

# Reminder that Your Benefit Claim Denial Letters Must Comply with ERISA

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**PRACTICES** Employee Benefits and Executive Compensation

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In our prior blog post available [here](#), we discussed the importance of ensuring that benefit claim denial letters comply with ERISA's requirements, and a recent case further illustrates the importance of complying with ERISA's procedural regulations. In *R.E. vs. Blue Cross Blue Shield of Illinois*, Blue Cross Blue Shield of Illinois ("**BCBS**") denied coverage under an employer's fully insured group health plan for an adolescent's stay in a residential treatment center for mental health issues, behavioral challenges, and substance abuse problems, with the claims totaling about \$390,000. The initial denial from BCBS was a verbal denial to the adolescent's parent (the "**Participant**"), with no accompanying written explanation behind the denial of benefits. On internal appeal, BCBS provided a decision in writing that upheld the initial denial but provided only ineligible reason codes to explain the denial. The letter contained no key for the decision codes and no references to the terms of the applicable group health plan. The Participant filed a claim for wrongful denial of plan benefits under ERISA.

The federal district court in Utah analyzed the initial denial and the denial on appeal against the statutory requirements for denying benefit claims. Both initial denial letters and appeal decision letters must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." On summary judgment, the court determined that the verbal denial and appeal letter both failed to meet these procedural requirements for sufficient communication to the Participant. The court remanded the case back to BCBS to conduct a full and fair review of the Participant's claim and awarded attorney's fees to the Participant.

The same issues could apply to a self-funded group health plan that uses BCBS or another entity as its third-party administrator ("**TPA**"). For self-insured plans, typically the administrative services agreement between the employer and the TPA requires the employer to indemnify the TPA in the event of litigation, with certain exceptions that may not apply in this type of situation. Employers should thus ensure that claims denial letters issued by their TPA comply with ERISA's claims review requirements, particularly if the employer is the responsible fiduciary under the plan and ERISA.

The opinion in *R.E. vs. Blue Cross Blue Shield of Illinois* is available [here](#).