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Do As I Say, Really Means Do As I Say: The Fourth Circuit's *Cogdell* Decision and the Cost of Missing ERISA Disability Claims Deadlines

By Joseph J. Torres, Emma J. O'Connor, and Christopher J. LeWarne

The Employee Retirement Income Security Act (ERISA) provides plan sponsors great latitude regarding whether to offer employee benefits and the scope of those benefits.[1] And plan sponsors can also add language to their plan documents that provides for deferential review of the plan administrator's interpretation and application of claims decisions.[2] However, ERISA also mandates that, once a plan offers employees the ability to receive benefits, that they are provided a "full and fair review" of any claims denial.[3] And a recent decision, *Cogdell v. Reliance Standard Life Insurance Co.*,[4] took on two key questions for ERISA practitioners regarding the dangers of running afoul of those requirements: (1) what kind of "special circumstances" may justify an ERISA disability plan administrator's delay in issuing a claims decision, and (2) how the Supreme Court's recent decision in *Loper Bright Enters. v. Raimondo*,[5] may affect the deferential review of ERISA claims. The Fourth Circuit opinion offers stark reminders for plan administrators about strict adherence to deadlines.

Joseph J. Torres is a partner in Jenner & Block LLP's Chicago office and chair of the firm's ERISA Litigation practice. Emma J. O'Connor is an associate in the firm's Washington, D.C., office and a member of the firm's ERISA Litigation practice. Christopher J. LeWarne is an associate in the firm's Chicago office. The authors may be contacted at jtorres@jenner.com, eoconnor@jenner.com, and clewarne@jenner.com, respectively.

APPLICABLE IMPLEMENTING REGULATIONS

General

The Department of Labor (DOL) promulgates rules and regulations for ERISA administration and enforcement that cover several key areas, including claims procedures.[6] The regulations set out detailed minimum requirements for how employee benefit plans must handle benefit claims, including filing procedures, timing of decisions, notice content, appeal rights, and special rules for group health plans, disability benefits, and urgent care claims.[7]

The DOL regulations include a "full and fair review" standard,[8] which provides that every employee benefit plan must establish a procedure giving claimants a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary, with a full and fair review of the claim. To meet this standard, a plan's claims procedures must provide claimants at least 60 days to appeal after receiving notice of an adverse determination, allow claimants to submit written comments, documents, records, and other information, give claimants free access to and copies of all documents relevant to their claim, and conduct a review that considers all information the claimant submits regardless of whether it was part of the initial determination.

For group health plans, the requirements are more demanding. Claimants get at least 180 days to appeal. The review must not defer to the initial adverse determination and must be conducted by someone other than the person who made the original decision (or that person's subordinate). When the appeal involves a medical judgment, the plan must consult with an appropriately qualified health care professional who wasn't involved in the original determination. The plan must also identify any medical or vocational experts whose advice was obtained.

The plan administrator generally has 60 days to decide an appeal, extendable by another 60 days for special circumstances. The regulation specifically mentions the need to hold a hearing (if the plan's procedures provide for one) as an example of a qualifying special circumstance. For plans with a committee or board of trustees that meets at least quarterly, the timeline is tied to meeting dates rather than fixed day counts, but "special circumstances" can still extend the deadline to a third meeting following receipt of the appeal request.

Disability Benefit Claims

The regulations for disability benefits were updated via a final rule the DOL published on December 19, 2016, which became applicable to disability benefit claims filed after April 1, 2018, and which focused specifically on strengthening protections for disability benefit claimants under §2560.503–1. For disability benefits, plans must meet all of the group

health plan requirements, and additionally must provide the claimant with any new or additional evidence the plan considered, relied upon, or generated in connection with the claim sufficiently in advance of the final decision to allow the claimant to respond. The same applies to any new rationale on which the plan intends to rely. In other words, a plan can no longer wait until the end of the period to spring new evidence or reasoning on the claimant and then immediately issue a denial.

For disability claims specifically, the initial decision period is 45 days, extendable by up to two additional 30-day periods for "special circumstances," or matters beyond the plan's control. Notably, when a disability claim extension is invoked, the notice must specifically explain the standards for entitlement, the unresolved issues preventing a decision, and what additional information is needed.

LEGAL BACKGROUND

Also relevant to this discussion is recent Supreme Court precedent regarding the appropriate deference to administrative agency regulations. In June 2024, the Supreme Court issued a landmark decision in *Loper Bright Enters. v. Raimondo*, which overturned the well-established precedent set by *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*[9] The *Loper Bright* decision altered the way courts interpret federal agency regulations, no longer requiring courts to defer to an agency's interpretation of ambiguous statutes (commonly known as *Chevron* Deference). How this new landscape would affect statute-based sectors of law like ERISA has been the subject of much debate.

