No.21-1514

In the U.S. Court of Appeals
For the Second Circuit

JOHN MCQUILLIN,
Plaintiff-Appellant,
v.
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY,
Defendant-Appellee.

On Appeal from the U.S. District Court
for the Eastern District of New York
Case No. 20-CV-2353(JS)(ARL)

Corrected Brief for the U.S. Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellant

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QUESTIONS PRESENTED

Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA) states that, "[i]n accordance with regulations of the Secretary, every employee benefit plan shall . . . 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." 29 U.S.C. § 1133(2). Pursuant to section 503, the Secretary promulgated a "claims-procedure" regulation requiring plans, among other things, to issue a "benefit determination on review" within 45 days of when an individual appeals a denial of disability benefits. 29 C.F.R. § 2560.503-1(i)(1)(i), (3)(i). If the plan fails to meet that deadline, then the "claimant is deemed to have exhausted the administrative remedies" and "is entitled to pursue any available remedies under [ERISA] section 502(a)." 29 C.F.R. § 2560.503-1(*l*)(2)(i). In that instance, the "appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary," meaning that the claim is reviewed by a court *de novo*. *Id.*

In this case, the plaintiff timely appealed the denial of his claim for disability benefits by Hartford Life & Accident Insurance Company

(Hartford). Before the 45-day period expired, Hartford notified the participant that it "overturned" its decision denying benefits, but it did not award benefits. Instead, Hartford said it would forward the participant's file to its "claim department" to render a new decision. On the 46th day after appealing his benefit claim—and before Hartford had issued a new decision—the participant filed suit under ERISA section 502(a)(1)(B). The district court dismissed plaintiff's case for failure to exhaust administrative remedies.

The Secretary of Labor addresses the following questions regarding the Department's claims-procedure regulation:

1. Whether a plan fiduciary's decision to overturn an initial denial of benefits and return the claim to an internal claims adjudicator for a new determination, without granting or denying benefits, is a "benefit determination on review" under 29 C.F.R. § 2560.503-1(i)(1)(i).

2. Whether a plan fiduciary's failure to timely issue a "benefits determination on review" causes the claimant's administrative remedies to be deemed exhausted and claims to be subject to *de novo* review under 29 C.F.R. § 2560.503-*1*(*l*)(2)(i).

INTEREST OF THE SECRETARY OF LABOR

The Secretary has primary authority to interpret and enforce Title I of ERISA, and to ensure fair and impartial plan administration and compliance with ERISA's requirements. See 29 U.S.C. §§ 1001, 1132-35; *Herman v. South Carolina Nat'l Bank*, 140 F.3d 1413, 1423 (11th Cir. 1998). One of those requirements is that ERISA plans allow participants to have their denied claims reviewed by a named plan fiduciary, "in accordance with regulations of the Secretary." 29 U.S.C. § 1133. The Secretary's resulting claims-procedure regulation establishes, among other things, minimum timing and procedural requirements by which plans must decide appeals of disability benefit denials. Enforcement of the 45-day time limit imposed by the regulation for review of disability claim denials is critical to protecting claimants who need the replacement income that disability benefits provide. The district court's interpretation of the regulation, if upheld, risks nullifying those requirements, thereby thwarting ERISA's purpose of providing "ready access to the Federal courts." 29 U.S.C. § 1001(b). Thus, the Secretary has an interest in ensuring that courts correctly interpret the Department's claims-procedure regulation.

The Secretary has authority to file this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2).

STATEMENT OF THE CASE

I. Factual Background

After receiving unsuccessful treatment for prostate cancer, Plaintiff John McQuillin suffered a host of maladies, including urinary incontinence, lack of concentration, and fatigue. (A15-16 ¶¶ 37-39). He filed a claim for long-term disability benefits pursuant to his employer's disability plan. *McQuillin v. Hartford Life & Accident Ins. Co.*, No. 20-CV-2353(JS)(ARL), 2021 WL 2323214, at *2 (E.D.N.Y. Feb. 12, 2021) (*McQuillin I*), report and recommendation adopted, 2021 WL 2102480 (E.D.N.Y. May 25, 2021) (*McQuillin II*). On October 25, 2019, Hartford—the plan's claims administrator—denied Plaintiff's claim, informing him that "the information we received isn't enough to show that you aren't able to work." (A84-85).

