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# When Close Is Not Good Enough: A Shift Towards Strict Compliance for ERISA Claim Procedures

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A string of cases in the Second Circuit Court of Appeals is putting ERISA claims administrators on notice that falling short of strict compliance with the Department of Labor's (DOL's)claims and appeal regulations may cost administrators a deferential standard of review. And, this shift towards "strict compliance" is not limited to the Second Circuit. Under the DOL's final regulations governing disability benefit claims, if a plan fails to strictly comply with the new disability claims regulations, a claimant may file a civil suit under ERISA Section 502(a) immediately without exhausting the plan's administrative remedies and the plan administrator's benefit determination will be subject to *de novo* review.[1] In light of the Second Circuit's and DOL's positions favoring "strict compliance," the recent cases offer some lessons about the types of violations that may cause a plan administrator to lose its deferential standard of review.

## Background

Normally, if ERISA plan documents grant the plan administrator (or appropriate claims fiduciary) discretionary authority to interpret the plan's terms, the court will review a denial of plan benefits under the "arbitrary and capricious" standard of review. This means that the court generally gives deference to the plan administrator's determination of benefits during the administrative process. However, a plan administrator can lose this deferential standard of review if it fails to establish or follow reasonable claims and appeal procedures. As a result, the court may apply a *de novo* standard of review, which does not provide deference to the plan administrator's prior findings and benefit determinations.

Generally, a plan that has properly vested the administrator with discretionary authority over benefit determinations will receive the benefit of the "arbitrary and capricious" standard of review if the plan "substantially complies" with the DOL's claims-procedure regulations. In a departure from this "substantial compliance" doctrine, the Second Circuit has adopted a "strict compliance" requirement regarding claims and appeal procedures.

## Second Circuit Requires Strict Compliance in *Halo*

In *Halo v. Yale Health Plan*, 819 F.3d 42 (2nd Cir. 2016), the Second Circuit held that "a plan's failure to comply with the [DOL's] claims-procedure regulations...will result in that claim being

reviewed *de novo* in federal court" unless the plan administrator can demonstrate that the failure to comply was "inadvertent and harmless." The Second Circuit rejected the district court's application of the "substantial compliance" doctrine, under which the district court held that the Yale Health Plan's denial of benefits was entitled to the "arbitrary and capricious" standard of review. The plaintiff in *Halo* alleged that the administrator of the Yale Health Plan had violated the DOL claims-procedure regulation as to (1) the timing of benefit determinations, and (2) the content of the determination notices. The Second Circuit remanded the case for the district court to apply the "strict compliance" doctrine in its analysis of the applicable standard of review (*de novo*, or arbitrary and capricious).

### *Salisbury v. Prudential Insurance*

On February 28, 2017, the Southern District of New York issued a decision that surprised many plan sponsors and administrators in its application of the "strict compliance" doctrine set forth in *Halo*. In *Salisbury v. Prudential Ins. Co. of Am.*, 2017 WL 780817 (S.D.N.Y. Feb. 28, 2017), the court held that the insurer violated the DOL claims-procedure regulations because it failed to properly establish the "special circumstances" that warranted an extension of time to decide an appeal of long-term disability benefits. As a result, the court conducted a *de novo* review of the insurer's denial of benefits.

The DOL claims-procedure regulations generally require a plan to deny a participant's disability benefit appeal within 45 days; however, the rules allow a 45-day extension if the "plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim."[2] To invoke the extension, the plan administrator must provide the claimant with a written notice of the extension before the first 45-day period ends, and the notice must "indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review."

Although Prudential provided the plaintiff written notice of the extension before the original 45-day period had expired, the only justification for the extension was that additional time was "required to allow for review of the information in Ms. Salisbury's file which remains under physician and vocational review." Before Prudential even rendered its determination upholding the denial of benefits, the plaintiff filed the lawsuit arguing that Prudential violated the claims-procedure regulations by failing to provide sufficient special circumstances to justify an extension of time.

