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Read the Instructions First! Recent Court Decisions Flag Possible "Full and Fair Review" Pitfalls for Plan Administrators

By Hope H. Tone-O'Keefe and Joseph J. Torres

Although some people may only honor this rule of thumb in the breach, most of us understand that it is always advisable to first understand the rules that govern any project or undertaking. Given their complexity, few lawyers would be surprised that this bit of advice is critical in administering benefits plans governed by the Employee Retirement Income Security Act ("ERISA").

This column looks at some of the pitfalls that await plan administrators who fail to heed this advice. Specifically, this column will discuss recent court decisions applying ERISA's "full and fair review" requirement. It will also review cases that address benefit plans' obligations to produce all "relevant" documents during the benefit claims review process. Finally, this column will outline some practical guidance and best practices for plan administrators to consider in light of some of these recent decisions.

BACKGROUND AND STATUTORY GUIDANCE ON "FULL AND FAIR REVIEW"

Before getting into the case developments, some background is helpful to understand the purpose and framework for requiring a benefit claims process.

Hope H. Tone-O'Keefe is an associate in Jenner & Block LLP's Chicago office. Joseph J. Torres, a partner in the firm's Chicago office, is chair of firm's ERISA litigation practice. They may be contacted at *htoneokeefe@jenner.com* and *jtorres@jenner.com*, respectively.

One of the key policies underlying the enactment of ERISA was ensuring clear and consistent rules for the processing of benefit claims.[1] Courts have observed that such pre-litigation processes advance several important goals. Specifically, they "further the overall purpose of [ERISA's] internal review process: to minimize the number of frivolous lawsuits; promote consistent treatment of claims; provide a nonadversarial dispute resolution process; and decrease the cost and time of claims settlement."[2]

To further emphasize that important tenet, ERISA expressly requires plans to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."[3] Notably, the "full and fair review" requirement applies only "once an adverse benefit determination has been issued," and does not apply to the initial adverse benefit determination.[4]

And to give additional force and effect to the "full and fair review" obligation the Department of Labor has long since promulgated regulations outlining what constitutes a "full and fair review" for employee benefit plans generally, group health plans, and plans providing disability benefits.[5]

Thus, to comply with the "full and fair review" requirement, the benefit plan administrator must:

- Provide the claimant 60 days to appeal an adverse benefit determination;

- Provide the claimant the opportunity to submit written comments, documents, records, or other information relating to the claim for benefits;

- Upon request, provide the claimant with reasonable access to and copies (free of charge) of all documents, records, and other information relevant to the claimant's claim for benefits; and

- Provide for a review that takes into account all comments, documents, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.[6]

Additional requirements apply both to group health plans and to plans providing disability benefits.[7]

For example, group health plans are also required to provide for a *de novo* review, or one that does not afford deference to the initial adverse benefit determination. The review must be conducted by an appropriate named fiduciary of the plan.

In addition, if reviewing an adverse benefit decision that is based in part or in whole on medical judgment, the fiduciary must consult with a

health care professional with the appropriate training and experience in the field of medicine involved in the medical judgment.[8]

More recently, in December 2016, the Department of Labor revised the "full and fair review" requirements as they pertain to disability benefit claims, effective for all such claims filed after January 1, 2018.[9] The additional requirements for reviewing disability benefit claims mirror requirements for reviewing group health claims imposed by the Affordable Care Act.[10]

The Department of Labor explained that the change was necessary to ensure that disability benefit claimants receive the same level of procedural protections as group health plan participants.[11] According to these revisions, plans providing disability benefits must require the plan administrator to give the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the plan. If the plan administrator intends to make an adverse benefit decision, the plan administrator must explain the rationale for that decision and give the claimant adequate time to respond.[12]

Because these later changes applied only to claims filed after January 1, 2018, federal courts are just now reviewing and interpreting the new language.[13]

CONSIDERING AND PROVIDING "RELEVANT" DOCUMENTS

For any type of adverse benefit decision, to comply with the "full and fair review" requirement, the plan administrator must additionally determine what constitutes a "relevant" document.[14]

Importantly, a document is considered relevant if it was either relied upon in making the benefit determination or if it was submitted, considered, or generated in the course of making the benefit determination.[15] This latter requirement imposes a broader obligation than just producing the documents the plan administrator may have relied upon in reaching a determination.[16]

Although the statute does not explicitly require the "production" of these documents, several courts have held that the production of the documents is "implied."[17]

CONSEQUENCES OF FAILING TO PROVIDE A "FULL AND FAIR REVIEW"

The purpose of the "full and fair review" is to "encourage resolution of the dispute at the administrator's level before judicial review."[18] Thus, before bringing an ERISA claim in federal court, the claimant must exhaust the administrative remedies laid out in the benefits plan.[19]

Why does any of this matter? Because if a benefit claim dispute reaches federal court, different standards of review apply, depending on the plan's review below. When a plan administrator has discretion to interpret a plan, a district court reviewing a final benefits determination applies the arbitrary-and-capricious standard, which means that the district court may disturb the determination only if it was "without reason, unsupported by substantial evidence, or erroneous as a matter of law."[20] This standard of review is highly deferential to the plan administrator's underlying review, which increases the likelihood that the federal court will not disturb a denial of benefits – an outcome that proceeds from the base requirement that the plan administrator has complied with the "full and fair review" requirements.

