ASSESSING THE 2018 ERISA LONG-TERM DISABILITY CLAIMS REGULATIONS: FIVE YEARS LATER

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I. INTRODUCTION

Five years have passed since the U.S. Department of Labor (DOL) revised how disability benefit claims are handled under the Employee Retirement Income Security Act of 1974 (ERISA). While the initial regulations governing these procedures date back to 1977,[1] they were revised and updated in 2000[2] and again in 2016.[3] The 2016 amendments became effective on April 1, 2018[4] (2018 Regulations) and are substantially the same today,

1. Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977).
2. Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70,246–70,271 (Nov. 21, 2000).
3. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92,316–92,343 (Dec. 19, 2016).
4. Claims Procedure for Plans Providing Disability Benefits; 90-Day Delay of Applicability Date, 82 Fed. Reg. 56,560–56,566 (Nov. 29, 2017).

aside from two small changes related to claimant notifications during the COVID-19 pandemic.[5]

The 2018 Regulations significantly revised the required claims procedures for the administrators of ERISA-covered employee disability benefit plans.[6] The 2018 Regulations created higher standards on ERISA fiduciaries, enhanced procedural safeguards to ensure fairness in assessing disability claims, and imposed severe consequences for failure to comply.[7]

Courts throughout the country have now had the opportunity to consider and apply many provisions of the 2018 Regulations. For each new provision, this article (a) identifies the intended effect; (b) discusses the relevant case law; and (c) provides a thorough analysis of the impact in both litigation and claim administration. Where applicable, the analysis will include predictions for future developments and make recommendations for further amendments to the Regulations.

II. BACKGROUND

In the preamble to the 2018 Regulations, the DOL acknowledged the need to amend its regulations to better achieve their primary purpose: to reduce lawsuits over benefit disputes, promote consistency in claims handling, and provide a non-adversarial method for resolving disputes.[8] The amendments responded to a 2012 study on managing disability claims initiated by the DOL's ERISA Advisory Council.[9] Based on that study, the Advisory Council learned that beneficiaries faced recurring administrative practices that were inconsistent with the existing regulations when appealing claim denials.[10] The DOL agreed.

To address these shortcomings, the DOL proposed regulation amendments aimed at ensuring that claimants receive a full and fair review process during their disability claims.[11] These amendments aimed to provide basic safeguards to claimants—including access to relevant evidence, impartiality in benefit determinations, notice and opportunity to respond to evidence and rationales, and clear communication of the basis for a decision to claimants.[12] Because courts often review disability claims under a

5. *See* Default Electronic Disclosure by Employee Pension Benefit Plans Under ERISA, 85 Fed. Reg. 31,924 (May 27, 2020); Default Electronic Disclosure by Employee Pension Benefit Plans Under ERISA; Correction, 85 Fed. Reg. 39,831 (July 2, 2020).

6. *See* 81 Fed. Reg. 92,316.

7. *Id.*

8. *Id.*

9. *Id.* at 92,317.

10. *Id.*

11. *Id.*

12. *Id.*

deferential standard that is limited to the ERISA "administrative record,"[13] claimant opportunities to supplement that record are substantially foreclosed.[14] Accordingly, the DOL emphasized the importance of giving claimants a full opportunity to develop the record and respond to relevant evidence and guidelines during the claims process.[15]

The aggressive stance of some insurers during the disability claims process and the inherent conflict of interest created by insurers who have a financial interest in the benefit claims that they decide further convinced the DOL of the need for amendments.[16] To address these issues, the DOL designed the 2018 Regulations to ensure a fair and transparent claims process for participants.[17] The 2018 Regulations were in substantial alignment with the ERISA Advisory Council's proposal.[18]

When interpreting the ERISA claims procedure regulations, courts must apply the *Chevron* doctrine.[19] Pursuant to *Chevron*, courts first ask whether the statute passed by Congress spoke directly to the question at issue.[20] If so, both the court and the relevant agency (in this case the DOL) "must give effect to the unambiguously expressed intent of Congress."[21] However, if the statute is silent or ambiguous on the relevant question, the court asks whether the agency's interpretation is "based on a permissible construction of the statute."[22] If Congress left a gap in the statute, there is an express delegation of authority for the agency to fill the gap with a regulation.[23] Courts should give these regulations controlling weight unless they are "arbitrary, capricious, or manifestly contrary to the statute."[24]

13. "The term 'administrative record' is a misnomer in an ERISA case. While an AR is normally compiled by a neutral governmental agency, . . . the AR in the ERISA context consists of the information and documents known to the administrator at the time of the administrator's final denial . . . ." Fredrich v. Lincoln Life & Annuity Co. of N.Y., 603 F. Supp. 3d 38, 40 n.1 (E.D.N.Y. 2022) (citing Halo v. Yale Health Plan, 819 F.3d 42, 60 (2d Cir. 2016)). Although some courts continue to use the term "administrative record," the ERISA statute does not use that term, and there are no hearings pursuant to the Administrative Procedures Act during the claim review or appeal process.

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831 (2003) ("If the Secretary of Labor found it meet [sic] to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference.") (citing Chevron USA Inc. v. Nat. Res. Def. Couns., Inc., 467 U.S. 837 (1984)).

20. *Chevron*, 467 U.S. at 842.

21. *Id.* at 843.

22. *Id.*

23. *Id.* at 843–44.

24. *Id.*

III. THE SEVEN MAJOR CHANGES IMPLEMENTED BY THE 2018 REGULATIONS

The 2018 Regulations implemented seven major changes to ERISA disability benefit plan administration, including the following enhanced requirements for processing benefit claims and appeals:[25]

1. *Avoiding Conflicts of Interest:* Claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination.[26]
2. *Expanded Basic Disclosure Requirements:* Benefit denial notices must include a complete discussion of why the plan denied the claim and the standards applied in reaching the decision, including the basis for disagreeing with the views of health care professionals, vocational professionals, or the Social Security Administration.[27] The denial notice must state the specific rules, guidelines, protocols, or standards relied upon in making the decision.[28] Claimants must also be given timely notice of their right to access their entire claim file and other documents relevant to their claim.[29]
3. *Right to Respond to New Information on Appeal:* Claimants must be given notice and a fair opportunity to respond before an appeal is denied based on new evidence or rationales.[30]
4. *Consequences for Failure to Comply:* Plans cannot prohibit a claimant from seeking immediate federal judicial review of a claim denial if the plan failed to comply with the claims procedure requirements[31] unless the violation was the result of certain de minimis errors.[32] With limited exceptions, a plan's failure to comply with the 2018 Regulations will trigger a *de novo* review in any resulting federal litigation.[33]

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25. U.S. Dept. of Labor Fact Sheet, Final Rule Strengthens Consumer Protections for Workers Requesting Disability Benefits from ERISA Employee Benefit Plans (Dec. 2016), https://www.dol.gov/sites/dolgov/files/legacy-files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rule-strengthens-consumer-protections-for-workers-requesting-disability-benefits-from-erisa-employee-benefit-plans_0.pdf; *see also* Joshua Rafsky, "The New ERISA Claims and Appeals Regulations for Disability Benefits" (Dec. 29, 2016) *available at* https://www.benefitslawadvisor.com/2016/12/articles/disability/the-new-erisa-claims-and-appeals-regulations-for-disability-benefits.
26. *See* 29 C.F.R. § 2560.503-1(b)(7); *see also* 81 Fed. Reg. 92,319–92,320.
27. *See* 29 C.F.R. § 2560.503-1(g)(1)(vii)(A); *see also* 81 Fed. Reg. 92,320–92,324.
28. *See* 29 C.F.R. § 2560.503-1(g)(1)(vii)(C); *see also* 81 Fed. Reg. 92,320–92,324.
29. *See* 29 C.F.R. § 2560.503-1(g)(1)(vii)(D); *see also* 81 Fed. Reg. 92,320–92,324.
30. *See* 29 C.F.R. § 2560.503-1(h)(4)(i); *see also* 81 Fed. Reg. 92,324–92,327.
31. *See* 29 C.F.R. § 2560.503-1(l)(2)(i); *see also* 81 Fed. Reg. 92,327–92,328.
32. *See* 29 C.F.R. § 2560.503-1(l)(2)(ii).
33. *See* Caccavo v. Reliance Standard Life Ins. Co., 2022 WL 1931420, at *1 (2d Cir. June 6, 2022) ("The plan bears the burden of establishing strict compliance with the regulation."); *see also* Halo v. Yale Health Plan, 819 F.3d 42, 58 (2d Cir. 2016)).

