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ERISA's "Full and Fair Review" Standard – What Can Courts Properly Require?

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In the Summer 2022 issue of this journal, this column looked at the always important issue of how administrators of benefit plans governed by the Employee Retirement Income Security Act (ERISA) could avoid pitfalls created by recent ERISA litigation regarding the "full and fair review" standard.

Here, this column again reviews what constitutes an ERISA-compliant "full and fair review," and analyzes recent cases that further discuss the role that courts may play in the "full and fair review" process. Specifically, this column outlines what tools a court may properly employ in evaluating whether a "full and fair review" occurs within the recognized framework for reviewing denial of benefit claims.

BACKGROUND ON "FULL AND FAIR REVIEW"

The purpose of "full and fair review" is to "encourage resolution of the dispute at the administrator's level before judicial review."[1] Thus, before bringing an ERISA claim in federal court, the claimant must exhaust the administrative remedies laid out in the benefits plan.[2] But as we discussed in our prior column, that review process also imposes certain obligations on plan administrators. However, that requirement also benefits the plan administrator. Specifically, providing a "full and fair review" and following clear and consistent rules in processing benefit claims both minimizes risk of litigation and promotes consistency in benefits administration.

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Once an employer issues an adverse benefit determination, they are required to afford the claimant a reasonable opportunity for a "full and fair review" of the denial by the appropriate fiduciary.[3] The Department of Labor has issued guidance on how to provide a "full and fair review" for employee benefit plans, group health plans, and plans providing disability benefits. 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;
- 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[4]

As discussed in our Summer 2022 column, the "full and fair" review requirement is fulsome. Plan administrators must carefully review a complete, and sometimes extensive, record during their review. Relevant documents in a "full and fair" review include any document that 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 at all stages of the claim for benefits, including the initial benefit determination and any subsequent claims or denials."[5] It is also important for administrators to remember that all documents submitted by a claimant should also be reviewed as opposed to "cherry-picking" facts that support denial of a claim, or ignoring evidence that might support granting an appeal.[6]

In 2018, the Department of Labor amended its regulation and required plan administrators to provide claimants the pertinent information regarding their claim for benefits, regardless of whether the claimant affirmatively requested those documents.[7] Last year, the U.S. Court of Appeals for the Seventh Circuit held in *Zall v. Standard Insurance Co.*, that this requirement applied retroactively.[8] There, the Seventh Circuit found that revised guidance applied to a 2013 claim for long-term disability that had not yet reached an adverse decision as of 2018, when the Department of Labor amended the regulation.[9] The court explained that "[w]hat matters is that when the new claims procedures under the amended regulation took effect, [Defendant] had not yet reached an

adverse benefit determination and [Plaintiff] had not yet begun his administrative appeals."[10]

Additional requirements apply both to group health plans and to plans providing disability benefits.[11] Fiduciaries of those plans, if reviewing an adverse benefit decision based on medical judgment, must also "consult with a health care professional with the appropriate training and experience in the field of medicine involved in the medical judgment."[12]

COURTS' ROLE IN "FULL AND FAIR REVIEW"

When a claimant alleges that they were denied a "full and fair review," they have the option, following the exhaustion of their administrative remedies, to seek review of the claim denial in federal court. In general, the court's role is limited to evaluating whether the plan administrator correctly or incorrectly denied benefits. And if the administrator acted reasonable in its review, a court is to defer to the judgment of the administrator.

It is well-recognized that a court generally cannot consider any additional arguments when reviewing an administrative record. For example, in *Shimomura v. UNUM Life Ins. Co. of Am.*, the district court refused to consider the plan administrator's post hoc rationalizations for the claim denial.[13] Similarly, in *Sutton v. Metro. Life Ins. Co,* a district court refused to "affirm MetLife's denial based on reasoning it did not rely on at the time."[14]

Courts also cannot fashion relief for claimants that would not otherwise be available to them under the terms of the plan. For example, in *Cloud v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, the plaintiff made a claim for disability benefits in 2014 and was granted some benefits.[15] Plaintiff did not appeal in 2014, rather he filed another claim for a higher tier of disability benefits in 2016, which was subsequently denied.[16]

The district court found that Plaintiff had been denied a full and fair review and granted him the highest tier of disability benefits available. [17] But the Fifth Circuit overturned the district court's decision and explained that "[a]lthough the NFL Plan's review board may well have denied [plaintiff] a full and fair review, and although [plaintiff] is probably entitled to the highest level of disability pay, he is not entitled to *reclassification* to that top tier because he cannot show changed circumstances between his 2014 claim for reclassification and his 2016 claim for reclassification – which was denied and which he did not appeal."[18] In short, the district court could not give the plaintiff a benefit that he could not have received even if he had been afforded a full and fair review.

Courts can, however, order extraordinary steps when it concludes that particularly egregious situations have occurred. *Lewis v. Hartford Life & Health Insurance* is such a case, and should be carefully considered by plan administrators and their counsel.