Citing the "strict compliance" doctrine set forth in *Halo*, the court noted that the standard of review in the case turned on the court's interpretation of the term "special circumstances." Because there was no applicable precedent, the court looked to the preamble of the DOL claims-procedure regulations.[3] In the preamble, the DOL makes the following comments regarding timelines for determining appeals: (1) time periods for making determinations "are generally maximum periods, not automatic entitlements," (2) an extension may only be imposed for reasons beyond the plan's control, (3) delays caused by cyclical or seasonal fluctuations in claims volume are not considered matters beyond the control of the plan, and (4) delaying a determination without a sufficient "special circumstance" is a violation of the procedural standards.

The court found that the explanation Prudential provided in its extension notice (the plaintiff's file "remains under physician and vocational review") cannot constitute a valid "special

circumstance" because virtually all appeals for disability benefits would require physician and vocational review. The Court rejected Prudential's argument that the plaintiff's file contained thousands of pages of medical records and several days of surveillance because this information was not included in the extension notice that was provided to the claimant. The court noted that Prudential's improper extension did not fall within the *Halo* exception for "inadvertent and harmless" violations because Prudential purposefully sought the extension (*i.e.*, the violation could not be inadvertent). Thus, the court held that the *de novo* standard of review would apply to the court's review of Prudential's disability benefit determination.

Lastly, it is important to note that neither party originally raised the "strict compliance" doctrine or cited to *Halo* in their briefs. The *Salisbury* court issued its opinion without providing the parties with the opportunity to submit additional briefs to address the "strict compliance" standard. In fact, in its analysis of the "inadvertent and harmless" exception, the court first-stated that the exception would not apply because Prudential did not include *Halo* in its brief (*i.e.*, Prudential failed to meets its burden of proof), before the court determined the exception on its merits.

## Takeaways

It is unclear whether other circuits will follow the Second Circuit and adopt more stringent claims compliance standards. Furthermore, even other district courts within the Second Circuit have applied the "strict compliance" doctrine with less devastating effects than *Salisbury*. Nevertheless, *Salisbury* serves as a good reminder of the potential scope of the "strict compliance" doctrine and its effects on the applicable standard of review. Plan sponsors and administrators, particularly those administering benefit plans within the jurisdiction of the Second Circuit, may want to review their administrative claims and appeal procedures for the following issues:

- Extensions for time to determine a claim or appeal should only be requested under limited circumstances that are out of the plan's control;
- Requests for extensions based on voluminous appeals should be carefully considered in light of the DOL's position regarding cyclical and seasonal fluctuations in claims;
- Notices of extensions should describe:
  - The specific reason(s) why an extension is necessary (*e.g.*, stating that the claim is still being reviewed is not sufficient)
  - Any issues that have made the claim or appeal more difficult to review
  - The date by which the administrator expects to render its decision
  - Any additional information that the claimant should submit and an explanation of why the information is necessary (if the extension is due to the claimant's failure to provide the necessary information);
- Claims and appeal determination notices must comply with the DOL claims-procedure regulations regarding required content (*e.g.*, reference to the specific plan provisions on which the determination is based, time limits for bringing a lawsuit, etc.);

- Claims and appeal determination notices should specifically address any objections raised by the claimant; and
- Requested plan documents and claim files should be furnished to the claimant (or authorized representative) timely.

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[1] The DOL published the final regulations on December 19, 2016. The final regulations, which apply to all claims for disability benefits filed on or after January 1, 2018, require plan sponsors and administrators to make significant changes to current disability adjudication procedures. Specifically, disability benefit plans will be required to strictly adhere to the new regulations, except for "de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant." Note: the exception is not available if the violation is part of a pattern or practice of violations. (See https://www.gpo.gov/fdsys/pkg/FR-2016-12-19/pdf/2016-30070.pdf)

[2] See 29 CFR 2560.503-1

[3] See Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 FR 70246-01 (November 21, 2000)

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