On December 5, 2019, Hartford notified Plaintiff that he had until April 22, 2020, to appeal the initial claim denial (180 days from the October 25, 2019 denial letter). *McQuillin I*, 2021 WL 2323214, at *2. Plaintiff then sought two extensions of time within which to appeal;

Hartford denied the first, and did not respond to the second. *Id.* Nevertheless, Plaintiff timely appealed on April 11, 2020. *Id.* at *2.

On April 23, 2020, Hartford notified Plaintiff that it had "overturned" its original denial. *McQuillin I*, 2021 WL 2323214, at *3. Hartford said in its letter that it would forward Plaintiff's claim file "to the claim department for ongoing handling and to determine if Disability is supported." (A90). It added that "the decision to reverse . . . does not guarantee payment of benefits," and that the claim department would "review the information submitted and determine if the claimant meets the definition of Disability and then render a new decision." *Id.* The letter did not state when Hartford expected to decide the claim. *Id.*

On May 27, 2020, 46 days after Plaintiff appealed the claim denial, he filed suit pursuant to ERISA section 502(a)(1)(B). *McQuillin I*, 2021 WL 2323214, at *2. Then, on July 17, 2020, Hartford notified Plaintiff that it had denied his disability claim yet again. *See McQuillin II*, 2021 WL 2102480, at *2; (A101). The July 2020 letter contained a verbatim restatement of the appeal rights notice set forth in Hartford's initial October 25, 2019 denial letter. *Id.* Plaintiff, who by that point had already filed suit, did not appeal that second denial. (A182).

II. Procedural History

Hartford moved to dismiss Plaintiff's action, alleging that he had not exhausted administrative remedies. *McQuillin I*, 2021 WL 2323214, at *1. Plaintiff filed an opposition brief arguing that, pursuant to 29 C.F.R. § 2560.503-1*(l)*, his administrative remedies were deemed exhausted when Hartford violated the claims-procedure regulation by failing to decide Plaintiff's appeal within 45 days by either affirming the denial or granting benefits. *Id.* at *4-5.

On February 12, 2021, the magistrate judge recommended that Hartford's motion to dismiss be granted. *McQuillin I*, 2021 WL 2323214, at *1. The magistrate judge cited language from Hartford's April 23, 2020, letter stating that "[w]e've overturned the original decision to deny claim," and concluded that "[t]he plain language of this letter indicates that Plaintiff's appeal was successful. *Id*. Thus, Plaintiff's argument that Hartford did not render a decision on his appeal within the 45 days proscribed by statute must be rejected." *Id.* at *5. On this basis, the magistrate judge recommended that Plaintiff's claim be dismissed for failure to exhaust administrative remedies. *Id.*

On May 25, 2021, the district court accepted the Report and Recommendation. *McQuillin II*, 2021 WL 2102480, at *1. Plaintiff argued that the magistrate judge erred because Hartford's April 23, 2020 letter was not a "benefit determination on review" because it neither approved nor denied his claim. *See id.* at *2. The court disagreed, stating that "there is nothing in [the regulation] requiring that a 'benefit determination on review' must either approve the payment of benefits or make a final denial of the claim. Certainly, nothing in that provision prohibits Defendant from issuing a 'benefit determination on review' that overturns the adverse determination of the claim department, and, in essence, remands the claim to the claim department for further evaluation and a new decision." *Id.* at *3. Because the court considered the April 23, 2020 letter to be a non-adverse benefit determination on review that Hartford issued within 45 days of Plaintiff's appeal, the court determined that Hartford complied with the claims-procedure regulation and that the "deemed exhausted" provision of § 2560.503–1(*l*) did not apply. *Id.* at *3-4.

SUMMARY OF THE ARGUMENT

The Secretary's "claims-procedure" regulation "sets forth the minimum requirements for employee benefit plan procedures pertaining to claims for benefits." 29 C.F.R. § 2560.503-1. Among other things, the regulation requires ERISA plans to decide benefit appeals within specified timeframes. For disability benefit claims, the regulation requires a plan to issue its "benefit determination on review" within 45 days of when a Plaintiff appeals a denial of benefits. 29 C.F.R. § 2560.503-1(i)(1)(i), (3)(i). As with other violations of the claims-procedure regulation, if the plan fails to meet that deadline, then the "claimant is deemed to have exhausted the administrative remedies" and "is entitled to pursue any available remedies under section 502(a)" of ERISA, subject to *de novo* review. *See* 29 C.F.R. § 2560.503-1(*l*)(2)(i).

