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HOW SHOULD COURTS APPLY THE UPDATED ERISA CLAIMS REGULATIONS TO OLDER CASES? ~ BY ERIC BUCHANAN

The Seventh Circuit Court of Appeals recognized another layer of complexity in ERISA[1] long term disability (LTD) and other ERISA benefits disputes. The Department of Labor (DOL) updated its claims regulations[2] in 2016 with new rules effective beginning April 1, 2018. The news rules give more protection for ERISA claimants, but the DOL used confusing language to explain what claims are covered by the new rules and when the changes apply.

The Seventh Circuit case[3] held that the DOL's newest rules apply to claims filed before the regulations were updated. This article will explore this circuit court's analysis and application of the ERISA claims regulations.

The DOL used language in its newest rules that is arguably ambiguous or confusing, taking into account the purpose of the new regulations. The DOL regulation used language that the effective date is based on when a claim is "filed." For many ERISA claims, such as those for health and life insurance, this would not create an ongoing problem, because in those cases there is usually one claim and, if denied, one administrative appeal under ERISA's claims regulations.

LTD cases are different, because a person found disabled can potentially be paid for years before an insurance company terminates benefits. Once denied, the person begins a new appeal under the ERISA claims procedures. The ambiguity is whether this new termination of benefits counts as a claim filed so that it should fall under the newest terms of the claims regulations. If not, why would the DOL write new regulations that might not apply to new disputes from the effective date and into the future?

As the Court of Appeals for the Seventh Circuit pointed out, and this article explores, this issue is confusing. The DOL's language creates the confusion because some of the new rules might arguably apply to some claim disputes after the effective date, and not to other future disputes, based on the arbitrary date of when the original claim in the matter was first filed. The DOL created more potential confusion because, if read to apply the changes on the date of the original filing and not the date of a new dispute, the language of the regulations would still allow some of the new rules to apply to claims with earlier original filing dates. And, more confusing than that, if taken to its logical conclusion, reading the applicability date that way would lead

to a portion of the new rules to apply to older claims and newer claims, but might not apply to claims filed in a window of about 15 months before the effective date. Finally, the DOL has not offered any good policy reason to explain why the newer rules should be read to be inapplicable to disputes that arise after the effective date based on the arbitrary date of the older filing of an original claim in the case.

Background

Private employers often offer employee benefits to attract good, reliable employees. Health insurance, life insurance, and long term disability insurance benefits are common. Disputes over claims for those benefits fall under the federal ERISA law. For example, when a person suffers severe injuries or an illness that prevents the person from working, that person should be paid benefits under an LTD plan if one is offered by that person's employer. Similarly, if a person has medical expenses that should be paid for under an employer's benefit plan, disputes over that coverage fall under ERISA.

Unfortunately, the insurance companies that offer those benefits frequently deny LTD claims or terminate LTD benefits for people who should still be getting paid. In that case, or in similar denials for other types of insurance offered at work, courts and the U.S. Department of Labor (DOL) have established a complex set of rules that apply to disputed ERISA claims.

The courts have developed a common law of ERISA that includes limiting a court's review to a closed record, limiting discovery to only certain topics if at all, allowing for the possibility of a limited standard of review in favor of the insurance company, and limiting the recovery to the benefits due with no possibility of extra-contractual damages (other than interest or attorneys' fees).

Additionally, the DOL's ERISA claims regulations, 29 C.F.R. § 2560.503–1, provide for minimum standards to apply to insurance companies and other fiduciaries deciding ERISA claims. The regulations require claims procedures to be reasonable. For example, insurance companies are required to make decisions within certain maximum time frames (45 days with limited extensions available) and to allow claimants minimum times to appeal (at least 180 days in the case of a claim for disability benefits). 29 C.F.R. § 2560.503–1(f)(3), (h)(3) and (4), and (i)(3)(i).

Other requirements for claims procedures to be "reasonable" include precluding a plan or insurance company from requiring a claimant pay a fee to make or appeal a claim, 29 C.F.R. § 2560.503–1(a)(3). Claims procedures may not, "preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal." 29 C.F.R. § 2560.503–1(a)(4). Other parts of the regulations require the insurance company to provide copies of documents relied on to make its decision, to include certain information in denial letters, and so on.

History of changes to the regulations

The DOL ERISA claims regulations were significantly overhauled 20 years ago, with an effective date for most changes to "apply to claims filed under a plan on or after January 1, 2002." There was an even older set of regulations that applied to earlier claims.

