THE HONORABLE JOHN C. COUGHENOUR

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

CONTINENTAL MEDICAL TRANSPORT LLC, d/b/a JET RESCUE, Plaintiff, v. HEALTH CARE SERVICE CORPORATION, d/b/a BLUE CROSS BLUE SHIELD OF ILLINOIS, *et al.*, Defendants.	CASE NO. C20-0115-JCC ORDER

This matter comes before the Court on the parties' respective motions for summary judgment (Dkt. Nos. 30, 35) and motions to seal (Dkt. Nos. 28, 33). Having thoroughly considered the briefing and the relevant record, the Court finds oral argument unnecessary and hereby DENIES Plaintiff's motion for summary judgment (Dkt. No. 35), GRANTS Defendants' motion for summary judgment (Dkt. No. 30), and GRANTS the parties' motions to seal (Dkt. Nos. 28, 33) for the reasons explained herein.

I. BACKGROUND

Plaintiff is a provider of "long-range international air ambulance" services. (Dkt. No. 1 at 2.) In July 2016, it transported D.O., a U.S. resident, from Lima, Peru to Miami, Florida for critical medical care to be rendered at Jackson Memorial Hospital. (*Id.*) D.O. initially fell ill

while travelling in Peru on July 10, 2016. (*Id.* at 5.) Shortly after, he arrived at Clinica Delgado, a 150-bed general hospital located in Lima, which Plaintiff describes as "one of the newest and most advanced hospital facilities in South America." (*Id.* at 5.) Nevertheless, D.O.'s physicians at Clinica Delgado and his representative in Peru decided to transfer D.O. to Jackson Memorial Hospital for additional care. (*Id.* at 5–6.) D.O. passed away on July 27, 2016, approximately five days after arriving in Miami. (*Id.* at 6.)

At the time of the transfer, D.O. was a participant in the Boeing Company's Consolidated Health and Welfare Benefit Plan ("Boeing Plan"), which Blue Cross Blue Shield of Illinois ("BCBS") administered. (*Id.*) The Boeing Plan is an ERISA-governed plan that expressly covers medically necessary air ambulance services. (*See* Dkt. No. 29 at 94.) Plaintiff presented charges to BCBS for the air ambulance services that it rendered to D.O. of $536,540, which Plaintiff asserted was the "usual, customary, and reasonable charge" for such services. (Dkt. No. 1 at 2.) BCBS denied the claim in December 2016. (*Id.* at 11.) Plaintiff, on behalf of D.O.'s estate,[1] internally appealed BCBS's denial through two successive appeals in 2018 and 2019. (*Id.* at 12–14.) In each instance, BCBS upheld the denial based upon its finding that the flights were the product of a "family preference" rather than medical necessity. (*Id.*) Plaintiff then sought external review by an Independent Review Organization ("IRO"), which agreed with BCBS's determination that the flight was not medically necessary. (*Id.* at 15.)

Following its unsuccessful appeals, Plaintiff brought suit against the Boeing Plan and BCBS in this Court. (*See generally id.*) Plaintiff seeks benefits allegedly due to it, on behalf of D.O.'s estate, under the terms of the Boeing Plan pursuant to 29 U.S.C. § 1132(a)(1)(B), along with attorney fees and costs. (*Id.* at 16–17.) Plaintiff also sought equitable relief pursuant to 29 U.S.C. § 1132(a)(3), (*see id.* at 17–18), but has since affirmatively withdrawn this claim, (*see*

[1] Prior to the flight, D.O.'s ex-wife, who was travelling with him in Peru and served as his representative for the medical decisions made in Peru, allegedly authorized the flight and executed a limited power of attorney and an assignment of benefits that authorized Plaintiff to seek reimbursement of the air ambulance services on D.O.'s behalf. (*See* Dkt. No. 1 at 8.)

Dkt. No. 36 at 2). Presently before the Court are Plaintiff's and Defendants' motions for summary judgment on Plaintiff's remaining ERISA-based claim, (*see* Dkt. Nos. 30, 35), as well as related unopposed motions to seal, (*see* Dkt. Nos. 28, 33).

II. DISCUSSION

The Employment Retirement Income Security Act of 1974 ("ERISA") allows a plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

A. Standard of Review

In an ERISA case, a motion for summary judgment is "the conduit to bring [that] legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply." *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 942 (9th Cir. 1999). The Court reviews a plan administrator's denial of benefits "under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). When a plan does give the administrator that discretion, the Court reviews a denial of benefits for an abuse of discretion. *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 629 (9th Cir. 2009). Whether an administrator abused its discretion is a question of law, not fact. *Nolan v. Heald Coll.*, 551 F.3d 1148, 1154 (9th Cir. 2009).

