May 17, 2022

The Honorable Robert C. "Bobby" Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
U.S. House of Representatives
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Scott and Ranking Member Foxx,

Our organizations write in strong support of two critical provisions (Titles VI and VII) contained in the Mental Health Matters Act (H.R. 7780) that take important steps toward ensuring parity in coverage of mental health and addiction care and strengthening Americans' coverage rights under ERISA. We urge the Committee to pass these important provisions.

The Strengthening Behavioral Health Benefits Act (Title VI) would confirm the Department of Labor's ability to directly pursue parity violations by entities that provide administrative services to ERISA plans and would make it clear that ERISA beneficiaries who have had their claims wrongly denied in violation of the Mental Health Parity and Addiction Equity Act can recover amounts lost. While the Department believes that it has these authorities under current law, in its recent report to Congress, the Department explicitly called for Congress to give it these enforcement powers. Congress should ensure that no question exists about the Department's access to these important tools. We also strongly support the significant increase in resources that this bill would provide to the Employee Benefits Security Administration and the Solicitor of Labor to enforce protections under ERISA, including the Federal Parity Act.

Our organizations also urge the Committee to support the Employee and Retiree Access to Justice Act of 2022 (Title VII), which includes critical patient-protection provisions for the 136 million Americans enrolled in ERISA health plans. This legislation would prohibit ERISA plans from inserting provisions into plan policies that force beneficiaries into mandatory binding arbitrations, taking away their access to federal courts in order to protect their rights under ERISA. The expansion of these clauses threatens to undermine Americans' ability to challenge wrongful coverage denials in the courts. Congress must act to ensure that ERISA beneficiaries' rights are protected. In particular, arbitration clauses would require beneficiaries to bring individual arbitrations to challenge even widespread policies that adversely impact thousands of individuals. Not only would such an individual arbitration process provide no ability to compel insurers to alter their behavior, allowing even clear cut misconduct to continue across the board, but most beneficiaries would be unable to identify attorneys to bring the claim at all, given that attorneys would have no financial incentive to do so. Thus, binding arbitration would only serve the interests of the insurance companies at the clear expense of ERISA beneficiaries.

The Employee and Retiree Access to Justice Act also addresses the unfairness of ERISA plans requiring beneficiaries to litigate their claims subject to an impossibly high burden of proof. By

inserting "discretionary clauses" into their plan policies, ERISA plans grant themselves broad discretion to interpret the meaning of the terms of the policies they administer *and* the facts they consider when adjudicating benefits under these policies. Many ERISA plans use discretionary clauses as a strategy to evade liability for improperly denying benefits, particularly for mental health and substance use disorders, because discretionary clauses obligate courts to broadly defer to insurers' coverage determinations. (See *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)*.) Under the deferential standard of review, courts only reverse benefit denials that are found to be "arbitrary and capricious"—even if they are incorrect determinations. In contrast, under state law, where insurers are generally not deemed to be fiduciaries, such deference is not granted. Instead, courts apply the ordinary, civil standard of *de novo* review and reverse insurers' benefit determinations that are wrong on the merits.

Ironically, the discretion courts grant to ERISA fiduciaries based on the application of these discretionary clauses actually conflicts with the underlying purpose of ERISA. In adopting ERISA, Congress made clear that it was designed "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." (29 U.S.C. §1001(b)). Thus, while ERISA was intended to place a heightened duties on fiduciaries, discretionary clauses have instead shielded fiduciaries from accountability for their misconduct—a perverse result given the legislative history.

A recent example of the perverse impact of the judicially-created, deferential standard of review is *Wit v. United Behavioral Health,* No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019), *rev'd,* 2022 WL 850647 (9th Cir. Mar. 22, 2022), an ERISA case that has been recognized nationwide as a landmark for mental health patients. Despite a devastating 100-page plus trial decision, which found that United Behavioral Health had breached its fiduciary duties by placing its own financial interests over the needs of its beneficiaries by denying nearly 70,000 claims based on substandard medical necessity guidelines that conflicted with generally accepted standards of care ("GASC"), in express violation of plan terms and the laws of four states, a 9th Circuit panel recently reversed that decision in a sparse, 7-page decision.