5. *Disclosing Contractual Limitation Periods to Initiate an Action:* If a plan specifies a limitation period for initiating an action to recover denied benefits, the denial notice must include the contractual limitations period and the specific calendar expiration date of the same.[34]
6. *Culturally and Linguistically Appropriate Notices:* Notices and disclosures required under the 2018 Regulations must be written in a culturally and linguistically appropriate manner.[35]
7. *Retroactive Coverage Rescission Triggers Appeal Protections:* A decision to retroactively rescind disability benefit coverage is an adverse benefit determination that triggers ERISA appeal protections.[36]

IV. ANALYSIS OF OUTCOMES AFTER FIVE YEARS

Each of the 2018 Regulations' seven major changes will be examined in detail below. For each new provision, this article (a) identifies the intended effect; (b) discusses the relevant case law; and (c) provides a thorough analysis of the impact in both litigation and claim administration. Where applicable, the analysis will include predictions for future developments and make recommendations for further amendments to the Regulations.

A. *Avoiding Conflicts of Interest*

The 2018 Regulations at 29 C.F.R. § 2560.503-1(b)(7) specifies:

> In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.[37]

1. The Intended Effect

The United States Supreme Court has long recognized that an ERISA long-term disability benefit administrator operates under an inherent conflict of interest as the dual payor and administrator of benefits.[38] This conflict of interest may extend to and infect the administrator's consulting

34. *See* 29 C.F.R. § 2560.503-1(j)(4)(ii); *see also* 81 Fed. Reg. 92,329–92,331.
35. *See* 29 C.F.R. § 2560.503-1(g)(1)(viii); *see also* 81 Fed. Reg. 92,329.
36. *See* 29 C.F.R. § 2560.503-1(m)(4)(ii); *see also* 81 Fed. Reg. 92,328.
37. 29 C.F.R. § 2560.503-1(b)(7).
38. *See* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 108, 113–14 (2008); *see also* Black & Decker Disability Plan v. Nord, 538 U.S. 822, 832 (2003).

physicians.[39] Yet, prior to the 2018 Regulations, the ERISA regulations did little to protect beneficiaries against the influence of this conflict of interest. The prior regulations only provided that the individuals who decided or reviewed any appeal must differ from (and not be the subordinate to) those involved in the initial adverse benefit determination.[40] There were no criteria requiring isolation from the potential conflict of interest.

In the preamble to the 2018 Regulations, the DOL expressed its belief that "there is potential for error and opportunity for the insurer's conflict of interest to inappropriately influence a benefit determination under highly automated claims processing, as well as claims processing with more human involvement."[41] The DOL rationalized that "[i]ncreased transparency and accountability in all claims processes is important if claimants of disability benefits are to have a reasonable opportunity to pursue a full and fair review of a benefit denial. . . ."[42]

2. Case Law from 2018 to 2023

To date, no court has found a violation of the 2018 Regulations at subsection (b)(7). Upon review of ERISA cases published on Westlaw through 2023, only one case has addressed an alleged violation of subsection (b)(7).

In *Walker v. AT&T Benefit Plan No. 3*,[43] the U.S. District Court for the Central District of California held that the plaintiff failed to provide sufficient evidence to support his claim of a subsection (b)(7) violation. In *Walker*, the plaintiff alleged the plan violated (b)(7) because the administrator "did not have agreements with the third-party physicians who conducted his medical reviews." The court ruled that this "provides no support for the conclusion that Defendants hired or retained any doctors based upon the likelihood these doctors would support a denial of medical benefits. Thus, Defendants did not violate subsection (b)(7)."[44]

3. Analysis

Subsection (b)(7) of the 2018 Regulations is structured in a way that actively invites discovery. It addresses various employment decisions at the insurance company, such as hiring, compensation, termination, and promotion, that would not typically be found in an ERISA record.

Given this clear invitation for discovery, it is surprising that no case has cited subsection (b)(7) in the past five years and no significant change has

39. *Id.*
40. *See* 81 Fed. Reg. 92,319–92,320.
41. 81 Fed. Reg. 92,318.
42. *Id.*
43. Walker v. AT&T Benefit Plan No. 3, 2022 WL 1434668, at *4 (C.D. Cal. Apr. 6, 2022), *aff'd*, 2023 WL 3451684 (9th Cir. May 15, 2023).
44. *Id.*

occurred in the scope of discovery granted in these cases. Perhaps, it is less surprising given the history of ERISA jurisprudence since *MetLife v. Glenn*.

In *Metropolitan Life Insurance Co. v. Glenn*,[45] the Supreme Court held that when an entity both determines benefit eligibility and pays those benefits "this dual role creates a conflict of interest."[46] Further, "a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits."[47]

Courts since *Glenn* have granted only limited discovery[48] and have noted that a conflict should only be considered if it can be demonstrated that the conflict actually impacted the decision.[49] This burden is particularly difficult to prove without significant discovery and resources. Given that a proven conflict would only be impactful if the other factors were already in equipoise, the substantial burden of proving the conflict is not worth the effort for a typical plaintiff.

The amendments to subsection (b)(7) may yet change this calculation in the future. More courts are likely to award additional discovery for (b)(7) violations, especially since a (b)(7) violation now triggers *de novo* review, rather than the limited role assigned to the conflict of interest in *MetLife v. Glenn*.

As is, however, subsection (b)(7) has not restructured the way that insurers decide claims and appeals. In practice, insurers continue to rely heavily on in-house medical reviews conducted by employee doctors. Although this course may be cost-effective for the insurer, questions arise about the independence and objectivity of such reviews.

To obtain the intended effect of subsection (b)(7) and achieve impartial independent decisions, the authors recommend further amendment to the 2018 Regulations. Specifically, the regulations should require that insurers obtain truly independent medical reviews from doctors who are not employees and who are in no way financially affected by the outcome of their medical reviews. The regulations should require assurances from insurers that the doctors are obtained from firms that are not impacted in any way by their relationship with the insurer or the outcomes of the medical reviews.

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45. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008).
46. *Id.* at 108.
47. *Id.*
48. *See* Denmark v. Liberty Life Assur. Co. of Boston, 556 F.3d 1, 10 (1st Cir. 2009) (*Glenn* contemplates some discovery on "whether a structural conflict has morphed into an actual conflict . . . [b]ut any such discovery must be allowed sparingly and, if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed.").
49. *See* Durakovic v. Bldg. Serv. 32 BJ Pension Fund, 609 F.3d 133, 139 (2d Cir. 2010) ("The weight properly accorded a *Glenn* conflict varies in direct proportion to the 'likelihood that [the conflict] affected the benefits decision.'") (quoting *Glenn*, 554 U.S. at 117).

B. *Expanded Basic Disclosure Requirements*

The 2018 Regulations at 29 C.F.R. § 2560.503-1(g)(1)(vii)(A) specify that benefit denial letters must include an explanation of the basis for disagreeing with following:

1. the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
2. the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
3. a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.[50]

The 2018 Regulations also require denial letters to state "[e]ither the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist."[51]

1. The Intended Effect

The preamble to the 2018 Regulations states that the DOL believed many of the 2018 Regulations' disclosure requirements were already mandated by existing ERISA regulations.[52] These requirements included ensuring the claimant can easily understand the notice; outlining specific reasons for the adverse decision; referencing the relevant plan provisions; describing additional information needed to perfect the claim; explaining the internal appeal process; and identifying the plan's rules used to deny the claim or indicating their availability upon request.[53]

Despite this language, the DOL acknowledged that plans frequently failed to comply with the prior regulatory requirements both in their letter and spirit.[54] The DOL based this acknowledgment on its experience in enforcing claims procedure requirements and in analyzing litigation activity.[55] It expressed concerns about the disproportionate litigation involving ERISA disability plans, the aggressive approach some insurers and plans

50. 29 C.F.R. § 2560.503-1(g)(1)(vii)(A).
51. 29 C.F.R. § 2560.503-1(g)(1)(vii)(C).
52. 81 Fed. Reg. 92,320.
53. *Id.*
54. *Id.*
55. *Id.*

took with disability claims, and the conflicts of interest that insurers and plans often had in making benefit claim decisions.[56]

The DOL concluded that explicitly adding supplementary requirements to the regulation—even if some might already be covered by the existing rule—was the most effective approach to reinforce the need for plan fiduciaries to transparently administer the claims procedure. This reinforcement aimed to foster constructive communication between claimants and the plan regarding adverse benefit determinations, aligning with the intentions of ERISA and the current claims procedure regulation.[57]

2. Case Law from 2018 to 2023

To date, no court has found a violation of the new regulations at § 2560.503-1(g)(1)(vii) in an ERISA long-term disability case. However, the applicability of subsection (g)(1)(vii)(A) (requiring administrators to provide an explanation when they disagree with specific evidence submitted by a claimant) has been examined in ERISA health insurance cases.

