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Failing to Heed ERISA's Claims Procedure: A Fast-Track to Court and De Novo Review

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Individuals denied benefits under an ERISA-governed plan must exhaust the plan's administrative remedies before going to court. However, in limited instances, a plaintiff can forego the claims procedure process, thereby obtaining a fast-track to litigation. In so doing, the plaintiff will cause a critical shift in the standard a court will apply to assess an administrator's decision to deny benefits.

This article explores those situations in which a plaintiff can shorten the process to challenge a denial of benefits and, at the same time, switch the court's standard of review from arbitrary and capricious to de novo.

What Are Claims Procedures and What Happens if the Plan Fails To Adopt One?

To protect the interests of participants and beneficiaries, ERISA requires every employee benefit plan to adopt a claims procedure that provides for (a) written notice setting forth the basis for any decision to deny benefits, and (b) a reasonable opportunity for a full and fair review of any benefits denial. ERISA §503.

In 2000, the Department of Labor rehauled its regulations to establish detailed *minimum* requirements that govern every claims procedure (DOL Regulations). 29 C.F.R. §2560.503-1. For example, the DOL Regulations require the plan administrator to give the claimant written notification stating the specific reason(s) for an adverse determination, the specific plan provision(s) on which the determination was based, a description of additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information would be necessary, and a description of the plan's review procedures and applicable time limits, including the right to commence an action under the civil enforcement provisions of ERISA. 29 C.F.R. §2560.503-1(g)(1)(i)-(iv).

In limited instances, a plaintiff can forego the claims procedure process, thereby obtaining a fast-track to litigation. In so doing, the plaintiff will cause a critical shift in the standard a court will apply to assess an administrator's decision to deny benefits.

The DOL Regulations also require every claims procedure to have an appeals process. 29 C.F.R. §2560.503-1(h)(1). At minimum and prior to any appeal, a participant or beneficiary

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must be provided, upon request and free of charge, any document, record, or information relied upon in making the benefits determination or submitted, generated, or considered in the course of making the benefits determination. 29 C.F.R. §2560.503-1(h)(2)(iii); 29 C.F.R. §2560.503-1(m)(8). Thereafter, a claimant must be given a reasonable opportunity to submit comments, documents, and records on appeal. 29 C.F.R. §2560.503-1(h)(2)(iv).

If a plan fails to establish a claims procedure (sometimes the result of a failure to amend an old plan after the DOL Regulations were revised), its participants and beneficiaries are deemed to have exhausted their administrative remedies. 29 C.F.R. §2560.503-1(l)(1). In other words, they may proceed with an ERISA action in federal court.

What Happens When a Plan Adopts a Claims Procedure But Fails To Adhere to It?

The DOL Regulations also provide that if a plan adopts a claims procedure but fails to follow it, then the affected participant and beneficiary are relieved of their obligations to exhaust their administrative remedies. 29 C.F.R. §2560.503-1(l)(1). A circuit split exists over whether a plan administrator must strictly comply with the claims procedure or whether substantial compliance is sufficient.

The U.S. Court of Appeals for the First, Fifth, Sixth, Eighth, and Tenth Circuits have held that substantial compliance with the DOL Regulations is sufficient so long as a claimant is supplied with clear reasons for the benefits denial so as to permit a meaningful appeal. *Niebauer v. Crane & Co.*, 783 F.3d 914, 927 (1st Cir. 2015); *Mirza v. Ins. Adm'r of Am.*, 800 F.3d 129, 136 (3d Cir. 2015); *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256-57 (5th Cir. 2005); *Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 436 (6th Cir. 2006); *Grasso Enterprises v. Express Scripts*, 809 F.3d 1033, 1038 (8th Cir. 2016); *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1317 (10th Cir. 2009).

In fact, the First Circuit requires a plaintiff to establish prejudice when arguing the administrator failed to provide adequate notice. *Niebauer*, 783 F.3d at 927 (citing *Bard v. Bos. Shipping Ass'n*, 471 F.3d 229, 240-41 (1st Cir. 2006)).