If, however, the administrator fails to follow claims procedures consistent with ERISA's requirements, including by failing to comply with the "full and fair review" requirement, the claimant can be excused from exhausting administrative remedies altogether.[21] If that happens, then the district court applies *de novo* review.[22] This increases the risk that the reviewing court may overturn an administrator's decision to deny a benefit claim.

RECENT DECISIONS EMPHASIZE THE IMPORTANCE OF "FULL AND FAIR REVIEW"

Courts are just now beginning to address the updated requirements that the Department of Labor clarified in 2016. In fact, in August 2021, the U.S. Court of Appeals for the Second Circuit was still using the previous version of the regulation to analyze the "full and fair review" standard.[23] But those courts that have begun to review these requirements have highlighted pitfalls that plan administrators must avoid to ensure their benefit denials are upheld.

For example, in *Jette v. United of Omaha Life Ins. Co.*, the U.S. Court of Appeals for the First Circuit applied the "full and fair review" standard for the denial of disability benefits and determined what documents and information were relevant to that review.[24] There, the claimant suffered from a degenerative back disease that made it impossible for her to sit or stand for a period of more than 20 minutes. The claimant's request for long term disability was denied via letter.[25]

When the claimant appealed the denial, she requested that the plan administrator provide any new medical opinions relied on as well as sufficient time for her to respond to those medical opinions.[26] As part of the appeal process, the plan administrator had the claimant evaluated by another doctor, who generated a report that the plan administrator ultimately relied on to deny claimant's request for disability benefits. [27] Although the claimant requested all medical opinions generated, which would have included this new report, the plan administrator refused to produce the report to claimant.[28]

The plan administrator argued that the medical reports generated during the "full and fair review" should not be considered "relevant" documents.[29] Instead, the plan administrator argued that "relevant" documents were limited to those relied upon in the initial benefit determination, not anything created or relied upon during the appeal.[30]

The First Circuit rejected this argument because the statute clearly states that the claimants should be provided all documents or information relevant to his or her "claim for benefit."[31] The court explained that "claim for benefits" included all stages of the claim for benefits, including the initial benefit determination and any subsequent claims or denials.[32] According to the First Circuit, this conclusion was buttressed by the fact that the Department of Labor used "claim for benefits," "adverse benefit determination," and "initial benefit determination" throughout the applicable regulations to refer to distinct concepts.[33] This supported the conclusion that when the DOL required production of all documents relevant to the "claim," it sought to encompass then entire process.[34] Thus, "'relevant' documents require a nexus to a 'benefit determination,' not an 'adverse' or 'initial' benefit determination."[35]

The court explained that the plan administrator's narrow reading of the statute would "frustrate the purpose" of the full and fair review because the claimant would not be able to meaningfully participate in the review process.[36]

The First Circuit also rejected the district court's decision that documents need only be provided if the benefit plan "relies on them to find a new reason to deny coverage."[37] The First Circuit held that no such requirement existed, and that any document was relevant if it was "submitted, considered, or generated in the course of *making* the benefit determination, regardless of whether it was relied upon in making the benefit determination."[38]

The First Circuit emphasized in reaching its conclusion that "'The purpose of [the 'full and fair review'] requirement is to provide claimants with enough information to prepared adequately for further administrative review or an appeal for the federal courts.'"[39] It further noted that participants would be prevented from engaging in a meaningful prelitigation "dialogue regarding the denial of benefits" "if the evidence is provided to them only after the final decision is rendered, which is too late for them to respond."[40]

Ultimately, the First Circuit vacated the district court's decision and remanded the case with instructions that the case be further remanded from the district court to the plan administrator for a full and fair review of the claim.[41]

The decision in *Jette* emphasizes the importance of providing a full and fair review and the consequences of failing to do so. Indeed, in *Jette*, in addition to the procedural shortcomings the court found, notably, the plan administrator made its final adverse benefit decision in 2016, but the parties are still litigating the case today. Obviously, such extended litigation increases the costs of benefit plan administration.