The district court's holding that Hartford timely issued a "benefit determination on review" by remanding Plaintiff's claim to its "claim department" is contrary to the plain language, structure, and purpose of the claims-procedure regulation. With respect to its ordinary meaning, a "benefit determination on review" requires just that: a determination of whether benefits are in fact due, in the form of an up or down

decision either granting or denying benefits. The operative word, "determination," means a decision that "end[s] a controversy" or "decid[es the outcome] definitely and firmly." *Determination*, MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY (11th ed. 2009). Hartford's remand to its claim department for an entirely new decision—which Hartford made clear could result in benefits being denied anew (which would have to be appealed anew)—ended nothing.

The regulation's structure further demonstrates that plans are to decide appeals definitely and firmly without a remand, as there is nothing a plan's claims adjudicator can do in the first instance that a fiduciary cannot do on appeal. For example, if a fiduciary hearing an appeal wants to consider a different or additional ground than was used in the initial benefits denial, the regulation allows the administrator to do exactly that, provided it gives notice to the claimant and adheres to the original 45-day timeline for deciding the appeal. 29 C.F.R. § 2560.503-1(h)(4). There is thus no need for a "remand" in that instance, except to evade the regulation's timeline. A remand also is not justified simply because the fiduciary needs additional time to consider the appeal, as the regulation also contains a provision (and requirements)

for obtaining an extension of time to decide a benefit determination on appeal—an extension Hartford never sought in this case. 29 C.F.R. § 2560.503-1(i)(1)(i). Nor is there a need for the fiduciary to remand the case in order to consider new evidence; the regulation allows for that too. 29 C.F.R. 2560.503-1(h)(2)(iv); 29 C.F.R. 2560.503-1(h)(4). Not only is a remand unnecessary under the regulation, it is contrary to the regulation's prohibition on plans requiring more than two levels of administrative appeals for disability claims, which Hartford's vacate-and-remand procedure subverts. *See* 29 C.F.R. § 2560.503-1(c)(2).

Finally, the notion that plans can "remand" benefit appeals back to themselves without deciding whether benefits are due undermines the regulation's goal of ensuring speedy decisions so that participants can quickly obtain the critical replacement income that disability benefits provide. If a "remand" decision qualifies as a "benefit determination on review," a plan could repeatedly issue vacate-and-remand decisions, miring participants in an endless cycle of appeals, without running afoul of the regulation.

When Hartford opted to remand Plaintiff's benefit appeal for further review, it did not make a "benefit determination on review." As

a result, the Plaintiff's claim was "deemed exhausted," thereby permitting him to proceed with a claim under ERISA section 502(a). This Court should reverse the decision below so that the district court can review the denial of Plaintiff's disability benefits claim under a *de novo* standard.

ARGUMENT

The Secretary's claims-procedure regulation makes clear that a plan's "benefit determination on review" requires an up or down decision either affirming a denial of benefits, or reversing the decision and awarding benefits. It does not include, as the district court held, a "remand" for an entirely new decision, which, if allowed, would circumvent the claims regulation's timing requirements and undermine its purpose of ensuring the timely determination of claims. Because Hartford failed to actually determine Plaintiff's entitlement to benefits within the 45 days required by the regulation, his administrative remedies are "deemed exhausted" and his claim is subject to *de novo* review by the district court.

I. The Department of Labor's Claims-Procedure Regulation

When the Secretary first promulgated the claims-procedure regulation in 1977, the regulation generally provided a 60-day time limit for all benefit determinations on review. 42 Fed. Reg. 27,426 (May 27, 1977). In 2000, the Secretary promulgated a new claims-procedure regulation designed "to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims." 65 Fed. Reg. 70,246 (Nov. 21, 2000) (Summary). Because "speedy decision making is a crucial protection for claimants who need . . . the replacement income that disability benefits provide," the new regulation imposed a 45-day time limit for review of disability claim denials. *See id.* 70,247 (Preamble); 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i).[1]

The 2000 regulation also provided that "a claimant shall be deemed to have exhausted the administrative remedies available under

[1] For claims other than disability benefit claims, the regulation requires the plan administrator to "notify a claimant . . . of the plan's benefit determination on review . . . not later than 60 days after receipt of the claimant's request for review . . . ." 29 C.F.R. § 2560.503-1(i)(1)(i).

the plan" if a plan fails to establish or follow claims procedures consistent with the regulation. *See* 29 C.F.R. § 2560.503-1(*l*). This "deemed exhaustion" provision reflected the Secretary's "view of the consequences that ensue when a plan fails to provide procedures that meet the requirements of section 503 as set forth in regulations." 65 Fed. Reg. 70,255. "[I]f a plan fails to provide processes that meet the regulatory minimum standards, the claimant . . . is free to pursue the remedies available under section 502(a) of [ERISA] on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." *Id.* This provision thus gives claimants a "fast track into court." *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 222 (2d Cir. 2006).

