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June 5, 2017

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EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

FEDERAL COURT DECISIONS HIGHLIGHT IMPORTANCE OF TIMELY CLAIMS PROCESSING FOR BENEFIT PLANS

Recent decisions in the Second Circuit Court of Appeals and the Southern District of New York highlight the importance of timely processing of claims for benefits under employee benefit plans. Plan administrators should review the claims processing standards currently followed by their plans, and take steps to ensure that claims are addressed in a compliant fashion by the applicable deadlines.

Background

The Employee Retirement Income Security Act ("ERISA") requires that employee benefit plans maintain procedures for deciding claims for benefits, and for reviewing appeals from a plan's initial decision to deny a claim. The U.S. Department of Labor (the "DOL") has issued regulations establishing timeframes for responding to initial claims and appeals of denied claims. Typically, plan documents empower a plan fiduciary, such as the plan administrator, to oversee this claims and appeals process and to interpret the plan document in its discretion when making decisions about claims and appeals. In most cases, if such a plan fiduciary denies a claim and the claimant has exhausted all mandatory levels of administrative appeals made available by the plan, the claimant then can proceed to court. Generally, if a claimant decides to sue after his or her appeal is denied, the reviewing court will not reverse the plan fiduciary's decision to deny the claim unless the court considers that denial to have been "arbitrary and capricious."

In contrast, federal courts are divided in their approach to situations in which a plan fiduciary failed to follow the claims procedures and/or failed to issue a timely response. In its 2017 decision in *Halo v. Yale Health Plan*, the Second Circuit took a particularly strict position on the question. In that case, the court ruled that a plan fiduciary that failed to provide a timely decision should not enjoy the deference that would have otherwise been given to its (delayed) decision, unless the plan had established compliant claims procedures and the fiduciary could show that the delay was both "inadvertent" and "harmless."[1] The Second Circuit also said that a compliance failure might allow a plaintiff to introduce new evidence for the first time in court, if the district court concluded there was "good cause" to do so. Normally, evidence that wasn't introduced by the plaintiff in the claims process cannot be introduced in court. At least for plans operating in the Second Circuit, this case raises the stakes associated with proper handling of claims.

In the absence of the usual deferential standard of review, a judge will decide the claim "*de novo*." In other words, after reviewing the administrative record (and if there is "good cause" to do so, additional evidence

[1] Under health care reform's internal claims and appeals rules (applicable to non-grandfathered group health plans), if the plan fails to strictly adhere to the internal claims and appeals rules (with an exception for de minimis violations), claimants may proceed directly to court or external review prior to first exhausting the internal review process. If a claimant proceeds directly to court (or, if the claimant proceeds directly to external review and is unsuccessful, and then files a lawsuit) without first having exhausted the plan's internal review process, the court will likely apply the less favorable *de novo* standard of review.

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presented in court) the judge will determine in his or her sole discretion whether the claim ought to be denied. In contrast, under the usual deferential "arbitrary and capricious" standard, a judge will uphold the plan fiduciary's decision so long as the decision was reasonable. While some benefit claims are straightforward and would be denied under either standard, many turn on fine points of judgment or plan document provisions that could reasonably be interpreted more than one way. Accordingly, the loss of the deferential standard of review increases the risk that a court will overrule the plan fiduciary and require a plan to pay the disputed claim. The application of a *de novo* standard may also allow the claimant some level of additional discovery, which can increase the time and expense associated with handling a case.

Salisbury v. Prudential

In *Salisbury v. Prudential Insurance Co. of America*, the federal District Court for the Southern District of New York interpreted the *Halo* decision and adopted a stringent interpretation of the standard for extending the regulatory deadlines. In that case the DOL claims regulations required a response to the claimant's appeal of her denied long-term disability claim within 45 days, or within 90 days in the event that "special circumstances" prevented a decision within 45 days and the claimant was notified, prior to the expiration of the initial 45 day period, of the need for an extension. Prudential provided timely notice that "an extension was required to allow for review of the information in Ms. Salisbury's file which remains under physician and vocational review." Prudential then issued its final denial within the 45-day extension period. However, the court concluded that Prudential did not demonstrate the "special circumstances" necessary to justify the extension. The court also held that Prudential's deliberate decision to impose an extension without adequate justification was not "inadvertent," and could not be excused under *Halo*. As a result, the court held that Prudential's decision to deny the plaintiff's claim for long-term disability benefits was untimely, and would be reviewed under the plaintiff-friendly *de novo* standard of review.

