

“Minor Error”: A Major Erosion of Consumer Protection

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Proposed Regulation, Paragraph 1(2)(ii)

This is a comment on the proposed “minor error” exception to the Department of Labor’s “minor error” provision in the proposed revisions to the ERISA regulations, which provides exceptions to the proposed “deemed exhaustion” requirement that applies when a plan does not follow the necessary claim protocol (which is usually at issue on appeal). Specifically:

The proposal would provide that any violation of the procedural rules in the Section 503 **Regulation would permit a claimant to seek immediate court action, unless the violation was: (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. In addition, the claimant would be entitled upon request, to an explanation of the plan's basis for asserting that it meets this standard, so that claimant could make an informed judgment about whether to seek immediate review.**

Background

The current ERISA regulations provide:

the plan administrator shall notify a claimant...of the plan’s benefit determination on review within a reasonable period of time, but not later than [45] days after receipt of the claimant’s request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan’s procedures provide for such a hearing) require an extension of time for processing the claim.” 29 C.F.R. § 2560.503-1(h)(4)(i)(1)(i).

Further, “If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ([45] day period...The 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.* The ERISA regulations mandate a deadline by which a fiduciary must make a decision on an appeal of an adverse benefits determination: “In no event shall such extension exceed a period of [45] days from the end of the initial period.” *Id.*

The ERISA regulations also establish that if the claims administrator does not make a determination within the required 90-day time window, a claimant may have immediate access to the courts:

In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under Section 502(a) of the Act 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. 29 C.F.R. § 2560.503-1(h)(1).

See also Gritzer v. CBS, Inc., 275 F.3d 291 (3d Cir. 2002); Ziesemer v. First Unum Life Ins. Co., 2007 WL 2123693 (D.N.J. July 20, 2007).

Gritzer explains why, upon deemed denial:

Where a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer. *Moench v. Robertson*, 62 F.3d 553, 567 (3d Cir.1995) (stating that de novo review was appropriate “because the record is devoid of any evidence that the Committee construed the plan at all. Thus, this is not a case implicating the arbitrary and capricious standard of review.... The deferential standard of review of a plan interpretation ‘is appropriate only when the trust instrument allows the trustee to interpret the instrument and when the trustee has in fact interpreted the instrument’ ”) (quoting *Trustees of Central States, Southeast and Southwest Areas Health & Welfare Fund v. State Farm Mutual Auto. Ins.*, 17 F.3d 1081, 1083 (7th Cir.1994)) (citations omitted); *id.* at 568 (citing *Firestone* for the proposition that a de novo standard is appropriate when the decisionmaker did not actually exercise its discretion. Ziesemer, 275 F.3d at 296.

In short, failure to exercise this fiduciary duty, which ERISA, the DOL Regulations, and any properly written plan require, means that there is nothing to apply discretion to and that de novo review is appropriate.

Nonetheless, Courts have entertained the application of the substantial compliance doctrine where an insurer argues for same after violating its fiduciary duties under ERISA. Specifically, the doctrine is “The rule that if a good-faith attempt to perform does not precisely meet the terms of an agreement or statutory requirements, the performance will still be considered complete if the essential purpose is accomplished, subject to a claim for damages for the shortfall.” Black’s Law Dictionary (10th Ed. 2014). It appears that the “minor error” provision in the proposed regulation enumerates precisely the types of errors that insurance companies argue that, while a technical violation of statutory, regulatory, and contractual requirement nonetheless have not impeded the accomplishment of the “essential purpose” of ERISA, its regulations, and the plans subject to the Law.

Analysis

Two problems are glaring from the proposed “minor error” provision which in fact threaten to undermine the equitable nature of ERISA and the purpose of the Act. First is the vague nature of the list of “minor errors,” which lacks a corresponding definition section to specify what precisely “(i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance” mean. The vagueness of these exceptions leaves them open to broad and inconsistent interpretation before the Courts, which more creates broad loopholes for insurer violations than specificity and clarification of fiduciary responsibilities.