In 2016, the Secretary amended the claims-procedure regulation to increase protections for disability claimants. The amended regulation, which applies to this case, provides that if a disability plan fails to "strictly adhere" to the regulation, the claimant's administrative remedies are not only deemed exhausted, but "the claim or appeal is deemed denied on review *without the exercise of discretion by inappropriate fiduciary*." 29 C.F.R. § 2560.503-1(*l*)(2)(i) (emphasis

added). This means that when a plan violates the claims-procedure regulation, a plaintiff's section 502(a) claim for disability benefits is reviewed *de novo* rather than for abuse of discretion (as is typically the norm).

II. A Plan's Internal Remand of a Benefit Claim Denial Following an Appeal Is Not a "Benefit Determination on Review" Under the Secretary's Claims-Procedure Regulation.

As noted, when a participant appeals a denial of a disability-benefits claim, the Secretary's claims-procedure regulation requires the plan to issue a "benefit determination on review" within 45 days of the appeal. 29 C.F.R. § 2560.503-1(i). The district court found that Hartford's decision to reverse the initial claim denial and remand the claim for re-adjudication and a new decision—with no promise of a benefit payment—qualified as such a determination. *McQuillin II*, 2021 WL 2102480, at *4. The plain language, structure, and purpose of the claims-procedure regulation preclude the district court's interpretation. Rather, a "benefit determination on review" requires exactly that: an actual determination of whether benefits are due.

1. The Secretary's claims-procedure regulation states, in relevant part, that "the plan administrator shall notify a claimant . . . of the

plan's benefit determination on review" within 45 days of receipt of the claimant's request for review. 29 C.F.R. § 2560.503-1(i)(1)(i), (3)(i). Because the regulation does not define the phrase "benefit determination on review," the "plain meaning of language in [the] regulation governs." *Forest Watch v. U.S. Forest Serv.*, 410 F.3d 115, 117 (2d Cir. 2005); *cf. Montefiore Med. Ctr. v. Loc. 272 Welfare Fund*, 712 F. App'x 104, 106 (2d Cir. 2018) ("[T]he Plan's plain text . . . is clear, and to interpret the Plan otherwise would require us impermissibly to overlook, and rewrite, the Plan's language."). As the Supreme Court recently explained in interpreting the undefined phrase "actual knowledge" in ERISA, courts "'must enforce plain and unambiguous statutory language in ERISA,' as in any statute, 'according to its terms.'" *Intel Corp. Inv. Pol'y Comm. v. Sulyma*, 140 S. Ct. 768, 776 (2020) (citation omitted).

The meaning of the regulatory provision's operative word, "determination," is plain and clear. As in *Intel*, "[d]ictionaries are hardly necessary to confirm the point, but they do." 140 S. Ct. at 776. Webster's dictionary defines a "determination" as "a judicial decision settling and ending a controversy," "the resolving of a question by argument or

reasoning," and "the act of deciding definitely and firmly." *Determination*, MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY (11th ed. 2009). Legal dictionaries similarly define "determination" as "[t]he act of deciding something officially; esp., a final decision by a court or administrative agency." BLACK'S LAW DICTIONARY (11th ed. 2019). Thus, the ordinary meaning of the phrase "benefit determination on review" is to "resolv[e]" or "decid[e]" whether the claimant is entitled to benefits.[2]

Hartford's decision remanding Plaintiff's claim for further review—while expressly noting the possibility that the claim would be denied again (which in fact it was)—is anything but a "final decision"

[2] "Before concluding that a rule is genuinely ambiguous, a court must exhaust all the 'traditional tools' of construction." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415 (2019). As set forth above, those "tools" permit a plain-language interpretation of the Secretary's regulation that resolves the question, leaving no ambiguity as to its meaning. But even if the regulation is ambiguous, the Secretary's interpretation is entitled to *Auer* deference because it is a reasonable agency interpretation within its area of expertise that is fair, considered, and consistent with prior agency guidance. *Id.* at 2415-18; *see also Halo v. Yale Health Plan*, 819 F.3d 42, 55 (2d Cir. 2016) ("The Department's interpretation of its own [claim procedure] regulation as contained in the regulation's preamble is entitled to substantial deference in light of the regulation's ambiguity as well as the timing . . . and history . . . of the preamble.).

that decides the question of whether benefits are due "definitely and firmly," thereby "ending a controversy." To the contrary, upon such a remand, the plan's claims adjudicator can take 45 days to issue its decision, 29 C.F.R. § 2560.503-1(f)(3); if the claim is denied, the claimant would then have to appeal that decision anew; and the plan fiduciary on appeal would then have 45 days to issue a new "benefit determination on review," 29 C.F.R. § 2560.503-1(i), which, under the district court's view, could take the form of yet *another* vacate-and-remand. In short, far from "ending a controversy," a vacate-and-remand decision does nothing but prolong it.