In contrast with its sister circuits, the U.S. Court of Appeals for the Second Circuit rejects the substantial compliance standard and instead requires strict compliance with the DOL Regulations. As explained in *Halo v. Yale Health Plan, Dir. of Benefits & Recs. Yale Univ.*, 819 F.3d 42 (2d Cir. 2016), when the 1977 version of the DOL Regulations had been in force, a number of courts applied a substantial compliance standard on the theory that it would be unduly harsh to strip a plan administrator of a deferential review as a penalty for a minor procedural violation. Id. at 56.

But the DOL rejected the substantial compliance doctrine when it amended the DOL Regulations in 2000, leaving courts no choice, according to the Second Circuit, but to reject that doctrine, too. Id. Accordingly, *Halo* held that a claimant will be deemed to have exhausted its administrative remedies and may proceed directly to court when a plan fails to comply strictly with its claims procedures. Id. at 57.

Importantly, the rule in *Halo* is not absolute. Even within the Second Circuit, hyper-technical arguments over non-compliance will not suffice. If a plan responds to a benefit request within 73 hours instead of a required 72 hours, for example, a claimant may not dispense with the claims procedure process and rush to court. Id. But the onus will be on the administrator to show that its technical failure was inconsequential; careful that an allowance for slight flexibility could be used to swallow its strict compliance rule, *Halo* requires the plan to show a minor deviation from the claims procedure was inadvertent *and* harmless before its failure to comply strictly may be excused. Id.

The U.S. Court of Appeals for the Seventh Circuit agrees with the holding in *Halo* to a point. In *Fessenden v. Reliance Standard Life Ins. Co.*, 927 F.3d 998, 1003-04 (7th Cir.

2019), it held that strict compliance is required with respect to deadlines set forth in the DOL Regulations. See id. at 1004 ("Substantial compliance with a deadline requiring strict compliance is a contradiction in terms."). It left for another day to decide whether substantial compliance suffices with respect to other aspects of the DOL Regulations or a plan's claim procedures. Id. at 1003.

The Standard of Review: De Novo or Arbitrary and Capricious?

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), the U.S. Supreme Court held that a plan's denial of benefits decision shall be reviewed de novo unless the plan administrator or other fiduciary making the decision is vested with discretionary authority to interpret and apply the plan's terms, in which case a court shall apply an arbitrary and capricious standard.

As a result of *Firestone*, plans today will typically grant discretionary authority to a plan administrator or other fiduciary so as to obtain the more favorable standard of review in the event a benefits denial is challenged.

However, the benefit of an arbitrary and capricious standard will be lost if the administrator or other fiduciary fails to comply with the plan's claims procedure. *Halo*, 819 F.3d at 60-61. This shift cannot be understated. An administrator's decision will fail under the arbitrary and capricious standard only if it is without reason, unsupported by substantial evidence, or erroneous as a matter of law. *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003).

Through this lens, the administrator's decision need only be supported by substantial evidence, defined as "more than a scintilla but less than a preponderance[.]" *Mayer v. Ringler Assocs.*, 9 F.4th 78, 89 (2d Cir. 2021) (quoting *Celardo v. GNY Auto. Dealers Health & Welfare Tr.*, 318 F.3d 142, 146 (2d Cir. 2003)).

On the other hand, under the de novo standard, courts will independently interpret a plan's terms, determine relevant facts, and apply those facts to the plan. *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 245 (2d Cir. 1999) ("[T]he de novo standard of review applies to all aspects of the denial of an ERISA claim, including fact issues[.]"). Courts will not give deference to an administrator's prior decision and may even look outside the record presented to the administrator if they determine good cause exists. *DeFelice v. Am. Int'l Life Assur. Co. of New York*, 112 F.3d 61, 66-67 (2d Cir. 1997).

Conclusion: Final Thoughts.

When challenging a benefits denial, a claimant can forgo a plan's administrative remedies and proceed directly to court if the plan's terms fail to satisfy the DOL Regulations or if the plan's administrator fails to comply with the plan's terms; the Second Circuit requires strict compliance as does the Seventh Circuit, in part, whereas several other circuits require substantial compliance.

A litigant permitted to leap into court under these circumstances will be afforded a de novo review. Thus, the litigant will not only be able to minimize the time and expense associated with a benefits challenge but will also escape a standard of review that would otherwise be highly deferential toward an administrator's denial of benefits.