ERIC BUCHANAN & ASSOCIATES

DISABILITY INSURANCE ATTORNEYS

ERISA & DISABILITY BENEFITS NEWSLETTER

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ABOUT OUR FIRM

The Disability Insurance Team at Eric Buchanan & Associates helps individuals nationwide who have been denied disability insurance benefits and employee benefits. Our insurance and employee benefits team helps people apply for, or fight denials of, disability insurance benefits, life insurance, health insurance, and similar insurance benefits.

For more information, visit our website at buchanandisability.com.

Contact our intake team at intaketeam@buchanandisability.com.

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THE DEPARTMENT OF LABOR'S STRICT COMPLIANCE PROVISION AND HOW IT CAN HELP YOU LEVEL THE PLAYING FIELD ~ BY: NOAH A. BREAZEALE

The Employee Retirement Income Security Act of 1974 ("ERISA") applies to and governs most insurance benefits offered to employees and their dependents, including long-term disability insurance. Following ERISA's enactment, Congress delegated to the Department of Labor ("DOL") the responsibility of creating rules that insurance companies and employer administrators must follow when deciding claims for employee insurance benefits. The purpose behind these rules was to ensure employee benefits remained protected and to ensure employees' claims were evaluated fairly. Thus, the DOL's Claims Procedures Regulations were born. *See* 29 C.F.R. § 2560.503-1

Over time, the DOL Regulations have been reworked, revised, and expanded to provide benefit administrators greater clarity about handling benefits claims and to provide employees with new safeguards. The latest iteration of the DOL Claim Procedure Regulations took effect in April 2018 and implemented several new and important rules to protect employee benefit claims, including the "Strict Compliance" amendment.

The "Strict Compliance" amendment marks an essential step towards balancing the playing field between disabled claimants and the insurance company that denied them. Once you understand how it works, the amendment can give you and your clients a significant advantage when taking an ERISA disability claim to court.

Disabled people suing an insurance company under ERISA for denying their claim will almost always face a grueling, uphill battle. These claims are so challenging to litigate because they are mostly litigated under an arbitrary and capricious standard of review, meaning that the reviewing court will defer to the insurance company's denial. Although not the "default" standard under ERISA, insurance companies can contractually guarantee the application of the arbitrary and capricious standard by simply including language in their insurance policies, "granting" them discretion to make benefit determinations and to interpret policy language.

Under the arbitrary and capricious standard of review, a court does not evaluate the merits of a person's claim and decide for itself whether the claim should be approved or denied. Instead, the court looks at the insurance company's denial and its decision-making process and determines whether the denial or

decision-making process was, on the whole, unreasonable (i.e., arbitrary and capricious). Although not impossible to win under this standard, insurance companies are good at making denials appear reasonable on their surface. Unless you are experienced in the ways insurers craft their denials, it can be challenging to persuade a court to look beyond the surface.

Courts applying the *de novo* standard of review will not defer to the insurance company's interpretation of the plan or its conclusions on the merits of the claim. Instead, the court will reach its own conclusions about whether a plaintiff has shown his or her entitlement to benefits by a preponderance of the evidence. While issues can still arise under the *de novo* standard of review, plaintiffs and their attorneys no longer have to worry about proving why the court should not give the insurance company the benefit of the doubt.

In 2018, the DOL amended its rules and procedures to include a "Strict Compliance" provision stating that an ERISA administrator's failure to "strictly adhere to all the requirements of this section with respect to a claim" will immediately trigger the right to seek judicial review under ERISA. The amendment clarifies that, under such circumstances, the reviewing court will treat the claim as "…denied on review without exercise of discretion by an appropriate fiduciary." *See* 29 C.F.R. § 2560.503-1(l)(2)(i). Thus, when an insurance company fails to strictly comply with the DOL's rules and procedures, the court will review the claim under the less-deferential *de novo* standard of review regardless of whether the policy contained a grant of discretion.

The DOL explained the "Strict Compliance" provision would not apply to an insurance company's *de minimis* violation of the DOL Claims Procedure Regulations, but that category is pretty hard to meet. *See* 29 C.F.R. § 2560.503-1(l)(2)(ii). Under the regulation, a violation is only *de minimis* if (1) it does not cause, or is unlikely to cause, "prejudice or harm to the claimant," (2) the insurance company proves "that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and claimant", and (3) that the violation is not "part of a pattern or practice of violations by the plan." *See* 29 C.F.R. § 2560.503-1(l)(2)(ii). An insurer must meet all these requirements to show that a violation of the regulations qualifies as *de minimis*. The District Court for the Northern District of California's holding in *Hasten v. Prudential Insurance Company of America* reinforces this interpretation. *See* 470 F. Supp. 3d 1076 (N.D. Cal. 2020).