Interpreting "benefit determination on review" as requiring an up-or-down decision is bolstered by the regulation's structure, which provides a plan fiduciary hearing an appeal with all of the authority the plan had at the initial-determination stage, and thus offers no reason to remand. As an initial matter, the entire distinction between Hartford and its "claim department" is an artificial one: Hartford's claim department is part and parcel of Hartford. While the claims regulation requires that appeals and initial determinations be decided by different *individuals* (and that the appeal reviewer cannot be subordinate to the

initial claims adjudicator),[3] it does not require that those individuals work for different entities. Rather, the regulation contemplates that the plan administrator will issue the initial adverse determination, 29 C.F.R. § 2560.503-1(f), and that the "benefit determination on review" will be made by an "appropriate named fiduciary," 29 C.F.R. § 2560.503-1(h), which is often the plan administrator. Hartford and its "claim department" are thus one and the same, and the implication that Hartford remanded Plaintiff's claim to a different entity is a fiction.

But even if Hartford as appeal reviewer is distinct from its "claim department," the regulation allows Hartford to do everything on appeal that its claim department can do in the first instance. The regulation, for example, authorizes a plan fiduciary on appeal to uphold a benefit denial on a different or additional ground than relied upon in the initial decision, as appeared to be Hartford's rationale for remanding here. 29 C.F.R. § 2560.503-1(h)(4). The pertinent language states 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 rationale must be provided [to the participant] as soon as possible and

[3] 29 C.F.R. §§ 2560.503-1(h)(3)(ii), (4).

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." *Id.* Indeed, the plan must provide the new or additional rationale well before the end of the 45-day period so that the participant has a "reasonable opportunity to respond prior to that date"—and the plan must still decide the appeal within the 45-day deadline. *Id.* But under the district court's interpretation, a plan armed with a new basis for affirming the denial need not go through this effort of notifying the participant and keeping to the original 45-day clock. Instead, the administrator can simply overturn the decision and remand to the claim department, which, as explained, can then take 45 days to issue a new initial decision, 29 C.F.R. § 2560.503-1(f)(3), which, if appealed, starts a new 45-day clock within which to render another "benefit determination on review." This alternative vacate-and-remand path would turn the procedure and notice requirements in 29 C.F.R. 2560.503-1(h)(4) into a dead letter.

The regulatory structure also provides no basis to vacate and remand for a new decision simply because a plan might need more than 45 days to decide the appeal. Here again, the regulation already

contains a provision (and requirements) for obtaining an extension of time to decide a benefit determination on review. 29 C.F.R. § 2560.503-1(i)(1)(i). That portion of the regulation states that if "the plan administrator determines that special circumstances . . . require an extension of time for processing the claim . . . written notice of the extension shall be furnished [and t]he extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review." *Id.* Hartford was thus free to seek a 45-day extension to consider whether Plaintiff met the definition of disability; it chose not to do so. If Hartford can instead effectively obtain an even longer extension by vacating and remanding the initial decision for further consideration, then the regulation's extension provision has no purpose. *See Mary Jo. C. v. N.Y. State & Local Ret. Sys.*, 707 F.3d 144, 156 (2d Cir. 2013) ("statute should be construed so that effect is given to all of its provisions, so that no part will be inoperative or superfluous, void or insignificant."); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 107 (2d Cir. 2005)

(rejecting substantial compliance doctrine because it would render the time limits for benefit decisions on appeal a nullity).[4]

Nor is remand justified in order for the plan to consider new or additional evidence, which the regulation also leaves the plan fiduciary free to do on appeal. In fact, the claims-procedure regulation *requires* plans to consider on appeal all evidence submitted by the claimant "*without regard* to whether such information was submitted or considered in the initial benefit determination." 29 C.F.R. 2560.503-1(h)(2)(iv) (emphasis added). It also allows the plan fiduciary to consider new evidence on its own, so long as that new evidence is provided to the claimant. 29 C.F.R. 2560.503-1(h)(4) ("[B]efore 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.").

