Your TPA’s Form Denial Letters May Violate ERISA

June 6, 2023

PRACTICES ERISA and Other Benefits Litigation, Employee Benefits and Executive Compensation

A recent Tenth Circuit case highlights ERISA’s requirement that benefit claim denial letters must contain reasoned explanations for the denial and address any supporting evidence provided by the claimant. Specifically, the U.S. Court of Appeals for the Tenth Circuit ruled that United Behavioral Health (***“United”***), as the third-party claims fiduciary for an employer-sponsored group health plan, acted “arbitrarily and capriciously” under ERISA by not adequately engaging with the opinions of a participant’s physicians and in not providing its reasoning for the denial of medical benefits in its claim denial letters.

United argued that, even if it was required to address the medical opinions provided by the claimant, it did so as evidenced by its internal notes. The Tenth Circuit determined that the federal district court below properly limited its review to the denial letters, not United’s internal notes or other evidence, and that United must engage in reasonable, meaningful dialogue in its correspondence addressing the denial of benefit claims. United’s denial letters did not mention or address the treating physicians’ opinions, despite the participant’s request for an explanation of what consideration was given to them. In addition, the court found that United’s denial letters included only conclusory statements, and United acted arbitrarily and capriciously in not providing analysis or citations to the medical record in its denial letters. The court concluded that, considering United’s clear and repeated procedural errors in denying the claim, it would be contrary to ERISA’s fiduciary duty principles to remand the case for further consideration by the district court. Thus, the Tenth Circuit affirmed the district court’s award of benefits to the claimant.

Use of a stock or form denial letter or any denial letter that is not customized to particular circumstances and that fails to include a reasonable discussion of the claimant’s medical records and treating physician opinions could result in an award of benefits under the plan in a situation where the claim may otherwise have been denied under the plan’s terms.

Employers should seek assurances from their third-party administrators (***“TPAs”***) to the effect that their claims appeal procedures include adequate consideration of any evidence provided to support claims, and that consideration of such evidence is reflected in the TPA’s denial letters, and not solely in the TPA’s internal notes. Employers should also be aware of their fiduciary duty under ERISA to monitor their service providers to ensure they are properly administering the plan’s claims and appeal procedures in accordance with ERISA. Complaints directly from participants or from a participant’s attorney regarding a denial of benefits should be researched to ensure that an adequate explanation of the denial is provided, as required by ERISA.

The case is *D.K. et al. v. United Behavioral Health et al.,* 2023 U.S. App. LEXIS 11794, 2023 WL 3443353 (10th Cir. May 15, 2023) is available here.

© 2026 Haynes Boone