defendant attempts to persuade the Court that even though accredited by URAC, they were not bound by the URAC certification standards because the plan they sold to plaintiff does not reference any criteria required by URAC. Instead, defendant contends the plan provides its own definition for and explanation of medical necessity, and the plan allows defendant to select guidelines from any authoritative medical source. However, defendant never controverts Ms. Covington's affidavit. Although the plan provides some cursory definitions of "medical necessity," it is clear when reading the plan that a beneficiary needs more information to determine what his or her rights are and what constitutes a medical necessity.

Because the definition of medical necessity determines the rights of plaintiff and the obligations of defendant, this Court finds that any criteria used to determine the medical necessity of mental health care does "operate" and "manage" the plan and its assets. The mental health care review criteria in the case before this Court are particularly essential to determine plaintiff's rights under the plan because, viewing the facts in the light most favorable to plaintiff, the review criteria are mandatory. Consequently, plaintiff must be allowed to review these criteria to satisfy "Congress' purpose in enacting the ERISA disclosure provisions--ensuring that the individual participant knows exactly where he stands . . . ." with respect to his rights under the plan. *Firestone Tires & Rubber Co. v. Bruch*, 489 U.S. 101, 118 (1989). The Court therefore finds that documents containing mental health review criteria, particularly if they are used to obtain accreditation with a major or national organization providing credibility and

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[2] Ms. Covington also states that URAC specifically requires that defendant Prudential disclose its criteria upon request by a patient or his or her physician.

prestige, are "other documents" and fall under 29 U.S.C. § 1024(b)(4). Thus, defendant's failure to provide the documents upon plaintiff's request was a violation of that statute.

In the alternative, plaintiff distinguishes defendant's cases, including *Doe*, on the fact that they involve plaintiffs seeking monetary damages rather than injunctive relief. Because plaintiff in the present law suit only seeks injunctive relief, plaintiff maintains, defendant's cases are inapposite. Defendant contends that this is a flawed distinction. The Court disagrees. Where a plaintiff simply seeks "to obtain other appropriate equitable relief" by requesting sufficient information to properly challenge the denial of a claim for benefits under an employee welfare benefit plan, the court may grant such injunctive relief. 29 U.S.C. § 1132(b)(3). This should be particularly true where defendant is not a named plan administrator, but instead is the sole arbiter of the claims, and where plaintiff for all practical purposes would have to sue himself to obtain information from defendant, through which plaintiff purchased the benefit plan in the first place.

Even if the review criteria were not "other documents" under § 1024(b)(4), the Court would have found that they are "pertinent documents" pursuant to 29 U.S.C. § 1133(2) and the accompanying regulation 29 C.F.R. §2560.503-1(g)(ii), as discussed further below.

2. A claims reviewer's credentials and rationale are "pertinent documents" under § 1133(2) and 29 C.F.R. § 2560.503-1(g)(ii)

Section 1133(2) provides, "[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." 29 U.S.C. § 1133(2). The accompanying regulation states that any plan's review procedure must allow "a claimant [to] . . . [r]eview *pertinent documents*." 29

C.F.R. §2560.503-1(g)(ii) (emphasis added).

The Tenth Circuit has not determined whether documents containing the identity, credentials and the reviewer's rationale are "pertinent documents" for purposes of ERISA. Defendant argues that § 1133(2) and the regulation applies only to the employee benefit plan and the plan administrator. Plaintiff has therefore, according to defendant, sued the wrong defendant. However, for the same reasons given above with respect to § 1024(b)(4), the Court finds that defendant is an ERISA fiduciary for purposes of § 1133(2) and § 2560.503-1. Nevertheless, defendant contends that even if it is found to be a fiduciary, the statute and regulation relied upon by plaintiff does not provide for the discovery of the reviewer's identity, credentials and rationale for denying the claim.

Again, the most analogous case directly on point is *Teen Help, Inc.* The *Teen Help, Inc.* court found that review criteria are "other documents" under § 1024(b)(4), but also found that documents containing medical reviewers' identity, credentials and rationale do not operate or manage the plan and do not fall under that section. Nevertheless, the court concluded that such documents should have been provided by defendant upon plaintiff's request under 29 U.S.C. § 1133(2), because "[w]ithout the medical reviewer's rationale, the claimant is left to shoot at a cloaked target and cannot deploy her arguments . . . [to] meaningfully address the administrator's concerns." 1999 WL 1069756, at *4. Similarly, the court found the medical reviewer's credentials to be essential to a beneficiary during the appeals process because "[t]he 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." *Id.* Consequently, the court held that documents containing the reviewer's rationale and credentials are "pertinent documents" and must be provided upon request pursuant to § 1133(2).

See id.

This Court agrees that a medical reviewer's identity, credentials and rationale are "pertinent documents" and should be disclosed upon request under § 1133(2) and § 2560.503-1(g)(ii). Defendant's refusal to provide these documents upon plaintiff's request was a violation of those sections.

D. Standing

Even if the Court finds that defendant is subject to ERISA as a fiduciary and the documents are discoverable under the various sections discussed above, defendant contends that this case should be dismissed because plaintiff does not have standing to bring the present lawsuit. When Eduardo Hernandez was admitted to Brightway, he executed an assignment of his ERISA rights to Brightway. As an assignor, defendant argues, plaintiff has no standing to bring this suit. Plaintiff replies that he has standing to sue because he is the guarantor of the amounts still owed to Brightway for Eduardo's treatment.

The assignment agreement states in § 3A that the Guardian, who is plaintiff in this case, assigned to Brightway all rights in the benefits payable for services rendered by Brightway. That same paragraph, however, also provides: "this assignment and transfer shall not take away [the Guardian's] standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s)." Plaintiff also agreed to guarantee payment for Brightway's services and "to make every reasonable effort to work" with his insurance company to ensure payment for the services provided by Brightway. The Court finds that plaintiff clearly has standing to bring this lawsuit under the terms of the assignment contract.

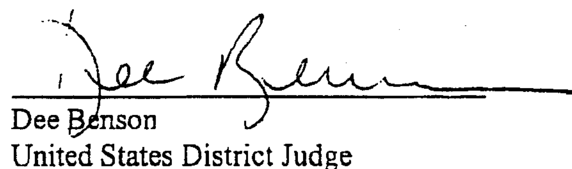
IV. Conclusion

The Court must deny defendant's summary judgment motion if plaintiff can prove any

set of facts that could entitle him to judgment when viewing the facts in the light most favorable to him. *See LaFoy v. HMO Colorado*, 988 F.2d 97, 98 (10th Cir. 1993). Under this standard, plaintiff has shown that defendant was bound to use the mental healthcare review criteria when determining whether treatment is medically necessary. The Court finds that such criteria are "other documents" for purposes of 29 U.S.C. § 1024(b)(4). As such, defendant should have disclosed the criteria upon plaintiff's request. Even if they were not "other documents," the documents are discoverable as "pertinent documents" under 29 U.S.C. § 1133(2) and 29 C.F.R. § 2560.503-1(g)(1)(ii). Similarly, viewing the evidence in the light most favorable to plaintiff, the Court finds that documents containing medical reviewers' identity, credentials and rationale for denying a claim are necessary for a full and fair review and are therefore "pertinent documents" under §§ 1133(2) and 2560.503-1(g)(1)(ii).

For the reasons stated above, the Court hereby DENIES defendant's Motion for Summary Judgment.

DATED this 27th day of March, 2001.



Dee Benson
United States District Judge