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Exhausting and Futile: Understanding the Futility Exception to Exhaustion of Administrative Remedies in Health Plan Litigation

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In this article, the authors explain that most recent caselaw demonstrates that exhaustion of plan remedies remains a powerful argument for insurers/administrators and a necessary requirement for insureds/providers. They add that the futility exception provides one method of excusing the exhaustion requirement, but that plaintiffs must prove futility by a clear and positive showing.

At its core, health plan litigation involves review of a health plan's benefits determinations to assess whether those determinations are consistent with the terms of the health plan itself. However, reaching the point where this assessment can be made in court, may be difficult as health plan beneficiaries must comply with several requirements prior to filing suit, including, satisfaction of health plan administrative remedies. The health plan administrative remedies provide plan beneficiaries with a mandatory requirement to challenge benefits decisions outside of litigation. If a beneficiary tries filing suit without satisfying with the plan's remedies, their lawsuit may be dismissed.

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This process is referred to as “exhaustion of administrative remedies” and can result in early dismissals of health plan lawsuits. Courts across jurisdictions though have found exceptions to the exhaustion requirement, including that exhaustion of remedies would be “futile.” This exception can provide beneficiaries with a work around in the event administrative remedies were not complied with, making it essential for beneficiaries, health plans, and their counsel to understand the procedures.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

ERISA requires health benefit plans to establish and maintain reasonable claims procedures, including procedures pertaining to appeals of adverse benefit determinations.¹ “A claimant who is denied benefits under an ERISA plan must exhaust all administrative remedies afforded by the plan before instituting litigation for recovery of benefits.”² Exhaustion of remedies under ERISA is a court-imposed requirement that is intended to “minimiz[e] the number of frivolous ERISA suits, promot[e] the consistent treatment of benefit claims, provid[e] a nonadversarial dispute resolution process, and decreas[e] the time and cost of claims settlement.”³ Under certain circumstances, a court may deem the exhaustion of remedies requirement excused, after which courts may evaluate whether the plan beneficiary was entitled to benefits.⁴ The most common administrative remedy provided by health plans is an appeal remedy. That is, health plans typically require plan participants to submit one or more appeals of benefits determinations prior to filing litigation. Courts have established various exceptions to the exhaustion of plan remedies requirements over the years. One such exception accepted in most jurisdictions is the “futility” exception.

THE FUTILITY EXCEPTION

The futility exception may excuse a plan beneficiary from “pursu[ing] an administrative review that is demonstrably doomed to fail.”⁵ To establish the futility argument, the plan beneficiary must establish by a “clear and positive” showing that complying with their plan’s mandatory remedies would be futile prior to commencing litigation.⁶ This clear and positive showing requires more than “bare allegations of futility,” as the insured is requesting the court to waive the requirements of the underlying benefits plan.⁷ Courts have analyzed the futility exception throughout the years, finding that various circumstances may rise to the level of permitting waiver of a benefits plan’s administrative requirements.

HOW HAVE COURTS APPLIED THE FUTILITY EXCEPTION?

The futility exception is applied across a majority of jurisdictions. Understanding the circumstances under which courts have and have not permitted the exception in recent years is instructive when considering whether plan beneficiaries may pursue their claims in court despite failing to comply with plan administrative requirements.

*Gordon Surgical Group, P.C., et al. v. Empire HealthChoice HMO, Inc., et al.*⁸ demonstrates that bare allegations of futility in appealing denied claims are not sufficient to excuse noncompliance with the exhaustion requirement. The case involved a suit filed by out-of-network surgical providers against the health plan administrators of numerous patients' health plans for alleged improper denials and underpayments for hundreds of claims in violation of ERISA.⁹ The plan administrators moved to dismiss, arguing, in relevant part, that the surgical providers had failed to exhaust the administrative remedies provided for under the plan by failing to complete each level of appeal required by each health plan.¹⁰ As to the hundreds of claims at issue, the plaintiffs provided evidence to rebut the motion to dismiss indicating appeals of certain claims and general follow-up discussions after these appeals.¹¹ The plaintiffs argued, without providing evidence, that they had initially appealed all of the claims at issue and followed up with correspondence that went nowhere.¹² The plaintiffs raised the futility defense on this basis.¹³ The court found these general allegations insufficient to support a futility defense, particularly as the plaintiffs had not provided evidence supporting any initial appeal or follow-up correspondence for hundreds of the claims at issue.¹⁴ The court rejected the futility defense on this basis and granted dismissal.¹⁵

The *Martinez v. Prudential Insurance Company of America*¹⁶ case demonstrates the importance some courts place on hostility from the health plan to the provider or insured in demonstrating futility. *Martinez* involved a complaint filed by a plan beneficiary against their insurer for wrongful denial of long-term disability benefits under ERISA.¹⁷ The insurer moved for summary judgment arguing, in relevant part, that the beneficiary had failed to exhaust the plan's administrative remedies by failing to appeal the plan's claim denials.¹⁸ The beneficiary countered that appealing the claims determinations would be futile as evidenced by written correspondence from the beneficiary claiming the administrative record was insufficient to file an appeal.¹⁹ The court rejected this argument finding that, even if this correspondence did demonstrate futility (which the court did not necessarily find), the beneficiary sent this correspondence well after the deadline to appeal under the plan had expired.²⁰ The court also considered

that, in the insurer's correspondence with the beneficiary, there was a complete lack of any hostility or bias demonstrated toward the beneficiary.²¹ The court found this particularly persuasive and granted summary judgment on these bases.²²