For example, in *D. K. v. United Behavioral Health*, an ERISA health insurance case, the Tenth Circuit rejected the defendant's assertion that subsection (g)(1)(vii)(A) exclusively applies to disability benefit cases.[58] The Tenth Circuit clarified that the regulations, like ERISA itself, serve as minimum guidelines applicable to both disability and healthcare claims and that ERISA imposes a broad fiduciary duty on administrators.[59] Administrators are obligated to conduct a full and fair review of the evidence through a reasonable process, consistent with the plan's requirements.[60] The Tenth Circuit ruled that administrators cannot avoid their extensive fiduciary responsibilities by citing the absence of specific minimum standards in a particular area.[61]

The U.S. Supreme Court denied United Healthcare's writ of certiorari in *D. K.*[62]

3. Analysis

As a practical matter, the 2018 Regulations did not add much to prior requirements under the regulations.[63] Now, an administrator's denial letter must specifically discuss each treating physician, vocational expert,

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56. *Id.*
57. *Id.*
58. D. K. v. United Behavioral Health, 67 F.4th 1224, 1238 (10th Cir. 2023) ("United argues that the regulations established stricter requirements for ERISA disability claims while declining to establish the same requirement for ERISA medical claims. This is simply not the case.").
59. *Id.* at 1239.
60. *Id.*
61. *Id.*
62. United Behavioral Health v. D. K., 2024 WL 674755 (U.S. Feb. 20, 2024).
63. *See* 81 Fed. Reg. 92,320.

reviewing physician, and the Social Security disability determination.[64] It cannot simply say that it considered all evidence and then summarily dismiss that evidence. However, the 2018 Regulations do not further define the term "explanation." No guidance is given on how to decide whether the administrator's explanation is sufficient. The 2018 Regulations describe black and white situations where evidence is omitted, but not grey situations where the evidence is discussed in only a cursory way. The paucity of subsection (g)(1)(vii) litigation is likely because most adverse benefit determinations are a grey situation where the evidence is insufficiently reviewed or discussed.

It is the grey situations that provide obstacles to achieving the DOL's intended effect.

First, although the 2018 Regulations requires an insurer to explain why it disagrees with the evaluating medical professionals, insurers might only provide lip service to this requirement. Insurers may attempt to bypass this requirement by offering conclusory or generic templated explanations lacking a specific factual foundation or based only on a cherry-picked review of the claimant's medical evidence.

Along the same lines, insurers could try to bypass this requirement by baselessly calling into question the intentions of any treating physician. Insurers have long encouraged judges to apply skepticism to treating physicians, assuming patient loyalty could cloud their professional medical judgment. Courts, however, have widely rejected this view to date.[65]

Second, although the 2018 Regulations require the insurer to explain why it disagrees with or does not follow the views of its consulting experts, insurers could conduct "off-the-record" conversations where they obtain views that remain undisclosed in writing. These views could be expressed by the watercooler, on the phone, or on internal chat messaging platforms like Slack or Microsoft Teams—all without the claimant ever knowing about it unless discovery is permitted.

Third, although the 2018 Regulations require the insurer to explain why it agrees or disagrees with the Social Security Administration's disability determination, insurers are likely to use stock or templated language containing blanket explanations.[66] Insurers have used blanket explanations

64. 29 C.F.R. § 2560.503-1(g)(1)(vii)(A).

65. *See* Dwyer v. Unum Life Ins. Co. of Am., 548 F. Supp. 3d 468, 486 (E.D. Pa. 2021) ("If a court were to adopt that view, in fairness it would have to employ similar skepticism in evaluating the opinions of a carrier's consulting physicians, who by the same logic would owe a duty of loyalty to the party paying them.") (cleaned up); *see also* Chicco v. First Unum Life Ins. Co., 2022 WL 621985, at *4 (S.D.N.Y. Mar. 3, 2022); Boersma v. Unum Life Ins. Co. of Am., 546 F. Supp. 3d 703, 714 (M.D. Tenn. June 29, 2021); Olis v. Unum Life Ins. Co. of Am., 2020 WL 4380948, at *11–14 (C.D. Cal. July 27, 2020).

66. *See, e.g.*, Ehlert v. Metro. Life Ins. Co., 2020 WL 6871021, at *16 n.20 (D. Mass. Nov. 23, 2020) ("The Social Security Administration's determination is separate from and governed

such as, "our reviewing experts reviewed different information than the Social Security Administration."[67] This is not a valid excuse. The information reviewed will differ in every case because the Social Security Administration conducts its own medical examinations and has a hearing with oral testimony before an administrative law judge.

Further litigation will likely be necessary to determine whether these insurer tactics provide an adequate explanation of the basis for disagreement with contrary opinions from treating health care professionals, vocational professionals, or the Social Security Administration. In the meantime, claimants should thoroughly document these disagreements throughout the claims and appeals process to highlight the inadequacy in any subsequent denials.

To obtain the intended purpose of subsection (g)(1)(vii), the DOL may need to further amend the 2018 Regulations to achieve the following:

- Mandate a standardized framework for how explanations must be provided when an insurer disagrees with the medical professionals who evaluated the claimant, consulting experts, or the Social Security Administration. This framework could include specific elements that must be addressed in any denial, aimed at preventing generic or templated responses.
- Require that all consultations between insurers and their in-house or external experts be documented and disclosed to claimants. This disclosure would minimize the opportunity for "off-the-record" conversations that might influence the claim decision without the claimant's knowledge.
- Implement a requirement that any communications between claims reviewers and medical or vocational experts be logged in real-time and made accessible to claimants. This record would increase transparency in the review process and ensure that claimants have all the information that they need to appeal an adverse decision.

C. *Right to Review and Respond to New Information on Appeal Review*

The 2018 Regulations at 29 C.F.R. § 2560.503-1(h)(4)(i) provide:

> The plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; such

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by different standards than MetLife's review and determination pursuant to the terms of Ms. Ehlert's employer's LTD Plan."); *see also* Sieg v. Hartford Life & Accident Ins. Co., 597 F. Supp. 3d 1287, 1297 (E.D. Wis. 2022).

67. *See, e.g.*, Taylor v. Unum Life Ins. Co. of Am., 2023 WL 2766018, at *10 (M.D. La. Mar. 31, 2023).

> evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date.[68]

1. The Intended Effect

Before the amended regulations took effect in April 2018, administrators handled new evidence developed during a benefit appeal, as follows:

1. The administrator would hire a medical professional to review the evidence on appeal.
2. The professional would write a report, on which the administrator would often rely when making its appeal determination.
3. Some administrators provided claimants with a copy of the report to respond. Others would not.

Administrators who did not provide an opportunity to respond to reports generated during appeals believed the prior regulations did not require them to do so. This belief was based on the prior regulations use of the term “upon request.”[69] Some courts determined this belief denied claimants their right to a full and fair review of their disability claims.[70] Other courts were concerned that changing the process would cause an endless feedback loop, involving rebuttal upon rebuttal.[71]

In the Preamble to the 2018 Regulations, the DOL clarified that, even under the prior regulations, claimants had a right to review and respond to new evidence developed by the insurer during an appeal.[72] Sending the claimant these reports after an appeal denial was insufficient.[73] If an administrator failed to provide claimants with the reports and an opportunity to respond, the claimant was denied a full and fair review.[74]

The 2018 Regulations further resolved the issue by eliminating the “upon request” language and proactively requiring an administrator to provide such new information “sufficiently in advance” of an adverse determination “to give the claimant a reasonable opportunity to respond.”[75] As the Seventh Circuit explained, “[U]nder the amended regulation, a plan

68. 29 C.F.R. § 2560.503-1(h)(4)(i).

69. 29 C.F.R. § 2560.503–1(h)(2)(iii), (m)(8)(i)–(ii) (2002); *see also* 81 Fed. Reg. 92,323.

70. *See*, *e.g*., Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 680 (9th Cir. 2011); Abram v. Cargill, Inc., 395 F.3d 882 (8th Cir. 2005); Hughes v. Hartford Life & Accident Ins. Co., 368 F. Supp. 3d 386, 398 (D. Conn. 2019).

71. *See*, *e.g*., Midgett v. Wash. Grp. Int’l Long Term Disability Plan, 561 F.3d 887, 896 (8th Cir. 2009); Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241 (11th Cir. 2008); Metzger v. Unum Life Ins. Co. of Am., 476 F.3d 1161, 1166 (10th Cir. 2007).

72. 81 Fed. Reg. 92,324.

73. *Id*.

74. *Id*.