In 2016, President Obama's DOL issued a proposed set of updates or amendments to the claims regulations. These were not an overhaul of the regulations, but did clarify and add several significant protections for claimants. The DOL gave the new regulations a general effective date of January 1, 2018.

However, the new regulations were issued shortly before the change in administrations; President Trump's administration initially put the new changes on hold. Eventually the new rules were approved and reissued by the new administration's DOL, with a change moving the effective date from January 1, to April 1, 2018. 29 C.F.R. § 2560.503–1(p)(3). But, as addressed throughout this article, the DOL chose to used "claims filed" in the language, without clarifying if that is limited only to a claim's original filing date or to further disputes over the same claim that happen after the new regulation's applicability date.

Additions and clarifications in 2016 regulations

The 2016 amendments provided several changes that, generally, required the process to be fairer to claimants. Changes included:

--Requiring people involved in making claims decisions to be independent and impartial. 29 C.F.R. § 2560.503 –1(b)(7)

--Requiring the insurance company or other ERISA fiduciary to explain its adverse decisions, its basis for disagreeing with treating health care professionals or evaluating vocational professionals, medical and vocational experts' advice obtained by the plan, as well as disability determinations made by the Social Security Administration. 29 C.F.R. § 2560.503–1(g)(1)(vii)(A) and (j)(6)(i).

--When considering an appeal of a claim, if an insurance company or plan obtains new evidence or bases a decision on new rationale, the insurance company or

fiduciary must provide that information to a claimant and "to give the claimant a reasonable opportunity to respond…" 29 C.F.R. § 2560.503–1(h)(4)(i) and (ii).

-- Requiring final decisions to provide "the calendar date on which the contractual limitations period expires for the claim." 29 C.F.R. § 2560.503–1(j)(4)(ii).

The 2016 changes, effective April 1, 2018, further added a provision giving more teeth to violations under the regulations. Under previous versions of the regulations, if an insurance company or other ERISA fiduciary violated the regulations, thus engaging in an "unreasonable claims practice," the claimant then had an immediate right to forgo further administrative appeals and to assert the claim was "deemed exhausted." 29 C.F.R. § 2560.503–1(l).[4]

The 2016 change added that, not only would a violation of the regulations result in a claim being deemed exhausted, but further be deemed decided "without the exercise of discretion by an appropriate fiduciary." 29 C.F.R. § 2560.503–1(l)(2)(i). Thus, for plans that grant discretion, insurance companies and other fiduciaries that violate the regulations lose their right to have the claim reviewed under an abuse of discretion standard in court. There is an exception if the violation is *de minimis*, but this is hard to meet. 29 C.F.R. § 2560.503–1(l)(2)(ii).

Notably, many of these 2016 additions are just clarifications of already existing and still applicable rules. For example, the rule requiring the insurance company or fiduciary to provide a claimant the opportunity to respond to new evidence and new rationale, 29 C.F.R. § 2560.503–1(h)(4)(i) and (ii), is really just a further clarification of a rule that precludes insurance companies from relying on new evidence or rationale that it had not presented to the claimant. Under the already existing rules, applicable since 2002, when denying a claim the insurance company or fiduciary has to give the "specific reason or reasons for the adverse determination;" has to refer to the "specific plan provisions on which the determination is based" and has to provide a "description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503–1(g)(1)(i) through (iii). Thus, even under the old rules, an insurance company would be engaged in an unreasonable claims practice were it to "sandbag" a claimant by bringing up new evidence or a new basis for the decision only in a final denial letter, without bringing it up in the original claim decision.

Which parts of the regulations apply?
Zall v Standard

The 2016 changes clearly apply to new claims filed after April 1, 2018. But, what about someone who filed a claim for LTD benefits before that date, was paid for a while, then received an adverse decision after that date? Should the regulations apply to that new decision? Or, did the DOL intend for the new provisions to be a clarification and to apply to any claim disputes after that date? Or, should only some apply retroactively to older claims based on the plain language of the regulations?

In *Zall v. Standard Ins. Co.*, 58 F.4th 284, (7th Cir. 2023) the Court of Appeals for the Seventh Circuit addressed these types of questions. Dr. Zall, who had worked as dentist, filed his claim in 2013 and was eventually awarded benefits in 2015. Standard paid benefits for several years, but reviewed his claim over time. Standard eventually denied Dr. Zall's benefits in August of 2020; Standard relied primarily on the report of a reviewing doctor. Standard offered to provide a copy of the report on request, but did not provide it to Dr. Zall for comments before issuing its decision. *Id.*, at 2.

