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Key Takeaways From an ERISA Fiduciary Breach Ruling on Behavioral Standards of Care After a 10-Day Trial

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Behavioral health claims administrators and plan sponsors alike may be looking more closely at their care guidelines—and how they are applied—after a federal court ruled in a California class action that a claims administrator had breached its fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) by applying standards of care that were more restrictive than generally accepted standards and by improperly prioritizing cost savings.

Claims administrator United Behavioral Health (UBH) was unable demonstrate during a 10-day trial that its guidelines were created and applied in an effort to ensure that patients received care that is necessary and within generally accepted standards. Instead, the court found that the guidelines were applied for UBH's own gain and that claim reviewers were not allowed to deviate from those guidelines for the good of patients.

The March 5, 2019, ruling by Chief Magistrate Judge Joseph C. Spero came in a class action involving denied claims for mental health and substance abuse under both fully-insured and self-insured plans from 2011 to 2017. The case—*Wit v. United Behavioral Health*, No. 14-cv-02346-JCS (U.S. District Court for the Northern District of California)—was certified as a class action because the participants did not challenge the benefit determinations but instead asked the court to require UBH to reopen claims that had been adjudicated under the faulty guidelines. The UBH care guidelines were cited in each of about 10 claims denials highlighted by the court.

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Drawing from expert trial testimony and criteria set by the American Society of Addiction Medicine (ASAM) and other medical groups, the court set forth what it found were seven generally accepted standards of care in behavioral health cases. One of those standards is that "patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective." Another is that "effective treatment requires treatment of the individual's underlying condition and is not limited to the alleviation of the individual's current symptoms." The court ruled that the medical guidelines used in each of the individual cases violated generally accepted standards of care and that the claims administrator deviated from these generally accepted standards of care to save money.

The court found that an emphasis on cost-cutting tainted the development of the relevant internal guidelines. As an example, it pointed out that certain ASAM standards were not adopted by the relevant UBH committee only because the company's finance department would not sign off on the change.

Employers usually would not be closely involved in the development or application of this sort of clinical criteria, and claims administrators may be reluctant to turn over copies of their internal guidelines. Employers, though, may find that *Wit* will prompt them to renew requests for such guidelines and to ask some timely questions of

their behavioral health claims administrators.

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