In reversing this landmark decision, the panel completely ignored detailed and extensive findings of fact, including that UBH had lied to regulators about its medical necessity guidelines and that its financial officers had vetoed UBH clinicians' unanimous preference to use non-profit guidelines that would have complied with GASC solely because the change would cost more money for UBH. Instead, the panel reversed this important holding solely based on the standard of review, finding that it was "not unreasonable" for UBH to interpret its ERISA plans to allow it to apply medical necessity guidelines that were substantially more restrictive than generally accepted standards of care.

In other words, the panel did not determine if using medical necessity guidelines that were more restrictive than GASC was actually consistent with the plan terms, nor did it consider whether UBH's actions to place its own interest above that of its insureds violated its fiduciary

duties, but instead it simply deferred to UBH's conclusions. As a result, if allowed to stand, tens of thousands of insureds will lose their ability to challenge UBH's denials, and it – and other insurers – will be able to continue using overly restrictive medical necessity guidelines going forward. This proposed statute is required to prevent such a travesty from happening in the future.

Nationally, there is a clear movement by states regulating fully insured ERISA plans to ban discretionary clauses. In fact, the National Association of Insurance Commissioners (NAIC) has adopted a model law entitled the "Prohibition on the Use of Discretionary Clauses Model Act." The NAIC describes the purpose of the model act to prohibit discretionary clauses "to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide when benefits are due." Recognizing the pernicious effects of discretionary clauses in insurance policies, nearly half of states have banned these clauses.

Because discretionary clauses are a powerful tool that insurers have to self-justify coverage decisions, such clauses have become ubiquitous. Where they are allowed to stand, patients are at a terrible disadvantage in challenging wrongful denials of healthcare coverage. This is because, in turning to the courts to challenge wrongful denials of benefits, patients must overcome a very high evidentiary bar by proving that their insurers' determinations were "arbitrary and capricious." This is true even if courts believe that, on an equal weighing of the evidence, the insurers' determinations were inconsistent with the terms of the insurance policies and/or relevant facts known to the insurers. As the NAIC recognizes, this paradoxically means that coverage promised in insurance policies is not necessarily contractually guaranteed.

Federal Circuit Courts have articulated the unfairness that can result from applying a discretionary review in benefits cases, while various federal trial courts have noted that the standard of review in benefits matters is determinative and that the abuse of discretion standards of review permits incorrect outcomes. (See Appendix for a list of relevant cases.)

If discretionary clauses were prohibited for ERISA plans such outrageous scenarios would no longer be permitted, because patients would have their claims adjudicated using an equitable *de novo* standard of review (meaning from the beginning, or without deference to the insurer's decision). This standard means that courts give patients and insurers equal consideration when deciding whether the insurers' coverage determinations were wrongful. The evidentiary standards applied by courts in benefit cases are not academic. Time and time again, the effect of discretionary clauses is that patients have little or no recourse for wrongful benefit determinations.

We urge you to support providing critical clarity on the Department's powers and protecting the legal rights of Americans in ERISA plans, ensuring they can access federal courts and receive a fair hearing of their claims.

Sincerely,

American Foundation for Suicide Prevention
American Psychiatric Association
American Psychological Association
Depression and Bipolar Support Alliance
Eating Disorders Coalition
Families USA
The Kennedy Forum
Health Law Advocates
Mental Health America
Mom Congress
National Federation of Families
National Association for Behavioral Healthcare
National Health Law Program
Psychotherapy Action Network
REDC Consortium
SMART Recovery
Treatment Advocacy Center
2020 Mom

APPENDIX –
IMPORTANT FEDERAL CASES INVOLVING DISCRETIONARY CLAUSES

Federal Circuit Court Cases

Standard Ins. Co. v. Morrison, 584 F.3d 837, 845 (9th Cir. 2009) – more losses will be covered where de novo review results from discretionary ban.

Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 976 (9th Cir. 2006) – observing that discretionary language must be apparent since discretion can leave insureds "high and dry."

Cosey v. Prudential, 735 F.3d 16, 167–68 (4th Cir. 2013) – same.

Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000) – "The broader that discretion, the less solid an entitlement the employee has."

Fischer v. Liberty Life Assur. Co. of Bos., 576 F.3d 369, 376 (7th Cir. 2009) – ruling for insurer because under abuse of discretion review the court must defer to plan administrator's findings of fact.