Standard would have satisfied the older rules by simply offering to make the information available, but the new rules explicitly required Standard to provide the medical report and allow Dr. Zall to comment before issuing its decision. 29 C.F.R. § 2560.503–1(h)(4)(i); *Zall* at 4.

The Court of Appeals looked closely at the language in subsection (p) of the claims regulations that set out the "Applicability dates and temporarily applicable provisions" 29 C.F.R. § 2560.503–1(p)(1)-(4), *Zall* at 5.

The Court of Appeals explained that the newest regulation version applies unless an exception applies. *Zall*, at 5. Specifically, "Paragraph (p)(1) establishes a general rule of applicability: 'this section shall apply to claims filed under a plan on or after January 1, 2002.' Because Zall filed his original claim in 2013, paragraph (p)(1) encompasses his case, so the new version governs unless an exception applies." *Id.*

Paragraphs (p) 2-(4) provide the exceptions. Paragraph (p)(2) applies to health plans and applies the new regulations to all claims filed since January 1, 2003, but only addresses health plans.

The key provisions are under paragraphs (p)(3) and (p)(4). These two provisions carve out some provisions as only applying since April 1, 2018 (listed in (p)(3) and others not applicable if the original claim was filed between January 18, 2017 and April 1, 2018, (p)(4). *Zall*, at 5.

The court explained that paragraph (p)(3) "identifies nine provisions—'(b)(7), (g)(1)(vii) and (viii), (j)(4)(ii), (j)(6) and (7), (*l*)(2), (m)(4)(ii), and (o)'—as applicable only to claims for disability benefits filed after April 1, 2018." *Zall*, at 5.

The court noted that, "[c]ritically, sub-paragraph (h)(4)(i), which eliminated the 'upon request' language and upon which Zall relies to argue that he was not afforded a 'full and fair review,' is not among those paragraphs identified in paragraph (p)(3). *Zall*, at 5.

> Finally, the (p)(4) exception renders five provisions—"(g)(1)(vii), (g)(1)(viii), (h)(4), (j)(6) and (j)(7)"—inapplicable to claims filed between January 18, 2017 and April 1, 2018. While paragraph (h)(4) with its removal of the "upon request" language is among the provisions identified in paragraph (p)(4), the exception does not apply to Zall's appeal since he filed his claim before this carve-out period began.

Zall, at 5. Thus, the provisions in 29 C.F.R. § 2560.503–1(h)(4)(i) and (ii), in plain text require the insurance company or fiduciary to give "the claimant a reasonable opportunity to respond…" to new evidence or new rationale, in all claims for disability benefits filed since January 1, 2002, except those claims originally filed in the window between January 18, 2017 and April 1, 2018. *Zall*, at 5.

The court rejected Standard's arguments that relied on a summary of the rule issued by the DOL, because it was only a summary and might miss nuances in the rules. *Zall,* at 6. The Court of Appeals also found the summary was actually not inconsistent, because, the applicability of the rule as of April 1, 2018, became the date the new rules governed, therefore, a dispute after that date would fall under the terms of the new rules, including the general provision that they applied to all claims filed since January 1, 2002. *Id.*

The court also rejected Standard's arguments that this would be an impermissible retroactive application of the amendments. The Court of Appeals held these were procedural rules, which could apply to pending claims. Quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 275 (1994), the court noted, "Changes in procedural rules may often be applied in suits arising before their enactment without raising concerns about retroactivity." *Zall*, at 8.

Ultimately, the court found the violation of the rules prejudicial to Zall's claim; rather than determining whether Standard acted arbitrarily, the court ordered the claim be remanded. *Id.*, at 9.

Takeaways

The Court of Appeals' analysis of the language of the regulations correctly points out that even if read in the most limiting manner, to apply the new rules based on when a claim was first originally filed, rather than when a new claim dispute arose, certain provisions in the newest ERISA claims regulations apply to any claims filed after January 1, 2002, unless they fall in the window covering parts of 2017-2018, *supra*.

The specific provisions that apply require the insurance company or fiduciary to provide claimants with certain information and a reasonable chance to respond before the claim is denied. These specific provisions, at 29 C.F.R. § 2560.503–1(h) state:

> (4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, …, the claims procedures—
>
> (i) Provide that before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date; and
>
> (ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provid-

> ed as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date.