It is undisputed that the Plan Administrator here had the authority to determine benefit eligibility and to construe the terms of the plan. (*Compare* Dkt. No. 30 at 11, *with* Dkt. No. 35 at 12.) This is also consistent with the Plan Supplement and the Master Welfare Plan ("MWP"). (*See* Dkt. No. 29 at 76 (Plan Supplement indicating that the "Plan Administrator has the exclusive right . . . to administer, apply, construe, and interpret the Plan"), Dkt. No. 29-12 at 51

(MWP indicating that the "Plan Administrator's powers include full discretionary authority to interpret the Plan").)

In this instance, it was not the Plan Administrator, but BCBS who made both the initial coverage decision and subsequent decisions denying Plaintiff's internal appeals. (Dkt. No. 1 at 11–14.) Therefore, at issue is whether the Plan Administrator effectively delegated its authority to BCBS. *See Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1283–84 (9th Cir. 1990). An effective delegation is one that is done in a manner consistent with the Plan. *See Shane v. Albertson's Inc.*, 504 F.3d 1166, 1171 (9th Cir. 2007) ("[T]he focus should [be] on whether the [] Plan contemplated the possibility of a transfer of discretionary authority to a third-party and whether there was evidence establishing [the] delegation.").

According to the MWP, the Plan Administrator may delegate its duties "in whatever manner and extent it chooses . . . [but a]ny allocation or delegation . . . will be in writing, approved by a majority vote." (Dkt. No. 29-12 at 52.) This vote occurred at the December 18, 2009 Employee Benefit Plan Committee meeting. (*See* Dkt. No. 38-1 at 2 (meeting minutes memorializing the decision and indicating the change is to occur no earlier than January 1, 2011).[2]) BCBS's delegation is consistent with the January 1, 2011 Administrative Services Agreement between BCBS and the Boeing Company, which provided BCBS with the "discretionary authority to administer claims in accordance with [the Plan] and to make initial claim determinations concerning the availability of Plan benefits and final review and benefit determinations for appealed Claims." (Dkt. No. 29-11 at 53.) It is also consistent with the Summary Plan Description, notifying Plan participants that BCBS handles "the day-to-day administration of the plan" including "mak[ing] benefit decisions" and "process[ing] claim appeals." (Dkt. No. 29-9 at 24.)

[2] The Court may consider evidence outside of the administrative record to determine the appropriate standard of review. *See Tremain v. Bell Industries, Inc.*, 196 F.3d 970, 977 (9th Cir. 1999).

Plaintiff argues that any such delegation, to the extent it was effective, did not extend to the IRO who provided the external review in this case. (Dkt. No. 35 at 15.) Therefore, according to Plaintiff, the Court must review the overall denial decision *de novo*. (*Id.*) The Court disagrees. As it has previously indicated, an affirmation of an internal benefit decision by an external IRO only serves to validate the internal decision. *Peter B. v. Premera Blue Cross*, 2017 WL 4843550, slip op. at 5 (W.D. Wash. 2017). The external review process does not convert this Court's review of a Plan Administrator or designee's discretionary decision to a *de novo* review. *See Yox v. Providence Health Plan*, 659 F. App'x 941, 944 (9th Cir. 2016) (reviewing a decision by a plan administrator that was upheld by an IRO for an abuse of discretion). To conclude otherwise would render *Firestone* deference meaningless, in light of the Affordable Care Act's requirement for external reviews. *See* Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,208, 37,210–11 (June 24, 2011) (to be codified at 45 C.F.R. pt. 147.)

The Court FINDS that in this instance the Plan Administrator effectively delegated its discretionary authority for making benefit determinations to BCBS. Accordingly, the Court will review BCBS's benefit determinations for an abuse of discretion.

B. Review of BCBS's Denial Decisions

The dispositive issue here is whether it was reasonable for BCBS to conclude that it was not medically necessary to transport D.O. by air ambulance from Clinica Delgado to Jackson Memorial Hospital between July 21 and July 22, 2016. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989) (applying a reasonableness calculus to an abuse of discretion review). A decision is unreasonable if it is "(1) illogical, (2) implausible, or (3) without support in inferences that may be drawn from the facts of the record." *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 676 (9th Cir. 2011). In assessing the reasonableness of a decision, the Court "consider[s] all of the relevant circumstances in evaluating the decision by the plan administrator" or its designee. *P. Shores Hosp. v. United Behavioral Health*, 764 F.3d 1030,

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