[4] Hartford did not argue that the extension provision applies, stating that "the present case does not involve the requirements of a Section 503-1(i) extension notice." Dkt. 42 at 12. Accordingly, the district court did not address whether an extension was warranted.

The district court's holding undermines the regulatory structure for still another reason. The claims-procedure regulation prohibits plans from requiring more than two levels of administrative appeals for disability claims. 29 C.F.R. § 2560.503-1(c)(2). Allowing "benefit determination[s] on appeal" that do not decide the claim, but simply restart the claim process, would create an end-run around the proscription on more than two appeals by potentially forcing claimants to appeal their claim denials repeatedly. This is precisely the type of delay tactic that the claims-procedure regulation is designed to prevent. *See* 65 Fed. Reg. at 70,253 (preamble) ("allowing plans to impose an unlimited number of levels of administrative appeals of denied claims does not serve the best interests of claimants").

Interpreting a "benefit determination on review" as requiring an up or down decision also fulfills the regulation's goal of ensuring prompt resolution of benefit claims. The preamble to the 2000 regulation stated that the new standards (including the 45-day review for disability benefit appeals) were "intended to ensure more timely benefit determinations," 65 Fed. Reg. at 70,246, given that "disability providers frequently delay resolving these claims unnecessarily in order to avoid

beginning to make payments." *Id.* at 70,249. This emphasis on timeliness also furthers ERISA's goal of providing claimants with "ready access to the Federal courts." 29 U.S.C. 1001(b); *see Halo v. Yale Health Plan,* 819 F.3d 42, 52 (2d Cir. 2016) ("[I]nterpreting [the claims procedure] regulation . . . requires us to examine . . . its purpose, as stated in the regulation's preamble . . . as well as the purpose of the regulation's authorizing statute, ERISA."). The delays caused by the district court's incorrect interpretation of the Secretary's claims regulation directly undermine these regulatory and statutory purposes. *See Gilbertson v. AlliedSignal, Inc.*, 328 F.3d 625, 636 (10th Cir. 2003) ("It would be manifestly unfair to claimants if administrators could extend the process indefinitely. . . The deadlines therefore empower the claimant to . . . insist on an up or down decision on the record as it stands."); *Asgaard v. Pension Comm.*, No. 2:06-CV-063, 2006 WL 2948074, at *8 (W.D. Mich. Oct. 13, 2006) ("Taken to its extreme, the defendants' argument would allow an ERISA plan administrator to avoid judicial review indefinitely").

Finally, because the claims-procedure regulation gives the plan fiduciary deciding the appeal all the tools that were available to the

plan when deciding the claim in the first instance, the normal rationale underlying vacate-and-remand in other contexts does not apply here. Unlike when an appellate court remands to a district court, a plan's "claim department" is no better positioned to make a decision on remand than the fiduciary on appeal; there is nothing the "claim department" can do that the fiduciary cannot do. Nor does the "claim department" possess any special expertise that the fiduciary lacks, as when district courts remand to administrative agencies (in an APA case). As noted, Hartford and its claim department are the same entity. An appeal of an adverse benefit determination is thus less like an appeal to a different adjudicatory body (with a different mandate and expertise) and more of a request that the original body (the plan) reconsider its decision. For that reason the factors motivating a court to remand a claim for benefits under ERISA section 502(a)(1)(B) to the plan (*e.g.*, deference to the plan administrator) also are not present when a plan remands an appeal to itself.[5]

[5] *See, e.g. Spears v. Liberty Life Assur. Co. Of Bos.*, No. 3:11-CV-1807 (VLB), 2015 WL 1505844 (D. Conn. Mar. 31, 2015).

2. The district court based its erroneous interpretation of the phrase "benefit determination on review," found in paragraph (i) of the regulation, on an erroneous implication it drew from a separate paragraph of the regulation, paragraph (j). Paragraph (i) states that the plan's "benefit determination on review" must be provided to the "claimant in accordance with paragraph (j) of this section." 29 C.F.R. § 2560.503-1(i)(1)(i). Paragraph (j), in turn, governs the "manner and content" of benefit determinations on review. It states that the plan must notify claimants of all benefit determinations on review either in writing or electronically (the manner), but sets out specific content requirements only for "adverse benefit determinations on view," which must include, among other things, the basis for the decision and the claimant's ability to sue in federal court. 29 C.F.R. §2560.503-1(j). According to the district court, because paragraph (j) contains "no provision governing the content of a 'benefit determination on review' that is not adverse to the claimant . . . there is nothing in that [paragraph] requiring that a 'benefit determination on review' must either approve the payment of benefits or make a final denial of the claim." *McQuillin II*, 2021 WL 2102480, at *3.