OTHER CASES HIGHLIGHT BEST PRACTICES FOR PLAN ADMINISTRATORS

Some recent decisions highlight common mistakes that plan administrators make when providing a full and fair review. Discussed below are a number of steps that claim administrators can take to ensure they provide adequately "full and fair review," and avoid prolonged litigation over an adverse benefits decision.

Review Plan Documents to Ensure That They Include Full Appeals Procedures

Several courts have recently addressed the sufficiency of a claimant's notice of the administrative appeal process. A court in the U.S. District Court for the Eastern District of Missouri held that a plan provider's notice was insufficient where the appeal procedure was described only in the denial letter, and not in the plan document itself. [42]

The court held that "a plan document that does not include information about internal appeal procedures cannot satisfy ERISA's requirement that it 'sufficiently, accurate[ly,] and comprehensive[ly]' describe the terms of the plan and regulatory dictates that it include procedures for reviewing denied claims, remedies available for denied claims, and procedures required under Section 503."[43] In light of the failure, the plaintiff in that case was excused from exhausting the plan's pre-litigation administrative remedies.[44]

The U.S. Court of Appeals for the Fifth Circuit recently addressed a similar issue, where the applicable plan documents described one appeal process and the benefits denial letter described another.[45] The Fifth Circuit found that the discrepancy between the two documents meant that the denial letter provided insufficient explanation of the available administrative remedies.[46] This was particularly the case where the denial letter "actively discourage[d]" the plaintiff from seeking further administrative review.[47] In that circumstance, the court rejected the idea that a participant is obligated to exercise some diligence to determine "what administrative remedies remain available after a plan administrator denies her claim on appeal."[48] Benefit denial letters should therefore be reviewed in conjunction with any plan documents to make sure that all documents consistently describe the administrative appeal process.[49]

Document Plan Administrator's Full Review of All Information Submitted by Claimant

A court in the U.S. District Court for the Northern District of Illinois recently held that a plan administrator had sufficiently considered a claimant's evidence while performing a full and fair review of an adverse

benefit decision.[50] The plan administrator corresponded "diligently" with the claimant to apprise him of what information he needed to submit to qualify for disability benefits.[51]

Accordingly, the court rejected the claimant's argument that the plan administrator needed to gather additional evidence to make its decision when the plan administrator already had relevant medical records and testimony regarding the claimant's injury.[52] As the court noted, "'the primary responsibility for providing medical evidence to support a claimant's theory rest with the claimant.'"[53] The court emphasized that the record demonstrated the plan administrator engaged in "meaningful dialogue" with the claimant and ultimately granted the plan administrator's motion for summary judgment.[54] Nonetheless, plan administrators should keep in mind their obligation to engage in meaningful dialogue with claimants, especially if relevant information is missing from the administrative record. [55]

Account For and Substantively Assess All Documents and Contentions Raised by Claimant

A court in the Eastern District of Michigan determined that by failing to consider the Social Security Administration's disability determination, which the claimant had provided to the plan administrator to review, the plan administrator deprived the claimant of her "full and fair review."[56] All documents submitted by a claimant should be accounted for and reviewed. Reviewers should also avoid "cherry-picking" facts that support denial of a claim, or ignoring evidence that might support granting an appeal.[57]

Be Familiar with Different "Full and Fair Review" Requirements for Different Types of Benefits Claims (e.g., Medical, Disability, Severance)

As discussed above, group health care plans and disability benefit plans have additional requirements to comply with the "full and fair review" requirement.[58] Those responsible for processing these claims should be familiar with the various requirements.

Consider Which Documents, Records or Other Information Shall Be Considered "Relevant" to Claimant's Claim

As the First Circuit's decision in *Jette* highlighted, an important part of providing a "full and fair review" is first determining which documents are relevant to that review.[59] Plan administrators should be familiar with what constitutes a "relevant" document.[60]

Avoid "Rubber Stamping" Initial Claims Denial

A court in the Northern District of Oklahoma recently analyzed whether a plan administrator actually considered the evidence it cited in its initial adverse determination when performing a "full and fair review."[61] In his appeal, the claimant provided evidence that conflicted with the evidence included in the initial adverse determination.[62] The court concluded that the plan administrator had not performed a "full and fair review" because it had failed to gather any evidence to confirm or refute claimant's statements.[63]

Adhere to Any Applicable Time Limitations

As discussed above, ERISA imposes various time limits on plan administrators when they are considering benefit claims. Plans should also generally be sure to meet applicable time limits established by ERISA or the plan.[64] Plans should be mindful of the fact that ERISA also imposes requirements on establish the "special circumstances" that would justify extensions of ERISA-imposed deadlines.[65]

CONCLUSION

As the recent decisions discussed above emphasize, the consequences of failing to provide a claimant with a "full and fair review" can be high. Plan administrators should take care to comply with the required "full and fair review" of claims and avoid common mistakes and pitfalls that other plan administrators have made in the past. Plan administrators should also carefully evaluate requests for documents related to a claim for benefits, to insure they are complying with ERISA's requirements regarding what documents fall within the relevant definitions.