In *Hasten*, the plaintiff sued under ERISA and asserted her claim should be considered exhausted under 29 C.F.R. § 2560.503-1(l)(2)(i) because Prudential failed to make a timely decision. *See Hasten*, 470 F. Supp. 3d at 1080. After finding Prudential did violate the regulation's timeliness requirements, the district court evaluated whether the violation was *de minimis* to preclude the claim from being exhausted and entitled to non-deferential review. Ultimately, the district court held the *de minimis* exception did not apply to Prudential's violation because Prudential did not show that its delays were for good cause. *See id.* at 1082. Even though the plaintiff conceded she was not harmed or prejudiced by the untimely decision and even though there was an ongoing exchange of information between the plaintiff and Prudential, the *Hasten* Court still found Prudential failed to show that its violation was for a good cause or due to matters beyond its control and therefore barred Prudential from seeking the benefit of the *de minimis* exception. *See id.* at 1082-83.

Although the insurer in *Hasten* was stripped of discretion because it made an untimely decision under the DOL Claims Procedures regulations, remember the "Strict Compliance" provision causes an insurer to waive its discretion when it violates *any* of the claims procedure requirements. For example, the "Strict Compliance" amendment would cause a disability insurer to waive its discretionary authority if it failed to consider a claimant's social security disability benefits award. *See* 29 C.F.R. § 2560.503-1(g)(1)(vii)(A)(iii). Likewise, an insurer can waive its discretion by relying on new evidence it obtained during review when denying a claim if it does not first provide the claimant with an opportunity to review and respond to the new evidence before making its decision. *See* 29 C.F.R. § 2560.503-1(h)(4)(ii).

As *Hasten* establishes, the "Strict Compliance" provision is not something insurance companies can easily avoid and is an effective way to strip insurance companies of their discretion and entitlement to arbitrary and capricious review. Yet just as a sword is only as powerful as its master, the "Strict Compliance" provision is only as powerful as a person's knowledge of the DOL Claims Procedure Regulations. To use this provision effectively, you must understand all the DOL's rules for ERISA claim administrators.

If you have questions or you are trying to figure out whether an insurer has violated the claims procedures and whether your or your client's claim is now deemed exhausted, please contact me or anyone else on the Buchanan Disability Team, and we will be happy to assist.

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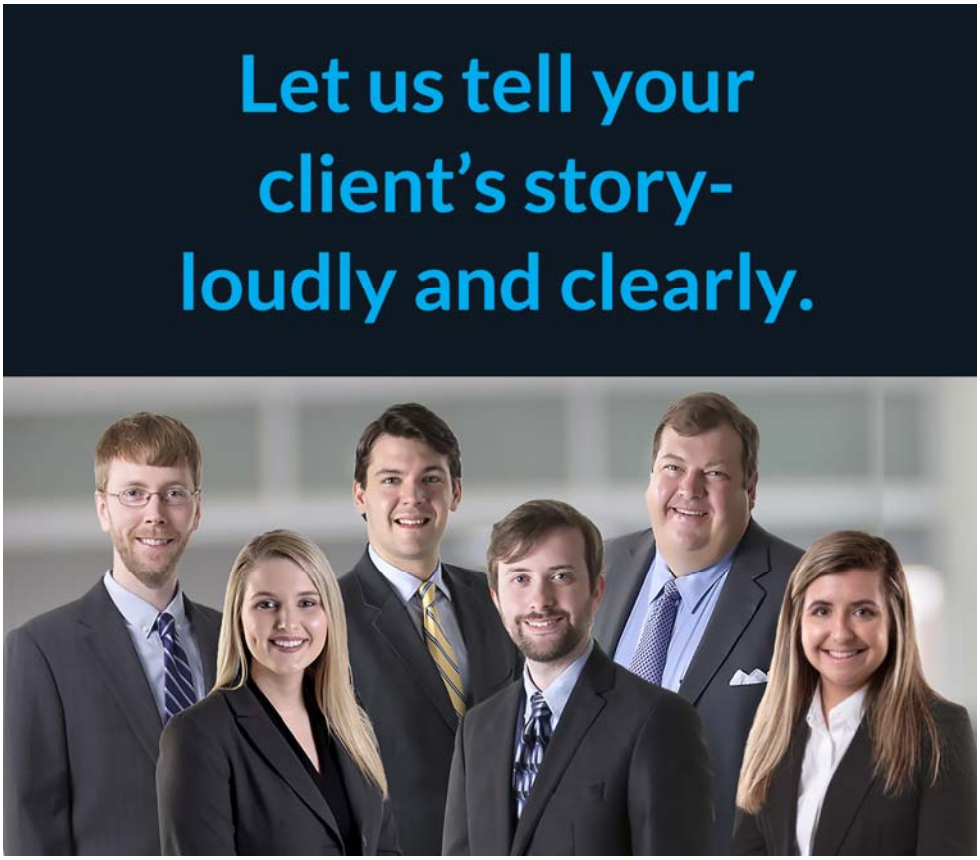
Eric Buchanan & Associates, PLLC is a boutique plaintiffs' firm located in Chattanooga, Tennessee. We help individuals nationwide obtain disability insurance benefits and other ERISA employee welfare benefits (such as life, health or disability benefits offered through work). Attorneys are our number one source of cases. If you have a client who could use our help, we would appreciate your referral.



We appreciate the opportunity to work with you on any of these cases.

Contact our intake team at intaketeam@buchanandisability.com.

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates, PLLC are available to speak to your organization regarding ERISA long term disability, group long term disability, private disability insurance, ERISA benefits, denied health insurance claims and life insurance claims.

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