But the fact that paragraph (j) does not regulate "the content of a benefit determination on review that is not adverse to the claimant" demonstrates that such a non-adverse determination can take only one form: approval of benefits. The claims-procedure regulation regulates the content of an adverse benefit determination on review (i.e., one that affirms a denial of benefits) because claimants who receive such a decision have a right to challenge it in court, and must be apprised of that right. So the fact that the regulation does *not* regulate the content of a non-adverse benefit determination on review indicates that such a decision is one that does *not* trigger procedural rights of which a claimant must be apprised. And the only type of non-adverse decision that does not trigger procedural rights is a decision approving benefits, since there is no remedy for the claimant to pursue and thus no right of which to apprise the claimant. By contrast, vacate-and-remand decisions certainly trigger procedural rights, such as the right to appeal the forthcoming remand decision (indeed, Hartford's vacate-and-remand decision advised Plaintiff of just that). In short, if a vacate-and-remand were a permissible type of non-adverse benefit determination on review, paragraph (j) would regulate the content for such determinations. The

fact that it does not further demonstrates that a "benefit determination on review" does not include a vacate-and-remand decision, but permits only a decision approving benefits. Paragraph (j) thus shows that a plan has only two options on appeal: (1) uphold the denial and comply with paragraph (j), or (2) approve the claim, in which case no further information is needed.

In support of its interpretation, the district court also relied on *Werb v. ReliaStar Life Insurance Company*, No. 08-CV-5126, 2010 WL 3269974 (D. Minn. Aug. 17, 2010). But that case did not even consider the question of whether a vacate-and-remand decision qualifies as a "benefit determination on review" under the claims-procedure regulation. The *Werb* plaintiff argued for the first time in his summary judgment reply brief that the plan failed to timely decide his initial appeal, and "relie[d] entirely on the decision of the Eighth Circuit in *Seman v. FMC Corporation Retirement Plan for Hourly Employees*, 334 F.3d 728, 733 (8th Cir. 2003)." *Werb*, 2010 WL 3269974, at *9-10. But the *Seman* decision does not contain any reference to the Secretary's claims-procedure regulation; rather, it was instead decided based on the terms of the plan at issue in that case. *Seman*, 334 F.3d at 731. In fact,

Seman could not have been decided based on the "benefit determination on review" language at issue here, because the plaintiff's claim was filed in 1999 and governed by the Secretary's original 1977 regulation that contained different language. *See Seman v. FMC Corp. Retirement Plan for Hourly Emps.*, No. Civ. 01-209 (DWF/AJB), 2002 WL 385571, at *2 (D. Minn. March 7, 2002); *see also* 42 Fed. Reg. at 27,429 (29 C.F.R. § 2560.503-1(h) ("Decision on Review")).

In sum, the Secretary's regulation unambiguously requires a "benefit determination on review" to actually *determine benefits.* The district court's contrary reading is inconsistent with the regulation's plain language, structure, and purpose and would nullify the regulation's time limits. Because Hartford failed to decide Plaintiff's claim within 45 days of his appeal, the district court's decision finding that Hartford did not violate 29 C.F.R. § 2560.503-1(i) should be reversed.

III. Because Hartford Failed to Issue a Benefit Determination on Review within 45 Days of the Appeal, Plaintiff's Administrative Remedies are Deemed Exhausted, and the District Court's Review Is *De Novo.*

The Secretary's claims-procedure regulation provides that if a plan fails to "strictly adhere to all the requirements" of the regulation

with respect to a claim for disability benefits, the claimant is deemed to have exhausted their administrative remedies and their claim is decided without the exercise of discretion by a fiduciary. 29 C.F.R. § 2560.503-*1*(*l*)(2)(i). Courts have interpreted this provision to "expressly provide [] for *de novo* review where a plan administrator failed to adhere to the claims processing requirements." *Bustetter v. Standard Ins. Co.*, No. CV 18-1-DLB-EBA, 2021 WL 1198305, at *6, n.3 (E.D. Ky. Mar. 29, 2021); *see also* 81 Fed. Reg. 92,316, 92,328 ("The legal effect of the definition [of a denial of a claim] may be that a court would conclude that *de novo* review is appropriate because of the regulation that determines as a matter of law that no fiduciary discretion was exercised in denying the claim.").