75. 29 C.F.R. § 2560.503–1(h)(4)(i); *see also* 82 Fed. Reg. 56,560.

administrator must provide the pertinent information whether the claimant has asked for it or not."[76]

Importantly, the DOL decided *not* to change the forty-five-day deadline by which the administrator is required to decide an appeal.[77] In the preamble to the 2018 Regulations, the DOL commented that the regulations already provided a "special circumstances" provision that permits extension and tolling of that forty-five-day deadline.[78]

2. Case Law from 2018 to 2023

In *Zall v. Standard Insurance Co.*, the Seventh Circuit ruled on an (h)(4)(i) violation alleged due to the insurer's failure to notify the claimant of a reviewing doctor's report until just nine days before denying his appeal, and without ever giving him a copy of the report.[79] Standard argued that the plaintiff waived any alleged (h)(4)(i) violation by not raising the issue during the administrative appeal.[80] The court rejected this argument, rationalizing that "Standard committed the procedural error in the very last stage of Zall's administrative appeal" and "[o]nly after Standard announced its final decision could Zall have known that Standard had failed to abide by the required procedures."[81]

The Seventh Circuit focused on the requirement to provide new or additional information "sufficiently in advance" of the adverse determination with a "reasonable opportunity to respond."[82] It held:

> We are confident that in this case, nine days advance notice of the existence of such a critical document was not a reasonable opportunity for Zall to respond substantively to the new evidence against his claim, such as by seeking to obtain updated diagnostic scans, to learn the results of those scans, and to communicate them to Standard before it made its final decision.[83]

However, the Seventh Circuit acknowledged that "[w]hat might be a reasonable opportunity will depend on the circumstances of the particular case."[84]

In *Dimry v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, the U.S. District Court for the Northern District of California determined that the plan violated subsection (h)(4)(i) when it excluded plaintiff from the remand

76. Zall v. Std. Ins. Co., 58 F.4th 284 (7th Cir. 2023).
77. 81 Fed. Reg. 92,326.
78. *Id.*
79. *Zall*, 58 F.4th at 289–90.
80. *Id.* at 293.
81. *Id.* at 295.
82. *Id.* at 296.
83. *Id.* at 295.
84. *Id.*

review process.[85] In affirming the district court's decision, the Ninth Circuit held that the plan left the plaintiff and his counsel "in the dark during the entirety of the remand process," including not allowing plaintiff the opportunity to respond to new and additional medical evidence.[86]

In *Rhodes v. First Reliance Standard Life Insurance Co.*, the U.S. District Court for the Southern District of New York considered whether First Reliance violated subsection (h)(4)(i) when it failed to provide the plaintiff with an opportunity to respond to a reviewing doctor's addendum report before denying his administrative appeal.[87] First Reliance argued that the addendum report did not constitute "new or additional evidence" because the doctor's conclusion was unchanged.[88] The court rejected this argument, ruling that the addendum qualified as new medical evidence and that First Reliance's failure to provide the report with an opportunity to respond violated subsection (h)(4)(i).[89]

In *Fitzgerald v. General Motors, LLC*, the U.S. District Court for the Eastern District of Michigan evaluated whether the administrator, General Motors, violated subsection (h)(4) when it provided the claimant with the reviewing doctor's rationale for denying the claim for the first time in the denial letter.[90] The court ruled that "Defendants therefore violated § 2560.503-1(h)(4)(ii) and did not provide Plaintiff with a full and fair review."[91]

In *Schwarz v. Hartford Life & Accident Ins. Co.*, the U.S. District Court for the Northern District of California reviewed whether Hartford violated subsection (h)(4)(i) when it refused to provide the plaintiff and her counsel copies of two expert file review reports before the final benefit denial.[92] Hartford only sent the reports to the plaintiff's treating physicians and notified her counsel (without providing copies) approximately two and a half weeks before the denial.[93] The court decided that Hartford violated (h)(4)(i) because the subsection explicitly mandates that administrators send the evidence to "the claimant," not just to the claimant's physicians.[94]

85. Dimry v. Bert Bell/Pete Rozelle NFL Player Ret. Plan, 487 F. Supp. 3d 807, 815 (N.D. Cal. 2020), *aff'd and remanded*, 855 F. App'x 332 (9th Cir. 2021).
86. *Id.* at 334.
87. Rhodes v. First Reliance Std. Life Ins. Co., 2023 WL 3099294, at *3 (S.D.N.Y. Apr. 26, 2023).
88. *Id.*
89. *Id.*
90. Fitzgerald v. Gen. Motors, LLC, 2021 WL 3079866, at *3 (E.D. Mich. July 21, 2021).
91. *Id.*
92. Schwarz v. Hartford Life & Accident Ins. Co., 443 F. Supp. 3d 1085, 1090 (N.D. Cal. 2020).
93. *Id.*
94. *Id.*

3. Analysis

Many more cases involving violations of subsection (h)(4)(i) will arise in the coming years, and most will weigh in favor of the plaintiff. Courts will find more violations of subsection (h)(4)(i) for two reasons.

First, courts will be quick to recognize the harm and unfairness that plaintiffs suffer when they are not given a reasonable opportunity to respond to evidence considered, relied upon, or generated by the insurer during a benefit determination. Even before applying the 2018 Regulations, courts had long held that insurers may not "sandbag" a claimant by failing to permit the claimant to review and comment upon all documents, records, and information relevant to the claim.[95]

Second, the straightforward requirements of (h)(4)(i) will make it relatively easy for most plaintiffs to successfully plead and prove violations under the subsection. For most cases, this will be an uncomplicated finding. Either the insurer gave the plaintiff an opportunity to respond to new information or not.

However, in some cases, more complicated questions will arise concerning what constitutes "new" information and a "reasonable" opportunity to respond. For example, it remains unclear whether "new" information might include relevant correspondence between the insurer and any consulting or examining doctor on appeal. It also remains unclear what the minimum requirements for a "reasonable" opportunity to respond might look like. Given the inherently unique and fact-specific nature of these issues for any given case, it is unlikely that the courts will provide a consensus. The DOL may need to add clarity in the future.

To obtain the intended purpose of subsection (h)(4)(i), the DOL might need to enact further amendments to:

- Provide more explicit guidelines on what constitutes "new or additional evidence" during the appeals process. This could involve listing specific examples or categories of information that must be shared with the claimant to give them a reasonable opportunity to respond.

95. *See*, *e.g.*, Abram v. Cargill, Inc., 395 F.3d 882, 886 (8th Cir. 2005) ("The process used by the Plan was not consistent with a full and fair review. Abram was not provided access to the second report by Dr. Gedan that served as the basis for the Plan's denial of benefits until after the Plan's decision."); Saffon v. Wells Fargo & Co. Long Term Disability Plan, 511 F.3d 1206, 1215 (9th Cir. 2008) ("Insofar as MetLife believed that a Functional Capacity Evaluation, or some other means of objectively testing Saffon's ability to perform her job, was necessary for it to evaluate Saffon's claim, it was required to say so at a time when Saffon had a fair chance to present evidence on this point."); Kosiba v. Merck, 384 F.3d 58 (3d Cir. 2004) (noting that insurer's hiring of a reviewing doctor after a claim decision was made undermines any deference being given to the insurer's decision); Hughes v. Hartford Life & Accident Ins. Co., 368 F. Supp. 3d 386, 401 (D. Conn. 2019) ("I do not see how sandbagging claimants with last-minute medical reports that they cannot respond to does anything to inspire enrollee confidence or to serve the Department of Labor's stated regulatory purpose to ensure a full and fair review.").

- While the 2018 Regulations require that new information be provided "sufficiently in advance," a clearer definition of what constitutes "sufficient time" could prevent disputes. For example, setting a minimum time frame (e.g., at least twenty days before a final decision) for releasing new evidence could make the process more transparent and equitable.
- Although the rule allows for extension and tolling in "special circumstances," it might be beneficial to clarify what these special circumstances could be. Examples could be provided for both claimants and administrators to understand when extensions might be applicable.

D. *Consequences for Failure to Comply*

The 2018 Regulations specify that if a disability plan fails to strictly adhere to all the requirements in the claims procedure regulations, the claimant is deemed to have exhausted their administrative remedies.[96] "If a claimant chooses to pursue remedies under section 502(a) of [ERISA] under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary."[97]

The "strictly adhere" standard replaces an older "substantial compliance doctrine" adopted by most circuits. This principle gave plan administrators some leeway for minor procedural errors, especially delay, as long as the administrators were acting in good faith and the claimant was not substantively harmed.[98] Essentially, prior to the 2018 Regulations, minor procedural missteps did not automatically result in a right to sue and *de novo* review. The new rule mandates strict compliance. Failure to strictly adhere leads to *de novo* review, effectively removing the plan administrator's discretionary authority.[99]

The 2018 Regulations provide a limited exception where:

- the violation was *de minimis;*
- the violation did not cause, and is not likely to cause, prejudice or harm to the claimant;
- the violation was for good cause or due to matters beyond the control of the plan; *and*
- the violation occurred in the context of an ongoing, good-faith exchange of information between the plan and claimant.[100]

This exception does not apply if the violation is part of a pattern or practice of violations by the plan.[101]

96. 29 C.F.R. § 2560.503-1(l)(2)(i).
97. *Id.*
98. *See* Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 634–35 (10th Cir. 2003).
99. *See* McQuillin v. Hartford Life and Accident Ins. Co., 36 F.4th 416, 419 (2d Cir. 2022).
100. 29 C.F.R. § 2560.503-1(l)(2)(ii).
101. *Id.*

1. The Intended Effect

The 2018 Regulations establishes a *quid pro quo* mechanism—an administrator only gets the privilege of the arbitrary and capricious standard of review, if it strictly adheres to the 2018 Regulations. The DOL rationalized that "claimants should not have to follow a claims and appeals process that is less than full, fair, and timely."[102] Indeed, even prior to the 2018 Regulations, the Second Circuit crafted a similar solution.[103]

Prior to the 2018 Regulations, the default standard of review was *de novo*. However, if the benefit plan explicitly granted the administrator discretionary authority to determine eligibility or interpret the plan's terms,[104] the standard of review would be the arbitrary and capricious standard.[105] Because most benefit plans granted discretionary authority, the vast majority of ERISA cases were litigated under the arbitrary and capricious standard. This put claimants at a significant disadvantage in ERISA cases.