Claimants bringing disability claims under ERISA often rely heavily on the DOL regulations discussed above, and the question of how *Loper Bright* would impact these regulations has been up for debate.

COGDELL V. RELIANCE STANDARD LIFE INSURANCE CO.

District Court Decision

Plaintiff Heather Cogdell worked at MITRE Corporation as a Principal Business Process Engineer. After contracting COVID-19 in July 2021 and suffering long-COVID-19 symptoms, she began to recover, but a second COVID infection in July 2022 left her unable to work.[10] She filed a long-term disability (LTD) claim in November 2022. To be entitled to LTD benefits, Cogdell must have been "Totally Disabled," meaning that she was unable to perform the material duties of her regular occupation.[11] In January 2023, Reliance Standard (the plan administrator) denied her claim.[12]

Cogdell filed an internal appeal on August 15, 2023, giving Reliance 45 days to decide.[13] With her appeal, Cogdell filed a 21-page letter

in support of her claim, and various other documents for Reliance to consider. A Reliance nurse reviewed all the new materials within eight days, but then the file sat idle for 27 days before being referred to the appeals department.[14] On September 25, Reliance sent Cogdell a letter saying it needed more time for an independent physician review, and that the letter served "as notice of [its] intention to take beyond [45] days to make a final decision."[15] However, the letter never identified a "special circumstance" or provided an expected decision date. On October 3 (after the 45-day window expired), Cogdell sued. Reliance did not issue its denial until October 26—72 days after Cogdell filed her appeal.[16]

The district court applied de novo review (rather than the more deferential abuse-of-discretion standard), found Cogdell was totally disabled, and awarded her over $210,000 in past-due benefits plus interest.[17] Reliance appealed.

The Fourth Circuit's Holdings

The Fourth Circuit affirmed the district court on every issue, issuing three major rulings.

First, the Fourth Circuit held that no "special circumstances" existed to justify a 45-day extension to decide Cogdell's appeal.[18] The court first rejected Reliance's argument that "so long as a plan administrator determines special circumstances exist, that finding in and of itself is sufficient."[19] Under a textual analysis, the court interpreted "special circumstances" to mean a circumstance which "does not regularly arise in an internal appeal from the denial of benefits."[20] A claimant submitting new records on appeal, and the need to have those records reviewed by a physician, are routine and expected parts of the appeals process — not "special" or "unusual" events. Reliance's own timeline showed it could have completed the review in about 36 days; the delay was caused by letting the file sit idle for nearly a month.[21] Furthermore, regulations require the administrator to explain what the special circumstance was that justifies an extension, and why such circumstances are special, which Reliance did not do.

Second, Reliance's untimely decision stripped it of deferential review.[22] Under the 2018 amendments to ERISA regulations, disability plan administrators must "strictly adhere" to processing deadlines.[23] Drawing on *Firestone Tire & Rubber Co. v. Bruch*,[24] and trust law principles, the Fourth Circuit reasoned that deference is owed only when a fiduciary actually exercises its discretion within the boundaries set by the plan, ERISA, and the regulations.[25] The court drew a distinction between "compliance with rules conditioning the exercise of its discretion" and "compliance with rules about its substantive exercise of that discretion."[26] Because the former concerns "the boundaries within which [a plan administrator]

can exercise its discretion," a decision issued after the deadline is made outside those boundaries and is therefore not an exercise of discretion at all.[27]

The court rejected Reliance's substantial compliance argument, agreeing with the Seventh Circuit's reasoning in *Fessenden v. Reliance Standard Life Ins. Co.*[28] (authored by then-Judge Barrett) that allowing late decisions to reset the standard of review would leave claimants in an impossible strategic position.

Finally, the Fourth Circuit held that Reliance's *Loper Bright* challenge failed. Reliance argued that a 2018 regulation—which stated that if a claimant seeks review of an entitlement to benefits in federal court, the claim is "deemed denied on review without the exercise of discretion"—was an impermissible exercise of the Secretary's rulemaking authority.[29] The court found this argument meritless, because its de novo review holding flowed independently from *Firestone* and trust law, not from the regulation. The regulation simply defines the circumstances; the courts independently determine the standard of review.

On the merits, the Fourth Circuit upheld:

(i) the district court's findings that Cogdell was totally disabled;

(ii) its definition of "regular occupation";

(iii) its exclusion of medical reports obtained after the claim was deemed denied; and

(iv) its weighing of treating physicians' opinions.[30]

SIGNIFICANCE OF COGDELL

The *Cogdell* decision is significant for several reasons.