Because the Court of Appeals found these provisions to apply under the plain language of the claims regulations, no matter whether the new changes should be read to apply based on when a claim was originally filed or when a current claim dispute arose, the court did not address whether other provisions should nonetheless apply for a claimant that is paid for a while and then is denied after April 1, 2018. They explained this open question:

> We have wondered why the date of Zall's original claim for benefits should control the applicable regulation as applied to Standard's 2018 move to terminate benefits he had already been receiving for several years. The regulation is written in terms that fit an application for new benefits better than a termination of existing benefits. If the relevant time were Standard's notice of termination of benefits or Zall's appeal of that decision, the 2018 amendments would certainly apply. For reasons explained in the text, we reach the same result even if the relevant date is Zall's original application date, so we need not choose here between the two approaches.

Zall, 5, n. 2. The Court of Appeals asks a fair question. This could be asked this way: If claimant A first filed her claim in March of 2018, is paid for 5 years, and receives an adverse benefits determination cutting off her benefits in March of 2023, why should she receive less protections under the regulations than someone with a very similar claim filed the next month, in April 2018? Should courts, as a matter of policy, read the language to apply to all new adverse benefits determinations? Should the Department of Labor clarify the regulations again?

Because the *Zall* court was able to resolve this particular issue without addressing those questions, we don't know. What we do know is that certain protections do apply to almost all claims filed since 2002, except those in a small window.

Conclusion

The Zall case correctly points out that the claimant-friendly updates to the ERISA claims apply to most claims, even if the claims were originally filed before the effective date of the regulations. However, the language used by the DOL creates the confusing argument that, based on the arbitrary old original filing dates, some provisions may not.

Left open is the question whether the DOL meant for the new changes to apply to all new claims disputes that arise after the effective date, no matter when the older original claim in a case was first filed. If the DOL meant to limit the applicability that based on that older original filing date, the DOL further did not clarify why courts should apply such an arbitrary approach.

The Seventh Circuit Court of Appeals asks fair questions left open by this case and the DOL: why shouldn't the newest rules apply to all claim disputes, such as terminations, that begin after the effective date? What would be the policy reason to have the rules apply differently? Hopefully, we will get more guidance from the DOL and courts soon.

End Notes:

[1] The Employee Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

[2] 29 C.F.R. § 2560.503–1

[3] *Zall v. Standard Ins. Co.*, 58 F.4th 284 (7th Cir. 2023)

[4] This is subsection lowercase "L."

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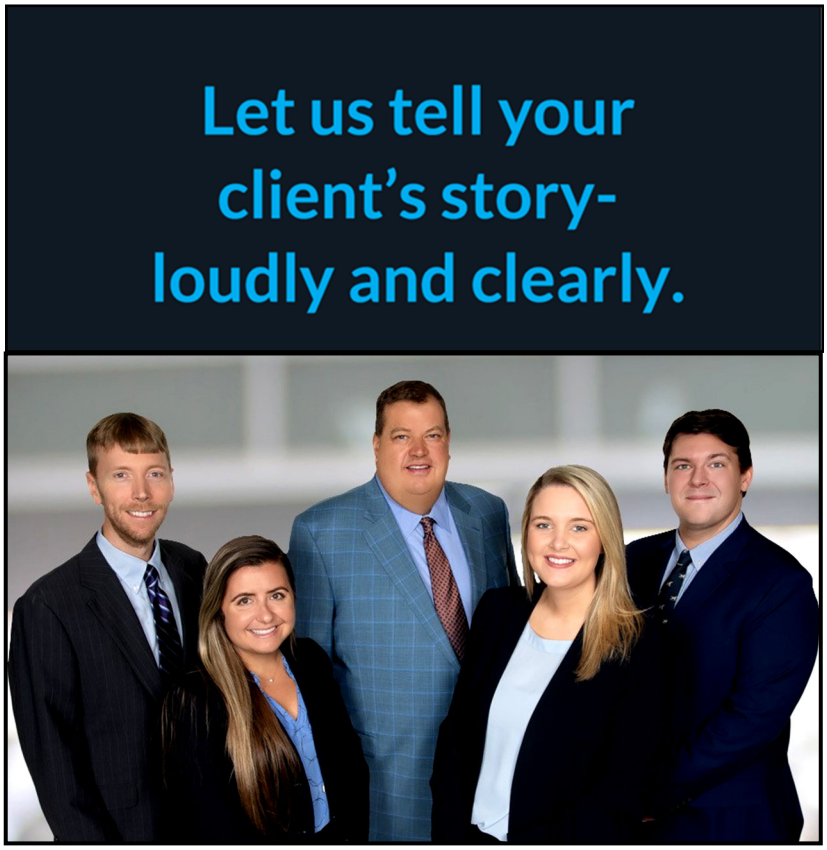

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