To fully appreciate the intended purpose of this amendment, it is necessary to understand the substantial difference between the *de novo* standard and the more deferential "arbitrary and capricious" standard (also known as the "abuse of discretion" standard).

Under the *de novo* standard of review, a case is litigated more like a contract claim than a trust claim. A plaintiff will prevail if they are able to establish the elements of their case by a preponderance of the evidence.[106] "To establish a fact by a preponderance of the evidence means to prove that the fact is more likely true than not true."[107] In the context of a disability claim, the court will determine whether the plaintiff established that the plaintiff is disabled within the meaning of the terms of the plan by a preponderance of the evidence. "The Court's *de novo* review 'applies to all aspects of the denial of an ERISA claim, including the fact issues,' and the

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102. 81 Fed. Reg. 92,327.

103. *See, e.g.*, Halo v. Yale Health Plan, 819 F.3d 42, 56–58 (2d Cir. 2016)); Jarosz v. Am. Axle & Mfg. Inc., 372 F. Supp. 3d 163, 176 (W.D.N.Y. 2019); Montefiore Med. Ctr. v. Local 272 Welfare Fund, 2019 WL 571455, at *3 (S.D.N.Y. Jan. 25, 2019), *adopted in relevant part*, 2019 WL 569805, at *1 (S.D.N.Y. Feb. 12, 2019); Aitken v. Aetna Life Ins. Co., 2018 WL 4608217, at *11 (S.D.N.Y. Sept. 25, 2018); Salisbury v. Prudential Ins. Co. of Am., 238 F. Supp. 3d 444, 451 (S.D.N.Y. 2017) (noting that forfeiting the abuse of discretion standard "may appear harsh" but that was the result of Prudential's failure to strictly adhere to the regulations).

104. Multiple states prohibit the use of discretionary clauses in insurance contracts. *See, e.g.*, Cal. Ins. Code § 10110.6; 50 Ill. Admin. Code § 2001.3; Mich. Admin. Code R. 500.2202. Courts have found that some of these state prohibitions, such as those in California, Illinois, and Michigan, apply to ERISA long term disability plans. *See* Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, 856 F.3d 686, 693–95 (9th Cir. 2017); Fontaine v. Metro. Life Ins. Co., 800 F.3d 883, 889 (7th Cir. 2015); Am. Council of Life Insurers v. Ross, 558 F.3d 600, 605 (6th Cir. 2009).

105. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

106. *See* Paese v. Hartford Life & Accident Ins. Co., 449 F.3d 435, 441 (2d Cir. 2006).

107. Fischl v. Armitage, 128 F.3d 50, 55 (2d Cir. 1997).

Court owes no deference to the administrator's determination."[108] Rather, the court "stands in the shoes of the original decisionmaker."[109] The court "interprets the terms of the benefits plan, determines the proper diagnostic criteria, reviews the medical evidence, and reaches its own conclusion."[110]

By contrast, under the deferential "arbitrary and capricious" standard, a case is litigated more like a trust claim than a contract claim. This choice makes it substantially more difficult for plaintiffs to prevail. In the context of a disability claim, the court is not determining whether the plaintiff is disabled, only whether the insurer's determination was reasonable.

The Supreme Court clarified what is meant by a deferential standard of review in ERISA matters. Deference "does not mean that the plan administrator will prevail on the merits."[111] It only means that the plan administrator's interpretation of the plan "will not be disturbed if reasonable."[112] Under such a standard, the court would uphold the determination of the administrator even it disagreed with the result, as long as the administrator's determination was reasonable.

2. Case Law from 2018 to 2023

In numerous cases, insurance companies have failed to render a decision on appeal within the strict forty-five-day deadline or the ninety-day special circumstances extension. Federal courts have ruled the failure to strictly adhere to these deadlines results in an exhaustion of administrative remedies and entitles a claimant to file suit in federal court.[113] In *McQuillin v. Hartford*, the Second Circuit held that missing these strict deadlines by even one day results in an exhaustion of remedies and immediately allows the claimant to file a lawsuit under ERISA.[114]

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108. Graziano v. First Unum Life Ins. Co., 2023 WL 4530274, at *13 (S.D.N.Y. July 13, 2023) (quoting Muller v. First Unum Life Ins. Co., 341 F.3d 116, 124 (2d Cir. 2003)); *see also* Locher v. Unum Life Ins. Co. of Am., 389 F.3d 288, 297 (2d Cir. 2004) ("Moreover, upon *de novo* review, a district court may render a determination on a claim without deferring to an administrator's evaluation of the evidence.").

109. McDonnell v. First Unum Life Ins. Co., 2013 WL 3975941, at *12 (S.D.N.Y. Aug. 5, 2013).

110. *Id*. (internal citations omitted); *see also* Tretola v. First Unum Life Ins. Co., 2015 WL 509288, at *22 (S.D.N.Y. Feb. 6, 2015).

111. Conkright v. Frommert, 559 U.S. 506, 508 (2010) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989)).

112. *Id*.

113. S*ee*, *e.g*., Fessenden v. Reliance Standard Life Ins. Co., 927 F.3d 998, 1005 (7th Cir. 2019); Card v. Principal Life Ins. Co., 2022 WL 15512209, at *13 (E.D. Ky. Oct. 27, 2022); Fredrich v. Lincoln Life & Annuity Co. of N.Y., 603 F. Supp. 3d 38, 40, 46–48 (E.D.N.Y. 2022); Krysztofiak v. Bos. Mut. Life Ins. Co., 2021 WL 5304011, at *2 (D. Md. Nov. 15, 2021); Hasten v. Prudential Ins. Co. of Am., 470 F. Supp. 1076, 1081 (N.D. Cal. 2020); Rossiter v. Life Ins. Co. of N. Am., 400 F. Supp. 3d 669, 677 (N.D. Ohio Sept. 11, 2019).

114. *See* McQuillin v. Hartford Life & Accident Ins. Co., 36 F.4th 416, 419 (2d Cir. 2022) ("McQuillin's duty to exhaust had ceased by the 46th day, the day he filed his federal case. Thus, the district court erred in dismissing McQuillin's suit.").

Some courts have gone further and ruled that a failure to strictly adhere to the appeal deadlines results in an exhaustion of remedies and a *de novo* review. For example, in *Fessenden v. Reliance Standard Life Insurance Co.*, the Seventh Circuit ruled that "when an administrator fails to render a final decision, there is no valid exercise of discretion to which the court can defer, and it decides *de novo* whether the insured is entitled to benefits."[115]

A growing list of other district courts have ordered *de novo* review for a failure to strictly adhere to the appeal deadlines, including the Northern District of Alabama;[116] the Eastern District of Kentucky;[117] the District of Connecticut;[118] and the Southern District of New York.[119]

Despite the 2018 Regulations, some district courts in the Sixth Circuit continue to find that the arbitrary and capricious standard of review applies even when a regulations violation results in a deemed denied claim.[120] However, more recent cases in the Sixth Circuit have ruled that such regulation violations result in a *de novo* review.[121]

Multiple cases in the Tenth Circuit have also questioned whether procedural violations automatically waive an administrator's deferential review.[122]

115. *Fessenden*, 927 F.3d, at 1001; *see also id.* at 999–1000 ("When a plan administrator commits a procedural violation, however, it loses the benefit of deference and a *de novo* standard applies.").

116. Brewer v. Unum Grp. Corp., 622 F. Supp. 3d 1113, 1128 (N.D. Ala. Aug. 22, 2022) ("[T]he regulation requires the court to assume that Unum denied Brewer's claim 'without the exercise of discretion by an appropriate fiduciary'—and thus to strip Unum of Firestone deference—if (a) Unum failed 'to strictly adhere to all the requirements of this section . . . .'") (quoting 29 C.F.R. § 2560.503-1(l)(2)(i)).