First, it establishes clearly that (at least in the Fourth Circuit) when an ERISA disability plan administrator misses its 45-day decision deadline without valid special circumstances, de novo review applies—even if the administrator eventually issues a decision. This removes a major advantage for plans, as abuse-of-discretion review is generally more difficult for claimants to overcome.

Second, the opinion also gives the term "special circumstances" some color, establishing that it must be something out of the ordinary, not a routine part of the appeals process like reviewing new records or consulting a physician. This limits administrators' ability to use boilerplate justifications for extensions.

Third, the Fourth Circuit's rejection of the *Loper Bright* challenge signals that post-*Loper Bright* attacks on ERISA's claims processing regulations

may face headwinds, particularly given the broad express rulemaking authority Congress delegated to the Secretary of Labor.

Finally, and perhaps most significantly, this decision is a reminder that, for disability claims subject to the post-2018 regulations, timing requirements are not mere technicalities. Failure to strictly comply with appeal deadlines may eliminate *Firestone* deference altogether.

BEST PRACTICES

In order to ensure strict adherence to the timing requirements set out in the DOL regulations—and avoid handing claimants a strategic advantage on appeal—plan sponsors and their plan administrators should keep the following best practices in mind:

- *Implement and maintain tracking and calendaring systems*. Having a reliable system to track every deadline is essential. The initial 45-day clock starts when the plan receives the claim, so documenting the exact date of receipt is critical. The system should automatically flag upcoming deadlines for the initial decision, any extensions, and the points at which extension notices must be sent to the claimant before the prior period expires.

- *Build in buffer time for extensions*. The regulations require that the claimant be notified of an extension before the current period expires. Waiting until the last day to decide whether an extension is needed creates unnecessary risk. Building in a review checkpoint well before the deadline (for example, at the 30-day mark of the initial 45-day period) allows the plan to assess whether it has enough information to make a decision and, if not, to send a timely and compliant extension notice that includes the required elements.

- *Front-load information gathering*. Delays are often caused due to waits for medical records, vocational assessments, or other documentation. Initiating requests for records and scheduling any independent reviews as early as possible after receiving the claim helps avoid situations where the plan runs out of time because of unanticipated document collection delays.

- *Coordinate with consulting experts*. If the plan uses outside medical or vocational reviewers, building contractual turnaround expectations into those service agreements helps ensure that expert opinions do not arrive too late to be incorporated into the decision within the applicable timeframe. This is especially important at the appeal stage, where the new evidence and rationale sharing requirements mean the plan needs time

not only to obtain the expert's opinion but also to share it with the claimant and allow a reasonable response window before the appeal decision deadline.

- *Standardize notice templates*. Maintaining pre-built templates for extension notices, adverse benefit determination notices, and appeal decision notices that already include all the required regulatory content reduces the risk of issuing a notice that is missing a necessary element.

- *Separate the appeal process from the initial decision*. The regulations require that the appeal be decided by someone other than the initial decision-maker or that person's subordinate, and that the process be independent and impartial. Having a clear organizational separation between initial claims adjudication and appeal review, with designated personnel for each, helps ensure that the independence requirements are met.

- *Document everything*. Thorough, contemporaneous documentation of all communications and decisions (and the reasoning behind any decisions) will help the plan administrator throughout the claims process.

- *Conduct regular compliance audits*. Periodically reviewing a sample of decided claims against the regulatory requirements can identify systemic issues before they become a pattern or practice.

CONCLUSION

For practitioners, the practical takeaway of *Cogdell* is clear: plan administrators that miss their deadlines face de novo review, which significantly increases claimants' chances of success. In addition to implementing the best practices above, plans should consult ERISA counsel to help design and refine their claims processes.

Notes

1. Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983).

2. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 102 (1989).

3. 29 CFR § 2560.503-1.

4. Cogdell v. Reliance Standard Life Insurance Co., 169 F.4th 238 (4th Cir. 2026).

5. Loper Bright Enters. v. Raimondo, 603 U.S. 369 (2024).
6. 29 CFR § 2560.
7. § 2560.503–1.
8. §2560.503–1(h).
9. Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837 (1984).
10. Cogdell, supra n.4.
11. Id.
12. Id. at 245.
13. Id.
14. Id.
15. Id.
16. Id.
17. Id.
18. Id. at 250.
19. Id. at 249.
20. Id.
21. Id. at 251.
22. Id. at 252–54.
23. 29 C.F.R. § 2560.503–1(l)(2)(i).
24. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).
25. Cogdell, 169 F.4th at 253.
26. Id. at 255.
27. Id.
28. Fessenden v. Reliance Standard Life Ins. Co., 927 F.3d 998 (7th Cir. 2019).
29. Id. at 256.
30. Id. at 257–59.

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