In *Lewis*, Hartford rejected plaintiff's disability claim.[19] The district court explained that, "a conflict of interest exists in so far as Hartford both determines eligibility for benefits and pays for benefits."[20] Due to the potential existence of a conflict of interest, the district court sua sponte appointed a medical examiner to serve as a "special master' to review the adverse benefits determination.[21]

Hartford petitioned the U.S. Court of Appeals for the Third Circuit for a writ of mandamus, arguing that the district court was "impermissibly 'compel[ling] [the plan] to participate in supplementing the record in favor of Plaintiff, constitute[ing] an extraordinary usurpation of power.'"[22] Typically, a court's review of a benefit determination is limited to the administrative record,[23] however, in situations of conflicts of interest, the record may be supplemented.[24] Invoking the latter principle, the district court had stated its reason for appointing an independent party to review the record was to help investigate whether there existed this conflict of interest.[25]

The Third Circuit recognized that a writ of mandamus is an extraordinary form of relief which is not mandated in the case at hand.[26] Hartford argued that it was improper under ERISA to appoint a third-party to review medical records – including those that were never before Hartford – or to generate a report opining on whether Plaintiff was disabled three years after Hartford made the final disability determination."[27]

However, Federal Rule of Civil Procedure 53 gives the district court the authority to appoint a "Special Master" under exceptional circumstances.[28] The Third Circuit explained that the district court, "correctly noted that 'reliance on a non-examining physician's opinion premised on a records review alone is suspect and [can] suggest[] that the insurer is looking for a reason to deny benefits,"[29] The Third Circuit felt that an important factor considered by the district court was the fact that defendant's doctors never did any in-person medical exam of plaintiff at all, this contradicted case law on subjective pain, which the court found relevant to the plaintiff's diagnosis of Fibromyalgia, a disease with subjective symptoms.[30]

Notably, Hartford took issue with the costs associated with this extraordinary decision by the district court, particularly a $3,000 retainer to be paid to the "special master."[31] Additionally, Hartford argued that by compelling them to pay a third-party physician, to act as a "special master," "obligated them to pay an entirely indeterminate amount in future fees."[32] The defendant's pointed to the fact that the special master's rate is $550 per hour, but the standard rate the court provided to Hartford refers to a rate of $600 per hour.[33]

The Third Circuit court conceded the district court's "explanation for the appointment makes clear that a court could reasonably conclude such remand was warranted on the basis of the existing administrative record, without incurring the delay and cost associated with the appointment of a special master." However, the court nonetheless denied the writ of mandamus and upheld the district court's order.[34]

The case reflects a court compelling an unusual amount of third-party involvement in a private employer's claims procedure. Indeed, the Third Circuit conceded that the appointment of a special master is an unusual circumstance and that "the district court itself acknowledges that it 'did not follow . . . black letter Third Circuit precedent when adjudicating disability claims of this nature.'" Despite the foregoing, the Third Circuit nevertheless denied the requested relief. This case therefore exemplifies a unique and costly remedy that at least one court has instated when an administrator was found to have failed to adequately follow procedural guidelines set forth in the "full and fair" review process.

CONCLUSION

The *Lewis* case is a cautionary tale for plan administrators that should provide additional motivation for having a fulsome, and consistent, claims review process. For example, plan administrators should seek to compile an administrative record that not only explains the reasons for the claim denial, but also walks the court through the review from start to finish.

Moreover, to the extent an administrator chooses not to credit a treating physician's opinion, the administrator should consider whether it is appropriate to bolster that conclusion with another third party who has relevant medical background to credibly review the particular disputed issue. Reviewing courts can only consider the administrative record that the plan administrator compiled when evaluating the benefit claim. Gaps in reasoning, or unexplained rejections of the claimant's evidence, potentially expose the plan to the same type of extreme remedies imposed by the *Lewis* court.

Finally, it is critical that plan administrators are careful to include all reasons for the denial in the record as they will not be able to come up with additional reasoning at a later date. And although courts are generally limited in the relief that they can provide to claimants who are denied a "full and fair review," the recent decision in *Lewis* illustrates the extraordinary (and expensive) measures that some courts are forced to go to.

Notes

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

2. 29 C.F.R. § 2560.503-1(k)(2)(ii).

3. 29 U.S. Code § 1133(2).

4. 29 C.F.R. § 2560.503-1(h)(2).

5. Jette v. United of Omaha Life Ins. Co. 18 F.4th 18, 27 (1st Cir. 2021).

6. 29 C.F.R. § 2560.503-1(g).

7. 29 C.F.R. Sec. 2560.503–1(h)(4)(i).

8. Id.

9. Id.

10. Id.

11. 29 C.F.R. § 2560.503-1(h)(3–4).

12. 29 C.F.R. § 2560.503-1(h)(3).

13. Shimomura v. UNUM Life Ins. Co. of Am, No. 3:22-CV-00455-SB, 2023 WL 5042930, at *16 (D. Or. July 3, 2023), report and recommendation adopted as modified, No. 3:22-CV-00455-SB, 2023 WL 6878637 (D. Or. Oct. 18, 2023).

14. Sutton v. Metro. Life Ins. Co., No. 222CV00732KJMCKD, 2023 WL 4669994, at *6 (E.D. Cal. July 20, 2023).

15. Cloud v. Bert Bell/Pete Rozelle NFL Player Ret. Plan, 83 F.4th 423, 425–26 (5th Cir. 2023).

16. Id.

17. Id.

18. Id.

19. Brief in support of petition of Writ of Mandamus at 2, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).

20. Memorandum re petition of Writ of Mandamus at 7, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).

21. Id. at 17.

22. Id. at 17.

23. Noga v. Fulton Fin. Corp. Employee Benefit Plan, 19 F.4th 264, 272 (3d Cir. 2021).

24. Id.

25. Id.

26. In re Kensington Int'l Ltd., 353 F.3d 211, 219 (3d Cir. 2003).

27. Brief in support of petition of Writ of Mandamus at 17, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).

28. See F.R.C.P. 53(a)(1).

29. Order at 2, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).

30. Id.

31. Brief in support of petition of Writ of Mandamus at 7, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).

32. Id.

33. Id.

34. Order at 3, Lewis v. Hartford Life & Accident Ins. Co., No. 21-cv-01438 (E.D. Pa. Aug. 31, 2023).