117. Bustetter v. Standard Ins. Co., 529 F. Supp. 3d 693, 703 (E.D. Ky. Mar. 29, 2021) (granting *de novo* review but dismissing on other grounds).

118. Spears v. Liberty Life Assurance Co. of Boston, 2019 WL 4766253, at *24 (D. Conn. Sept. 30, 2019) (reviewing the case *de novo* due to procedural violations including failure to meet the claims procedure deadlines following a remand).

119. Rhodes v. First Reliance Std. Life Ins. Co., 2023 WL 3099294, at *4 (S.D.N.Y. Apr. 26, 2023) (ruling the *de novo* standard of review applies due to three regulation violations, including First Reliance's failure to meet the required deadlines).

120. *See* Rossiter v. Life ins. Co. of N. Am., 400 F. Supp. 3d 669, 677 (N.D. Ohio Sept. 11, 2019) ("The Sixth Circuit has held that 'the standard of review is no different whether the appeal is actually denied or is deemed denied.'") (quoting Daniel v. Eaton Corp., 839 F.2d 263, 267 (6th Cir. 1988); *see also* Smith v. Hartford Life and Accident Ins. Co., 421 F. Supp. 3d 416, 421 (E.D. Ky. Oct. 11, 2019) (applying *Daniel* to the 2002 regulations).

121. *See* Card v. Principal Life Ins. Co., 2022 WL 15512209, at *9 (E.D. Ky. Oct. 27, 2022); *see also Bustetter*, 529 F. Supp. 3d at 703 ("[I]n light of the substantial changes to the regulations, cases such as *Daniel* interpreting the pre-2002 version of the regulations are outdated.").

122. *See, e.g.*, S.K. v. United Behavioral Health, 2023 WL 7221013, at *23 (D. Utah Sept. 29, 2023) ("Plaintiffs here allege violations akin to those in *D.K.* But where the Tenth Circuit has not had occasion to rule on the issue, and because the Defendants' denials were improper even under the more deferential arbitrary and capricious standard of review, it is unnecessary to determine if the alleged breaches might amount to procedural irregularities warranting de novo review."); James C. v. Aetna Health and Life Ins. Co., 499 F. Supp. 3d 1105, 1117 (D. Utah 2020) ("The Tenth Circuit has questioned the continued viability of this exception

Most recently, in *Easter v. Hartford Life & Accident Insurance Co.*, the Tenth Circuit concluded:

> While Hartford is correct that we have never extended the procedural-irregularity exception beyond two limited scenarios—*viz.*, where a claim administrator either did not issue a decision or issued a substantially late appeal decision—we need not decide whether the exception could extend to other scenarios. Even assuming *arguendo* that the procedural-irregularity exception covers other instances of non-compliance, we conclude that there is no procedural irregularity here that calls for an alteration of the standard of review. . . . Accordingly, we review Hartford's denial of benefits under an arbitrary-and-capricious standard.[123]

Although deadline violations are the most common, subsection (l)(2)(ii) applies to all ERISA claims procedure violations. In *Israel v. Unum Life Insurance Co. of America*,[124] the U.S. District Court for the Southern District of New York considered whether administrative remedies were deemed denied when Unum failed to provide an administrative appeal despite the submission of additional medical evidence following a denial. After Unum initially denied Israel benefits, she disputed the denial and submitted additional medical evidence.[125] Unum did not follow the appeals procedures provided in the ERISA claims procedure regulations.[126] As a result, the court ruled in Israel's favor and remanded the case to the insurer for a decision on the merits.[127]

In *Wallace v. Oakwood Healthcare, Inc.*, the Sixth Circuit reviewed whether a claim for benefits was deemed denied because the plan did not define any internal claims review process, despite being required the 2018 Regulations.[128] After the claimant's initial application for benefits was denied, she filed a federal lawsuit alleging exhaustion of her administrative remedies because the plan did not define any internal claims review process.[129] The Sixth Circuit ruled that "because Defendant did not describe any internal claims review process or remedies in its plan document, the plan did not establish a reasonable claims procedure pursuant to ERISA regulations;

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in light of regulatory changes. But it remains the law of the Circuit that courts do not apply 'a hair-trigger rule' requiring de novo review whenever the plan administrator, vested with discretion, failed *in any respect* to comply with the procedures mandated by this regulation.").

123. Easter v. Hartford Life & Accident Insurance Co., 2023 WL 3994383, at *5 (10th Cir. June 14, 2023).

124. 2023 WL 491039, at *11–12 (S.D.N.Y. Jan. 27, 2023).

125. *Id.* at *5.

126. *Id.* at *11–12.

127. *Id.*

128. Wallace v. Oakwood Healthcare, Inc., 954 F.3d 879, 885–86 (6th Cir. 2020).

129. *Id.*

therefore, Plaintiff's administrative remedies must be deemed exhausted."[130] The Eighth Circuit reached the same conclusion in a substantially similar case.[131]

In *Select Specialty Hospital-Memphis, Inc. v. Trustees of Langston Cos., Inc.*, the claimant received a denial notice that did not contain any information regarding the right to appeal, and, subsequently, the claimant missed an administrative appeal deadline.[132] In the subsequent litigation, the U.S. District Court for the Western District of Tennessee dismissed the case because the claimant failed to exhaust all administrative remedies prior to filing the lawsuit.[133] The court differentiated *Wallace* because the plan document in *Select* did contain the necessary information regarding the claimant's appeal rights.[134]

In *Fuhrer v. Hartford Life & Accident Insurance Co.*, the decedent was covered under an ERISA accidental death policy at the time of his death.[135] The decedent's widow, Fuhrer, timely filed a nine days after the prescribed deadline.[136] Fuhrer did not file an appeal with Hartford for nearly two years, which Hartford denied as untimely.[137] During the subsequent litigation, the U.S. District Court for the Eastern District of Pennsylvania agreed with Hartford that Fuhrer failed to exhaust her administrative remedies and that any harm caused by the nine-day delay in the initial decision was *de minimus* because it did not prevent Fuhrer from filing a timely appeal.[138]

3. Analysis

Contrary to the idea that the amendment's harsh penalties would incentivize administrators to "try harder" to comply with regulations, the practical impact appears to be more nuanced. While administrators generally prefer to maintain the "arbitrary and capricious" standard, they seem to calculate that the occasional shift to a *de novo* review is a manageable risk. Most denials never reach litigation, either because potential plaintiffs are discouraged or because the financial stakes of the claim do not ultimately justify legal

130. *Id.* at 887.
131. Yates v. Symetra Life Ins. Co., 60 F.4th 1109, 1113 (8th Cir. 2023) ("A participant in an employee benefit plan governed by ERISA is not required to exhaust administrative remedies before challenging a denial of benefits in court when the written plan documents make no mention of any review process or administrative remedies that can be exhausted.").
132. Select Specialty Hosp.-Memphis, Inc. v. Trustees of Langston Cos., Inc., 2021 WL 1131714, at *8 (W.D. Tenn. Mar. 24, 2021).
133. *Id.*
134. *Id.* at *9.
135. Fuhrer v. Hartford Life & Accident Ins. Co., 2022 WL 1172971, at *1 (E.D. Pa. Apr. 20, 2022).
136. *Id.*
137. *Id.* at *2.
138. *Id.* at *3.

action. As such, the real-world effect of the amendment may be limited in compelling administrators to improve their claims handling practices.

When claim reviews are filled with unfair procedural violations, many potential plaintiffs see litigation as a no-win situation, feeling both defeated and likely unaware of the legal ramifications. This emotional toll often leads potential plaintiffs to abandon their claims, which inadvertently boosts the administrator's bottom line.

While the amendment makes it more appealing for attorneys to take on these cases, *de novo* review can sometimes be a double-edged sword. Unrepresented claimants may not adequately support their claims during the claim process, leading to an uphill battle in court where only a closed ERISA record is considered. Additionally, when the record can be supplemented, litigation costs can skyrocket due to the need for additional medical evaluations, expert witnesses, and discovery efforts. Supplementation of the record also can result in substantial delay, where the plaintiff is already without critical fixed-disability income. The amendment does not directly address these issues, leaving a gap in its effectiveness.

In sum, although the 2018 Regulations aim to create a more level playing field between claimants and administrators, its real-world impact appears to be constrained by various factors. Administrators still seem willing to risk the occasional penalty of a *de novo* review, calculating that the volume of claims that never reach litigation makes it a gamble worth taking. Meanwhile, claimants face their own set of challenges that the Rule does not fully address, particularly when it comes to *de novo* review.