Prudential had not alleged in its notice of extension to Ms. Salisbury that additional time was needed because her file was unusually voluminous or complex, yet it argued for the first time in court that her file contained 4,623 pages of medical records and days of surveillance footage that required extended time to review. The court, citing the preamble to the DOL's claims regulation, emphasized that "having too much work," and "delays caused by cyclical or seasonal fluctuations in claims volume" are insufficient reasons to justify an extension. Reviewing Prudential's stated justification for an extension in this light, the court concluded that Prudential had not identified anything about Ms. Salisbury's claim that made it unusual, commenting that virtually all disability appeals require medical and vocational review, and that allowing an extension on these grounds would allow a plan fiduciary to extend the review period for almost any disability claim. [2]

Since Prudential had not alleged in its notice of extension that Ms. Salisbury's file was unusually voluminous or complex, the court declined to consider the details that Prudential provided in its court filings to bolster its assertions that additional time for review was needed in Ms. Salisbury's case. The court

[2] Interestingly, the court, which was deciding a case in which a plan took an extension of time to decide an appeal, stated that plans should not take an extension of time unless it is for a reason "beyond the control of the plan." However, under the DOL regulations, the "beyond the control of the plan" rule is only applicable to extensions regarding the time frame to decide claims, not appeals. The appeals rules only require "special circumstances" for an extension, and so on an appeal, there may be circumstances in which a plan could take an extension even if not due to matters beyond the control of the plan.

also commented that even if it were to take those details into account, it doubted that "4,623 pages of medical records and several days of surveillance" would be sufficient to justify an extension, categorizing this circumstance as in line with the "fluctuations in claim volume" rejected by the DOL preamble. The court also emphasized that, as stated in the DOL's preamble, the claims regulations are clear that the time periods for rendering decisions are maximum periods, not automatic entitlements.

Next Steps

The *Salisbury* case represents one court's interpretation of the Second Circuit's plaintiff-friendly *Halo* decision. Some courts have taken similarly plaintiff-friendly approaches, while others have rejected the *Halo* approach outright. The Ninth Circuit recently took a middle path when it ruled in *Smith v. Reliance Standard Life Ins. Co.* that a violation of the regulatory claims processing requirements "may alter" the standard of review if it caused the claimant "substantive harm." However, a plan fiduciary can maximize the odds of avoiding the issue entirely by adhering to fully compliant claims procedures and emphasizing to staff and vendors that claims are to be processed promptly and within non-extended deadlines except in unusual circumstances. Reducing the possible grounds for dispute in this fashion and protecting the plan's right to a deferential standard of review will reduce litigation costs, risks and complexity. Where claim adjudication responsibility resides with a third party, such as an insurance carrier or claims administrator, it may be more difficult for the plan administrator to ensure compliance with the claims procedure. Strong contractual language and periodic monitoring of the third party's claim processing performance (beyond simply accuracy measurement) and adverse benefit determination communications may help to reveal and correct flawed processes.

Furthermore, a claimant whose claim has been handled in a thorough, timely and courteous fashion and who has received the detailed information required by the claims regulations is more likely to be satisfied that the process was fair and that the conclusion was accurate- and hence is less likely to litigate or to seek assistance from the DOL. Likewise, a court reviewing a claim handled in this fashion is less likely to look for reasons to justify a *de novo* review of the grounds for the decision. Finally, the employer offers the plan for the purpose of delivering benefits to employees and their beneficiaries, and presumably wants them to receive their proper benefits in a timely and efficient fashion. A confusing claims and appeals process fraught with delays and lacking in transparency is likely to frustrate the employer's intentions by resulting in potentially harmful long waiting periods, denials of meritorious claims, and dissatisfied employees. In the long run, no one benefits from a poorly operated claims process.

Specifically, in the wake of *Salisbury*:

- Plan fiduciaries should confirm that their claims staff and vendors are adhering to applicable deadlines. As a matter of best practice, claims should be processed as soon as reasonably possible, and not deliberately left until the applicable deadline.
- Extensions should be the exception, not the rule. Management should exercise appropriate oversight of decisions that an extension is warranted.

- Any notice to a participant or beneficiary regarding an extension of time to render a decision on a claim or an appeal should include the specific reason(s) why the extension is necessary, and should not speak in empty generalities.
- Be prepared to defend the need for an extension.
  - For example, a natural disaster that destroyed documents necessary to the plan administrator's determination would be beyond the control of the plan and would likely warrant an extension of time to render a decision while the facts reflected in the documents were reconstructed.
  - The DOL claims regulations give the example of the need to hold a hearing (if the plan's procedures call for such a hearing) as a "special circumstance" which could justify an extension. Similarly, the desire to have a claim or appeal reviewed by a committee or specialist that will not be available within the specified time from the filing of a claim or appeal might justify an extension. However, in both of these cases, the plan would want to be able to demonstrate that the need to adjust the timeframe was caused by unusual circumstances and that its claims and appeals infrastructure is adequate to enable most claims and appeals to be processed within the usual timeframe.
- Fiduciaries should also confirm that staff and vendors are in compliance with other aspects of the claims regulations, such as disclosure and notice requirements. This is particularly important with regard to self-insured medical plans, which are subject to more onerous requirements than other types of benefit plans, particularly since the enactment of the Affordable Care Act in 2010.
- Fiduciaries should make sure that their plan documents and any administrative procedures reflect current legal requirements, align with actual plan operations, and contain appropriate language granting the claims fiduciary the discretion to decide claims and interpret the plan.

For More Information

As always, please feel free to contact a member of the Employee Benefits & Executive Compensation group for more information about the items discussed in this newsletter, or for assistance in other matters.