When a plan fiduciary does not render a timely decision on a claim or appeal, it fails to strictly adhere to the claims-procedure regulation. In *Hasten v. Prudential Ins. Co. of Am.*, the plan administrator notified the claimant that it would be taking an extension, but failed to provide the special circumstances requiring an extension or an anticipated decision date. 470 F. Supp. 3d 1076, 1078 (N.D. Cal. 2020). The plan administrator eventually denied the claim for disability benefits 80

days after the 45-day deadline. *Id.* Citing 29 C.F.R. § 2560.503-1(*l*)(2)(i), the court held the plan administrator failed to strictly adhere to the regulation because it did not decide the claim or take a valid extension within the required time frame. *Id.* at 1079. Here, Hartford's violation of the regulation's 45-day deadline was far more flagrant, as it failed altogether to issue a "benefit determination on review" or seek an extension.[6]

The claims-procedure regulation has an exception to the "deemed exhausted" provision for *de minimis* violations, but the plan has the burden of proving that the violation was for good cause or due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information. 29 C.F.R. § 2560.503-1(*l*)(2)(ii); *see Hasten*, 470 F. Supp. 3d at 1082 (N.D. Cal. 2020). Hartford has not attempted to invoke this exception. Even if

[6] While Hartford eventually denied Plaintiff's claim again 97 days after he filed his appeal, that decision was not a "benefits determination on review" (*i.e.*, an appeal decision) but was instead another initial claim denial that, under the terms of the denial letter, Plaintiff would then have had to appeal to the plan administrator. *See* A101-102 (July 17, 2020 letter) ("If this disability claim has been denied in whole or in part, or if you feel your claim should be certified for a longer period, you can ask us to look at it again. This is called an Appeal.").

Hartford raised it for the first time during this appeal, the request would fail because the abject failure to issue a benefit determination on review is not "*de minimis*," but rather goes to the very heart of the claims process.

Finding that Plaintiff's claim is deemed exhausted and subject to *de novo* review is consistent with this Court's decision in *Halo*, addressing the pre-2017 claims regulation. 819 F.3d at 45. In *Halo*, the Court considered the claims regulation that applied to all claims (not just disability claims), and explained:

> [W]e hold that, when denying a claim for benefits, a plan's failure to comply with the Department of Labor's claims-procedure regulation, 29 C.F.R. § 2560.503-1, will result in that claim being reviewed *de novo* in federal court, unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the regulation in the processing of a particular claim was inadvertent *and* harmless.

819 F.3d at 45.

In *Halo,* this Court clarified that "deviations should not be tolerated lightly" and that the defendant bears the burden of proof to show that the violation was inadvertent and harmless. *Id.* at 57-58. As examples, it stated that an excusable error is a plan responding "in 73 hours when the regulation requires that it do so in 72" or "in 16 days

when the regulation specifies 15." *Id.* at 57. Hartford's complete failure in this case to issue a benefit determination on review is not an excusable error. *See also Spears v. Liberty Life Assurance Co.*, No. 3:11-CV-1807 (VLB), 2019 WL 4766253, at *35 (D. Conn. Sept. 30, 2019) (finding the plan's delay in issuing a decision was not inadvertent because the plan "intentionally decided not to govern itself by the ERISA deadlines" and applying *de novo* review); *Satter v. Aetna Life Ins. Co.*, No. 3:16-CV-1342(AWT), 2019 WL 2896410, at *6 (D. Conn. Mar. 20, 2019) (applying *de novo* review because denying a claim 64 days after the regulatory deadline "is not comparable to responding in 73 hours instead of 72 hours, or in 16 days instead of 15 days"). As such, this Court's precedent supports finding that Plaintiff's administrative remedies are deemed exhausted and that his claim should be reviewed *de novo*.

CONCLUSION

The Secretary respectfully requests that this Court reverse the district court's dismissal of Plaintiff's claims.

October 5, 2021

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(G), 32(g)(1), and 32(a)(7)(B) and Local Rule 29.1(c), I certify that this amicus brief contains 6,310 words.

Dated: October 5, 2021

/s/ Marcia Bove
Marcia Bove

CERTIFICATE OF SERVICE

I hereby certify that on this day, October 5, 2021, I electronically filed the foregoing, Brief for the U.S. Secretary of Labor as Amicus Curiae in Support of Plaintiff-Appellants, with the Clerk of the Court for the U.S. Court of Appeals for the Second Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Marcia Bove
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