In *Ligotti v. United Healthcare Services, Inc., et al.*,²³ the Southern District of Florida considered whether a history of claim denials by the defendant-insurer/administrator for the same type of service at issue may support the futility argument and waive exhaustion of administrative remedies. The case involved a physician and their private practice, which filed suit against the claims administrator for claims submitted by numerous patients on the basis that the claims were wrongfully denied.²⁴ The defendant moved for summary judgment arguing, in relevant part, that the plaintiff and/or their patients had failed to exhaust administrative remedies by failing to complete the plans' appeals processes.²⁵ The plaintiffs relied, in part, on the futility argument, by raising for the court the fact that the defendant had denied all prior appeals on other claims it had submitted for the same services.²⁶ The court was unpersuaded, explaining that the defendant had not conceded these appeal denials were wrongful and the plaintiffs had failed to satisfy their burden to establish futility by a clear and positive showing.²⁷ The court ultimately granted summary judgment.²⁸

In *Wilson v. UnitedHealthcare Insurance Company*,²⁹ the Fourth Circuit Court of Appeals considered one of the more common arguments for futility – the insurer/administrator's failure to provide plan documents upon request. The case pertained to the defendant-health plan administrator's denial of the plaintiff-insured's claim for residential treatment for the insured's son on the basis of medical necessity.³⁰ The insured filed suit for wrongful denial of benefits.³¹ The administrator moved for dismissal for failure to exhaust administrative remedies, which was granted.³² On appeal, the plaintiff argued that, prior to filing suit, its counsel had submitted a HIPAA authorization form to the plaintiff's insurer and requested relevant plan documents to allow them to appeal.³³ The plan administrator did not respond to these inquiries and later claimed it did not respond because the HIPAA authorization form was not correctly completed.³⁴ On this basis, the insured argued that exhausting administrative remedies was futile.³⁵ The Fourth Circuit Court of Appeals agreed, find that, even if the HIPAA authorization form was correct, the correspondence between the plaintiff's counsel and the administrator was sufficient to put the administrator on notice of the plaintiff's intent to appeal and the administrator, consistent with their fiduciary obligations, should have notified the plaintiff of the errors with the authorization form.³⁶ Accordingly, the court found exhaustion to be futile and reversed the lower court's order granting dismissal.³⁷

In *Hendricks v. Aetna Life Insurance Company*,³⁸ insureds of the defendant-health plan filed a class action lawsuit for denial of benefits for coverage of lumbar artificial disc replacement surgery as investigational or experimental.³⁹ The insureds moved to certify the class and the insurer opposed on several grounds, including that the insureds had not satisfied their respective health plan's administrative remedies by failing to appeal each claim and, therefore, the plaintiffs' claims are not typical for class certification purposes.⁴⁰ In considering this argument, the court reviewed the plaintiffs' evidence of voluminous correspondence with the insurer, requesting reconsideration of its claim denials for this specific service, in which the insurer repeatedly relied on the same external guidance and supported its determination on the same basis.⁴¹ The court reasoned that, because the insurer was repeatedly relying on its interpretation of the same external policy and reaching the same conclusion, appeals by the plaintiffs would have been futile.⁴² The court found the plaintiffs were excused from exhausting plan remedies and found the plaintiffs had established typicality for class certification purposes.⁴³

CONCLUSION

The most recent caselaw demonstrates that exhaustion of plan remedies remains a powerful argument for insurers/administrators and a necessary requirement for insureds/providers. The futility argument provides one method of excusing the exhaustion requirement, but plaintiffs must prove futility by a clear and positive showing. Caselaw demonstrates that plaintiffs may be able to make such a showing if the health plan or administrator ignored requests for plan information, particularly when an anticipated appeal is mentioned, and if there is a strong history of the insurer denying the same claims on the same basis in reliance on an external policy. In other circumstances, the futility argument may not be available and exhaustion is likely required.

NOTES

1. 29 C.F.R. § 2560.503-1(b).
2. *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256 (5th Cir. 2005).
3. *Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997).
4. *Riggs v. Ballard Tire & Oil Co. Pension Plan & Tr.*, 979 F.2d 848, 1992 WL 345584, at *2 (4th Cir. 1992).
5. *Diaz v. United Agr. Emp. Welfare Ben. Plan & Tr.*, 50 F.3d 1478, 1485 (9th Cir. 1995).

6. *Id.*
7. *Makar v. Health Care Corp. of Mid-Atlantic (CareFirst)*, 872 F.2d 80, 82 (4th Cir. 1989); see *Hickey v. Digital Equip. Corp.*, 43 F.3d 941, 945 (4th Cir. 1995) (rejecting an assertion of futility when claimant did not file a written claim and alleged, with no further foundation, that doing so would have been “a mere formality if not a charade”).
8. 724 F.Supp.3d 158 (S.D. NY Mar. 14, 2024).
9. *Id.* at 164.
10. *Id.* at 164-65.
11. *Id.* at 167-68.
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.* at 168.
16. 615 F.Supp.3d 519 (S.D. Tex. Jul. 14, 2022).
17. *Id.* at 524-25.
18. *Id.* at 525, 529.
19. *Id.* at 531-33.
20. *Id.*
21. *Id.* at 534-35.
22. *Id.* at 534-35.
23. 542 F.Supp.3d 1301 (S.D. Fla. Jun. 8, 2021).
24. *Id.* at 1305.
25. *Id.*
26. *Id.* at 1330-31.
27. *Id.*
28. *Id.* at 1335.
29. 27 F.4th 228 (4th Cir. 2022).
30. *Id.* at 232.
31. *Id.*
32. *Id.*
33. *Id.* at 241-43.
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.* at 252.
38. 339 F.R.F. 143 (C.D. Cal. Jun. 11, 2021).

39. Id. at 146-47.

40. Id. at 150.

41. Id.

42. Id.

43. Id.

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