Second, the proposed “minor error” provision erases a crucial distinction between a deemed denial exhaustion of administrative remedies and the substantial compliance defense to de novo review that should flow from a deemed denial exhaustion of remedies. Deemed denial is a concept inherent in the ERISA regulations, and further clarified by the Courts. Regardless of the standard of review applied to cases “deemed denied,” Courts and equitable maintain that failure to render a claims decision within ERISA’s prescribed time period is a deemed denial as a matter of law, regardless of whatever extenuating factors or “substantial compliance” a defendant may claim. See Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S.Ct. 604, 614 (2013) (“The United States suggests that administrators may attempt to prevent judicial review by delaying the resolution of claims in bad faith...But administrators are required by the regulations governing the internal review process to take prompt action...and the penalty for failure to meet those deadlines is immediate access to judicial review for the participant.”); Ziesemer, 2007 WL 2123693, *5 (D.N.J. July 20, 2007) (“if the doctrine of substantial compliance is allowed to delay accrual of the right to sue, it permits plan administrators to indefinitely tie up claimants with ongoing requests for information. While substantial compliance may be a useful doctrine when reviewing an administrator’s decision, this Court agrees with the Second Circuit that it cannot be used to delay accrual of the right to commence litigation.”).

To clarify this distinction with a real example, in Ziesemer, Unum failed to render a decision on plaintiff’s appeal by the deadline which was, at the latest, December 13, 2004. Therefore, plaintiff filed suit, alleging deemed denial. On December 21, 2004, Unum sent a letter requesting further medical information from plaintiff, and then argued that plaintiff’s deemed denial complaint must be dismissed due to an exchange with plaintiff’s counsel. 2007 WL 2123693, at *4. The Court ruled, that the appeal was deemed denied by operation of law when Unum failed to render a decision by December 13, 2004, despite the fact that plaintiff’s counsel communicated with Unum subsequent to that date in response to Unum’s request for information (by revoking authorizations), which defendant argued tolled the review process. The Court explained:

Defendants do not explain how this revocation might have stopped the review process but, even if they did, the 120-day period had already expired. Even

accepting defendants' argument that the period ended on December 13, 2004, on that date, when First Unum failed to render a decision, Plaintiff's appeal was deemed denied by operation of § 2560.503-1(h)(4), and she exhausted her administrative remedies. Id.

Unum argued that the doctrine of substantial compliance entitled it to abuse of discretion [if Unum's position is correct], it permits plan administrators to indefinitely tie up claimants with ongoing requests for information. While substantial compliance may be a useful doctrine when reviewing an administrator's decision, this Court agrees with the Second Circuit, that it cannot be used to delay accrual of the right to commence litigation. Id. at *5.

In short, deemed denial must be automatic once the ERISA claims regulations are violated. A law, including the proposed provision, holding otherwise, encourages behaviors that tie up a claimant's right to seek redress in Court under any standard of review. Examples of such improper activity include Ziesemer's example of continuously asking the claimant for information; allowing the insurer further time to gather evidence to support a denial where all evidence supports disability at the end of the 90-day period; allowing the insurer to delay payment for financial reasons; or exploiting Heimeshoff to drag the case out beyond the statute of limitations, a problem which these proposed regulations do not even address, and which therefore makes the proposed "minor error" provision all the more problematic.

Without automatic access to the Courts for insureds when their claim rights have been violated, insurers are left to engage in such dilatory conduct with the hope that they can claim that the violation was one of the proposed provisions vaguely enumerated "minor errors." If an insurer or the Court finds it appropriate for an insurer to argue substantial compliance/minor error and hence the standard of review once in the judicial forum, at least the plaintiff has already been allowed the crucial protection of access to that forum—an important protection separate and apart from the de novo standard of review.

Conclusion

Under the proposed "minor error" exception, the question of whether a "deemed denial" has occurred—that is, whether a claimant whose ERISA rights have been violated may upon that violation have access to the Courts—and what the standard of review will be (vis-à-vis evaluation for "minor errors" which is essentially "substantial compliance") for that plaintiff—must necessarily be answered at the same time and worse, in the same way. Passage of this provision therefore impedes claimants' rights rather than clarifying or enhancing them. Therefore, it is proposed that this provision not be passed and, if a "minor error" provision is to be enacted, that it be separate and unbound from the exhaustion of remedies provisions and provide an extensive definition section as to these "minor errors" to prevent large loopholes and judicial inconsistency in the force and application of these regulations.