Krolnik v. Prudential Ins. Co. of Am., 570 F.3d 841, 844 (7th Cir. 2009) – ruling for plaintiff under de novo review but noting that if discretionary review applied the insurer's decision "would be sustained easily."

Gibbs ex rel. Estate of Gibbs v. CIGNA Corp., 440 F.3d 571, 577–78 (2d Cir. 2006) – holding that the standard of review affects a participant's substantive rights, since abuse of discretion review allows a court to uphold erroneous decisions.

Brigham v. Sun Life of Canada, 317 F.3d 72, 86 (1st Cir. 2003) – explaining that though "it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled" the deferential standard of review permits it.

Federal Trial Court Cases

Robertson v. Blue Cross & Blue Shield of Texas, 99 F. Supp. 3d 1249, 1261 (D. Mont.), aff'd sub nom. *Robertson v. Blue Cross*, 612 F. App'x 478 (9th Cir. 2015) – "The masks of the law in this case conceals the person at risk of dying by a deferential standard of review and the rules of legal interpretation. The result is a determination that Blue Cross's denial of benefits was legally, but perhaps not morally, reasonable."

Criss v. Union Sec. Ins. Co., 26 F. Supp. 3d 1161, 1164 (N.D. Ala. 2014) – "In response to Bruch, an increasing number of states have adopted a statute or insurance industry rule that precludes the inclusion of the so-called "discretionary clause" in a disability insurance policy" and "have

accomplished in their states what Congress intended, namely, trials de novo for beneficiaries after they have been denied and unsuccessfully exhausted their internal plan remedies."

Morgenthaler v. First Unum Life Ins. Co., No. 03 CIV. 5941 (AKH), 2006 WL 2463656, at *3 (S.D.N.Y. Aug. 22, 2006) – describing its two contradictory rulings on Unum policies due to the different applicable standards of review.

Harrison v. UnitedHealth Grp., No. 2:16-CV-11406, 2018 WL 1528177, at *6 (S.D.W. Va. Mar. 28, 2018) – a court could disagree but must defer.

Fessenden v. Reliance Standard Life Ins. Co., No. 3:15CV370-PPS, 2018 WL 461105, at *1-6 (N.D. Ind. Jan. 17, 2018), vacated and remanded, 927 F.3d 998 (7th Cir. 2019) – deferential review means "the die was essentially cast" against insured's claim and "the claimant may lose even if a preponderance of the evidence supports a finding of disability, so long as the decision has "rational support in the record."

Hafford v. Aetna Life Ins. Co., No. 16-CV-4425 (VEC)(SN), 2017 WL 4083580 (S.D.N.Y. Sept. 13, 2017) – adopting Magistrate's facts but reversing and entering judgment in favor of insurer after concluding that the Magistrate had wrongly applied de novo review.

Rizzi v. Hartford Life & Acc. Ins. Co., 613 F. Supp. 2d 1234, 1249 (D.N.M. 2009), aff'd sub nom. *Rizzi v. Hartford Life & Acc. Inc. Co.*, 383 F. App'x 738 (10th Cir. 2010) – describing the court's role as "not to referee a battle of physicians or to decide whether Defendant's decision to terminate Plaintiff's LTD benefit payments was correct. It is simply to determine whether Defendant reasonably exercised its discretion and based its determination on substantial evidence."

Johnston v. Commerce Bancshares, Inc., 276 F. Supp. 3d 926, 939 (W.D. Mo. 2017), aff'd sub nom. *Johnston v. Prudential Ins. Co. of Am.*, 916 F.3d 712 (8th Cir. 2019) – "if the Court were the claims administrator, it might have reached a different conclusion" but holding the plan administrator did not abuse its discretion.

Graham v. L & B Realty Advisors, Inc., No. CIV.A. 3:02CV0293-N, 2003 WL 22388392, at *4 (N.D. Tex. Sept. 30, 2003) – outcome would be different under de novo review where court could perform its own fact-finding.

Deloach v. Great Atl. & Pac. Tea Co. LTD Plan, No. 09-14087, 2013 WL 363840, at *5 (E.D. Mich. Jan. 30, 2013) – "While it appears to the court that an examination of the administrator's actions for arbitrary and capricious decision making would result in a finding for defendants, under the de novo standard of review, the court is convinced that its weighing of the evidence requires reversal of Cigna's decision to terminate benefits."