Careful attention to both these issues will go a long ways towards reducing plan administration costs and the risk of litigation.

NOTES

1. S. Rep. No. 117 (1993).

2. *Spradley v. Owens-Illinois Hourly Employees Welfare Ben. Plan*, 686 F.3d 1135, 1140 (10th Cir. 2012) (citation and internal quotation marks omitted).

3. 29 U.S. Code § 1133(2).

4. *Id.; William Callas, Thomas Cassese, & Natalie Ferd, v. S&P Global Inc.*, No. 19-cv-1478, 2022 WL 255114, at *13 (S.D.N.Y. Jan. 26, 2022).

5. 29 C.F.R. § 2560.503-1.

6. 29 C.F.R. § 2560.503-1(h)(2).

7. 29 C.F.R. § 2560.503-1(h)(3-4).

8. 29 C.F.R. § 2560.503-1(h)(3).

9. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 243, 92318 (Dec. 19, 2016).

10. *Id.*

11. *Id.*

12. 29 C.F.R. § 2560.503-1(h)(4).

13. *Id.*

14. 29 C.F.R. § 2560.503-1(m)(8).

15. 29 C.F.R. § 2560.503-1(m)(8).

16. *Nguyen v. Sun Life Assurance Co. of Canada*, No. 14-cv-05295, 2015 WL 6459689, at *2 (N.D. Cal. Oct. 27, 2015).

17. *Viani v. Lincoln Nat'l Life Ins. Co.*, No. 21-cv-00004, 2021 WL 4358729, at *6 (S.D. Cal. Sept. 23, 2021), *modified on reconsideration,* No. 321-cv-00004, 2021 WL 6075866 (S.D. Cal. Dec. 23, 2021); *Nguyen*, 2015 WL 6459689, at *2.

18. *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 540 (5th Cir. 2007).

19. 29 C.F.R. § 2560.503-1(k)(2)(ii).

20. *Novella v. Westchester Cnty.*, 661 F.3d 128, 140 (2d Cir. 2011).

21. 29 C.F.R. § 2560.503-1(k)(2)(ii).

22. *Halo v. Yale Health Plan*, 819 F.3d 42, 60-61 (2d Cir. 2016).

23. *Mayer v. Ringler Assocs. Inc.*, 9 F.4th 78, 88 (2d Cir. 2021).

24. 18 F.4th 18, 27 (1st Cir. 2021).

25. *Id.* at 21.

26. *Id.* at 25-26.

27. *Id.* at 25-26.

28. *Id.* at 25-26.

29. *Id.* at 27.

30. *Id.* at 27.

31. *Id.* at 27.

32. *Id.* at 28.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.* at 27.

37. *Id.* at 29 (emphasis added).

38. *Id.* at 29.

39. *Id.*

40. *Id.*

41. *Id.* at 33.

42. *Yates v. Symetra Life Ins. Co.*, No. 4:19-cv-154, 2022 WL 19211, at *5 (E.D. Mo. Jan. 3, 2022).

43. *Id.*

44. *Id.* at *2.

45. *Theriot v. Bldg. Trades United Pension Tr. Fund*, 850 F. App'x 231, 236 (5th Cir. 2021).

46. *Id.* at 237.

47. *Id.* at 236.

48. *Id.* at 237.

49. 29 C.F.R. § 2560.503-1(b).

50. *Lane v. Structural Iron Workers Loc. No. 1 Pension Tr. Fund*, No. 20-cv-6769, 2021 WL 6197074, at *9 (N.D. Ill. Dec. 30, 2021).

51. *Id.* at 10.

52. *Id.* at 10.

53. *Id.* at 10.

54. *Id.* at 11.

55. *Id.* at 12.

56. *Nuffer v. Aetna Life Ins. Co.*, No. 1:20-cv-10935, 2021 WL 4391119, at *3 (E.D. Mich. Sept. 24, 2021), *amended,* No. 1:20-cv-10935, 2021 WL 5851021 (E.D. Mich. Nov. 24, 2021).

57. 29 C.F.R. § 2560.503-1(g).

58. 29 C.F.R. § 2560.503-1(h)(3-4).

59. 18 F.4th at 27.

60. 29 C.F.R. § 2560.503-1(m)(8).

61. *Edith Evans, v. United Healthcare of Oklahoma Inc.*, No. 20-cv-0670, 2022 WL 319973, at *9-10 (N.D. Okla. Feb. 2, 2022).

62. *Id.*

63. *Id.*

64. *See* 29 C.F.R. § 2560.503-1(f).

65. *Id.*