To obtain the intended purpose of subsection (l)(2)(i), the DOL may need to further amend the 2018 Regulations to reach the following goals:

- Provide more clarity regarding when *de novo* review applies following a procedural violation. Although many courts agree that failure to strictly adhere to all procedural regulations will result in *de novo* review, some courts disagree to the detriment of claimants. The DOL could also clarify what types of violations are *de minimis*.
- The DOL could provide additional guidance regarding when it is appropriate for courts to supplement the ERISA record under *de novo* review. The DOL also could advise courts of when discovery may be appropriate following procedural violations.
- The DOL could further enhance the impact of the amendment by expanding disclosure requirements about the standard of review in denial notices. Informing would-be plaintiffs of the consequences of administrators' non-compliance could encourage such plaintiffs to seek legal advice. Furthermore, enhanced disclosure would better inform potential legal counsel about the intricacies of the case, making them more willing to take on such claims.

E. *Disclosure of Contractual Limitations Period to Initiate a Civil Action*

The 2018 Regulations require that an adverse benefit determination following an administrative review shall provide a statement of the claimant's right to bring legal action, and

> [i]n the case of a plan providing disability benefits . . . the statement of the claimant's right to bring an action under section 502(a) of the Act shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.[139]

1. The Intended Effect

By adding subsection (j)(4)(ii), the DOL intended to make it easier for claimants to understand the applicable limitation period. ERISA does not set a limitation period for filing an action, and many federal courts previously looked to analogous state laws to determine an appropriate limitations period.[140] However, the Supreme Court held that if a plan document or insurance contract contains its own contractual limitations period, that could override analogous state law, so long as the contractual limitations period is reasonable.[141] The DOL acknowledged that this holding caused confusion because the states' contractual limitations periods are not uniform, the events that trigger the clock may vary by state, and the plan documents containing the limitations periods may be difficult for a claimant to appreciate.[142]

The DOL determined that "[a] limitations period that expires before the conclusion of the plan's internal appeals process on its face violates ERISA section 503's requirement of a full and fair review process."[143] The DOL noted:

> [I]n rejecting the challenge to the contractual limitations period at issue in *Heimeshoff*, the Court emphasized that the claimant was allowed a year or more to bring suit after the close of the internal claims review process. A contractual limitations period that does not allow such a reasonable period after the conclusion of the appeal in which to bring a lawsuit is unenforceable.[144]

The DOL further stated that "traditional doctrines, such as waiver and estoppel, may apply if a plan's internal review prevents a claimant from bringing section 502(a)(1)(B) actions within the contractual period."[145]

139. 29 C.F.R. § 2560.503-1(j)(4)(ii).
140. 81 Fed. Reg. 92,329.
141. *See* Heimeshoff v. Hartford Life & Accident Ins. Co., 571 U.S. 99, 107 (2013).
142. 81 Fed. Reg. 92,329.
143. *Id.* at 92,330.
144. *Id.*
145. *Id.* at 92,331; *see also Heimeshoff*, 571 US. at 114.

Plans that offer appeals or alternative dispute resolution beyond the ERISA claims procedure regulations must also toll the limitations period during those reviews.[146]

By including subsection (j)(4)(ii) in the 2018 Regulations, the DOL sought to resolve any ambiguity in prior federal court decisions regarding a requirement to disclose contractual limitations periods in adverse benefit determinations. It did so because "an adverse benefit determination on review would be incomplete and potentially misleading if it failed to include limitations or restrictions in the documents governing the plan on the right to bring . . . a civil action."[147]

2. Case Law from 2018 to 2023

To date, there have been no cases where a court found a violation of the new regulations at subsection (j)(4)(ii) for an administrator's failure to disclose a contractual limitations period to initiate a civil action in an ERISA disability case. However, several courts have considered the application of subsection (j)(4)(ii) in ERISA healthcare insurance cases. These cases have largely supported the DOL's intended effect of making it easier for claimants to understand the applicable limitation period.

In *Anne A. v. United Healthcare Insurance Co.*, the U.S. District Court for the District of Utah considered an ERISA healthcare plan that required all civil actions to be filed within 180 days of the final determination, but the administrator's final denial letter did not disclose the 180-day deadline.[148] When the claimant filed a lawsuit outside of the 180-day window, United moved to dismiss.[149] Although the court found that (j)(4)(ii) only applies to disability benefits, the court still found United was required to disclose the contractual limitation provision in its denial letter under subsection (g)(1)(iv).[150] In support of this position, the court specifically noted that the DOL has "indicated approval of notice requirements in all contexts."[151] "In fact, in promulgating the amendments, the Department [of Labor] stated that it 'believes that notices of adverse benefit determinations on review for other benefit types [such as health benefits] would be required to include some disclosure about any applicable contractual limitations period.'"[152]

In a substantially similar decision released by the same judge on the same day, the district court judge again found that United Healthcare was

146. 81 Fed. Reg. 92,331; *see also* 29 C.F.R. § 2560.503-1(c)(3)(ii).
147. 81 Fed. Reg. 92,331.
148. Anne A. v. United Healthcare Ins. Co., 2022 WL 957199, at *1 (D. Utah Mar. 30, 2022).
149. *Id.*
150. *Id.* at *6.
151. *Id.*
152. *Id.*

required to disclose the contractual limitation provision in its denial letter under subsection (g)(1)(iv).[153] In *E.F. v. United Healthcare Insurance Co.*, the judge used largely identical language to strike down a three-year limitation period for failure to disclose this limitation period in the final benefit denial letter.[154]

In *Hatch v. Wolters Kluwer U.S., Inc. Health Plan*, the U.S. District Court for the Northern District of Illinois considered the same issue, whether to apply the requirements in (j)(4)(ii) to a medical benefit denial.[155] The court determined that it did not need to decide whether (j)(4)(ii) applied "because section (g) of the regulation independently requires notice of contractual limitations periods in adverse benefit determinations."[156] The court noted the disagreement among circuit courts on this issue, but explained that its decision is consistent with the First, Third, and Sixth Circuits' opinions which "are better reasoned because they consider the statute and regulation in the context of the ameliorative intent of the Congress in enacting ERISA."[157]

In *Popovchak v. UnitedHealth Group Inc.*, the U.S. District Court for the Southern District of New York also found that an ERISA healthcare insurance administrator must include a description of the "claimant's right to bring a civil action under section 502(a) of [ERISA]" in any adverse benefit determination.[158] "Because Defendants failed to include the applicable six-month limitations period in their denial letter to Popovchak, they 'fail[ed] to substantially comply' with DOL notice requirements," and the six-year New York statute of limitations period for breach of contract claims applies.[159] Note that *Popovchak* did not discuss whether subsection (j)(4)(ii) applied, but relied on a substantially similar requirement under subsection (g)(1).[160]

However, not all courts have found that requirements similar to (j)(4)(ii) apply to other ERISA benefit determinations. In *Theriot v. Building Trades United Pension Trust Fund*, the U.S. District Court for the Eastern District of Louisiana considered whether to apply subsection (j)(4)(ii) to an ERISA

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153. E.F. v. United Healthcare Ins. Co., 2022 WL 957200, at *6 (D. Utah Mar. 30, 2022).

154. *Id.*

155. Hatch v. Wolters Kluwer U.S., Inc. Health Plan, 2023 WL 4930286, at *1 (N.D. Ill. Aug. 1, 2023).

156. *Id.* at *11.

157. *Id.* (quoting Hewitt v. Lincoln Fin. Corp., 2021 WL 353884, at *3 (N.D. Ill. Feb. 2, 2021)); *see also* Mirza v. Ins. Adm'r of Am., Inc., 800 F.3d 129, 134-37 (3d Cir. 2015); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503, 505 (6th Cir. 2014); Ortega Candelaria v. Orthobiologics LLC, 661 F.3d 675, 680 n.7 (1st Cir. 2011).

158. Popovchak v. UnitedHealth Grp. Inc., 2023 WL 6125540, at *7 (S.D.N.Y. Sept. 19, 2023) (quoting 29 C.F.R. § 560.503-1(g)(1).

159. *Id.* at *8 (quoting Burke v. Kodak Ret. Income Plan, 336 F.3d 103, 107–09 (2d Cir. 2003)).

160. *Id.*

post-retirement survival benefit determination.[161] The court found that "subsection (j) only imposes an obligation to inform plaintiff of contractual time limits for judicial review when the claim is for disability benefits."[162] "Because this is not a disability benefits case, this requirement does not apply."[163]

3. Analysis

ERISA disability benefit administrators will likely continue to comply with subsection (j)(4)(ii). Adding the required language into an adverse benefit determination is straightforward and can be done automatically using basic software. Further, the consequences for failing to do so are severe because it will enable claimants to revive benefit claims under subsection (j)(4)(ii) that would otherwise have been dismissed.

Despite the relative ease with which insurers could comply with this requirement in all ERISA benefit determinations, we may continue to see failures to notify claimants of contractual limitation periods in non-disability ERISA benefit determinations. This failure may occur more often where benefit plans are self-funded by the employer because self-funded employers may not have the same safeguards in place to ensure compliance with the 2018 Regulations. As discussed above, a circuit court split exists regarding whether administrators are required to include contractual limitation periods in adverse medical benefit determinations, but momentum is building in favor or required disclosure.[164]

To obtain the intended purpose of subsection (j)(4)(ii), the DOL may need to further amend the 2018 Regulations to clarify whether subsection (j)(4)(ii) applies only to claims for ERISA disability benefits or whether it applies to all ERISA benefit claimants. If the DOL intends for this to apply to all ERISA benefit claimants, the 2018 Regulations should be amended to state this.

F. *Culturally and Linguistically Appropriate Notices*

The 2018 Regulations require that an adverse benefit determination regarding disability benefits "shall be provided in a culturally and linguistically appropriate manner."[165] To provide a notice in a culturally and linguistically appropriate manner, the section requires the following:

161. Theriot v. Bldg. Trades United Pension Tr. Fund, 2022 WL 2967439, at *5 (E.D. La. July 27, 2022).

162. *Id*. (citing 29 C.F.R. § 2560.503-1(j)(4)(ii)).

163. *Id*.

164. *See Popovchak*, 2023 WL 6125540, at *7; Hatch v. Wolters Kluwer U.S., Inc. Health Plan, 2023 WL 4930286, at *1 (N.D. Ill. Aug. 1, 2023); E.F. v. United Healthcare Ins. Co., 2022 WL 957200, at *6 (D. Utah Mar. 30, 2022); Anne A. v. United Healthcare Ins. Co., 2022 WL 957199, at *1 (D. Utah Mar. 30, 2022).

165. 29 C.F.R. § 2560.503-1(g)(1)(viii).

> (i) The plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;
>
> (ii) The plan must provide, upon request, a notice in any applicable non-English language; and
>
> (iii) The plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.[166]

The 2018 Regulations further specify:

> With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.[167]

1. The Intended Effect

By adding the culturally and linguistically appropriate standards requirement to the 2018 Regulations, the DOL sought to "appropriately balance the objective of protecting claimants by providing reasonable language assistance to individuals who communicate in languages other than English with the goal of mitigating administrative burdens on plans."[168] The DOL believes that "it is important to provide claims denial notices in a culturally and linguistically appropriate manner to ensure that individuals get the important information needed to properly evaluate the decision denying a claim and to allow for an informed decision on options for seeking review of a denial."[169]

2. Case Law from 2018 to 2023

Upon review of ERISA cases published on Westlaw through 2023, no court has yet found a violation of the 2018 Regulations at subsection (g)(1)(viii) or subsection (o). Any cases mentioning these amended regulations discuss the subsections in passing, but the culturally and linguistically appropriate notice requirements are not part of the dispute.

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166. 29 C.F.R. § 2560-503-1(o).
167. 29 C.F.R. § 2560.503-1(o)(2).
168. 81 Fed. Reg. 92,329.
169. *Id.*

3. Analysis

Given the lack of litigation involving violations of subsections (g)(1)(viii) and (o), most ERISA disability administrators are likely complying with the culturally and linguistically appropriate notice requirements in their adverse benefit determinations. Such compliance furthers the DOL's intended effect of "protecting claimants by providing reasonable language assistance to individuals who communicate in languages other than English."[170] However, given the language and communication barrier involved in any relevant dispute, it may take more time before adversely affected claimants are identified and are able to bring a lawsuit.

If any non-compliance is uncovered in the future, courts are likely to remand the case back to the administrator to ensure that the claimant has a full opportunity to develop and submit all evidence relevant to their case. This remand should include the opportunity to submit any evidence needed to rebut the insurer's non-complying adverse benefit determination. The remand should not consider the timing of claimant's rebuttal evidence in a negative light because the insurer's failure to comply with the regulations prevented the claimant from initially developing the evidence.

To obtain the intended purpose of subsection (g)(1)(viii), the DOL may need to further amend the 2018 Regulations to:

- specify whether a remand is automatically warranted in the event of a violation and whether a claimant can submit additional evidence in support of their case following the violation.
- more fully protect ERISA benefit claimants who do not speak English, the DOL could require that all adverse benefit determinations contain a short notice prominently displayed on the first page in multiple languages that directs claimants to a webpage where the notice can be translated into any language.

G. *Retroactive Coverage Rescission Triggers Appeal Protections*

The 2018 Regulations state:

> In the case of a plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.[171]

170. *See id.*
171. 29 C.F.R. § 2560.503-1(m)(4)(ii).

1. The Intended Effect

In the 2018 Regulations, the DOL sought to expand the definition of the term "adverse benefit determination."[172] This change makes it clear that a claimant who loses disability insurance coverage due to a recission of benefits, even retroactively, has experienced an adverse benefit determination.[173] Since this loss of coverage is an adverse benefit determination, the individual who lost benefit coverage is entitled to certain rights under ERISA, including the right to appeal the decision.[174]

2. Case Law from 2018 to 2023

Upon review of ERISA cases published on Westlaw through 2023, only one case has cited the amended regulation at 29 C.F.R. § 2560.503-1(m)(4)(ii). In *Provident Life and Accident Insurance Co. v. McKinney*,[175] the U.S. District Court for the District of Connecticut considered the recission of an ERISA supplemental disability insurance policy. After McKinney enrolled in the supplemental disability insurance policy, the administrator, Provident, learned details about his medical history that were not disclosed on his initial application and rescinded the supplemental disability insurance.[176] After upholding the rescission on appeal, Provident filed a lawsuit against McKinney requesting the court rescind the policy under 29 U.S.C. § 1132(a)(3).[177] Neither party disputed that the rescission of a disability insurance policy was an adverse benefit determination. Nevertheless, the court ruled that a rescission is an adverse benefit determination under 29 C.F.R. § 2560.503-1(m)(4)(ii) in support of its partial approval of McKinney's discovery requests.[178]

3. Analysis

By expanding the definition of the term "adverse benefit determination" with its amendment to subsection (m)(4)(ii), the DOL gave more claimants the right to a full and fair review of their claims and the right to appeal any retroactive recission of coverage at the administrative level and through federal litigation. These additional protections should lead to more just outcomes for claimants who have their coverage retroactively rescinded.

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172. 81 Fed. Reg. 92,328.

173. *See id.*

174. 29 C.F.R. § 2560.503-1(h)(1).

175. Provident Life & Accident Ins. Co. v. McKinney, 2021 WL 7264743, at *1 (D. Conn. Sept. 14, 2021).

176. *Id.* at *1–2.

177. *Id.* at *3; *see also* Provident Life & Accident Ins. Co. v. McKinney, 2022 WL 4120768 (Sept. 9, 2022) (later granting Provident's motion for summary judgment).

178. *McKinney*, 2021 WL 7264743, at *6.

However, for many claimants, the administrative appeals process for retroactive recissions can be onerous. If significant time has elapsed between the application and the retroactive rescission, it may be difficult for claimants to gather all necessary information within the 180-day appeal deadline period prescribed by 29 C.F.R. § 2560.503-1(h)(3)(i).[179] The DOL could improve the effectiveness of the regulation by extending the timelines for appeals in cases involving retroactive rescission. A longer period for appeal would allow claimants adequate time to gather necessary documentation and consult experts, leading to a more equitable process.

V. CONCLUSION

What Are the Key Takeaways from the 2018 Regulation's Impact?
Since its inception, the 2018 Regulations ushered in significant improvements in the administration of ERISA disability claims. The mandate for impartiality and comprehensive disclosures ensures that claimants receive a fair review of their claims and appeals. The transparency required by the rule empowers claimants with crucial information to challenge adverse decisions effectively.

What Happens When Administrators Do Not Follow the Rules?
Non-compliance with the 2018 Regulations has serious repercussions for plan administrators—notably shifting any subsequent court reviews to a *de novo* standard. This change is significant because it encourages strict adherence to the rules by removing the deference previously given to administrators' decisions.

Are Claimants Better Protected Now?
Yes, claimants stand to benefit from the 2018 Regulations' protective measures. The right to respond to new evidence during appeals and clearer communication regarding decisions helps level the playing field, providing a more just and responsive system.

Have Courts Enforced the 2018 Regulations?
Courts have actively enforced many aspects of the 2018 Regulations thus far, ensuring that administrators are held to their obligations. Through case law, courts have shown that they are willing to penalize non-compliance, upholding the Regulations' intent to protect claimants.

179. *See* 29 C.F.R. § 2560.503-1(h)(3)(i).

Could Further Amendments Improve the Regulations?

While the 2018 Regulations made strides in claimant protection, the potential for future amendments exists. These amendments may address new challenges and further refine the regulations to ensure they continue to meet claimants' needs effectively.

In conclusion, the 2018 Regulations represent a milestone in ERISA claims processing, enhancing fairness and transparency for claimants. It holds administrators accountable and provides a framework for the judicious resolution of disputes, marking a positive step for those navigating the complexities of disability benefit claims.

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