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Employee Benefit Plan Review

Second Circuit Court of Appeals Holds Disability Benefit Claim Must Be Fully Determined on Internal Appeal Review Within 45 Days

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The U.S. Court of Appeals for the Second Circuit, in McQuillin v. Hartford Life and Accident Insurance Co.,[1] has held that, under the Employee Retirement Income Security Act (ERISA) and Department of Labor (DOL) regulations governing administrative benefit claims and appeals,[2] when considering an appeal of a denied disability claim, a plan administrator must make full determination of benefits.

In doing so, the Second Circuit rejected the claim administrator's argument that reversing the claim denial and remanding the claim internally for reevaluation satisfied the regulations – instead, a decision on whether or not benefits would be awarded was required.

Background

McQuillan involved a disability benefits claim brought by Plaintiff against Hartford Life and Accident Insurance Company (Hartford), the claim administrator. Plaintiff sought disability benefits in September 2019. On October 25, 2019, Hartford denied the benefits because the record lacked documentation and proof needed to determine disability.

Plaintiff appealed the determination on April 11, 2020 and included additional documentation and evidence to show disability. Twelve days after the appeal was filed with additional information, Hartford said that it completed the review of the additional documentation, overturned the initial decision to deny, and referred the claim back to the claim department to consider whether disability was supported. The letter communicating that decision also stated that no benefits were guaranteed.

Forty-six days after the appeal was made, plaintiff filed a lawsuit seeking disability benefits. Hartford argued that that the litigation should be dismissed because it was filed before administrative remedies were exhausted, given that the claim was being redetermined. Plaintiff argued that because Hartford did not make a final determination of benefits within 45 days of the appeal, the plan's administrative remedies were deemed exhausted by Hartford's failure to strictly comply with the DOL's claim handling procedures.

The lower court ruled that administrative remedies had not been exhausted and dismissed the claim. The Second Circuit reversed and ruled that the claim could proceed in court.

The Appellate Decision

The Second Circuit began by noting that under the DOL's claim regulations, a plan's remedies are deemed exhausted if the plan

administrator does not strictly adhere to Section 503-1's requirements.[3]

The court then endorsed plaintiff's argument that Hartford overturning the claim denial and sending the claim back for further review did not provide a "benefit determination on review" within the 45-day window required by Section 503-1(i)(3)(i). The court reasoned that the "regulation's plain language, structure, and purpose" supports the conclusion that a valid benefit determination on review must determine whether a claimant is entitled to benefits or not. Because Hartford did not make such a determination within 45 days of appeal, internal remedies were exhausted and the case could move forward.

The court's analysis began with looking to the text of the DOL regulation. The court concluded that the use of "benefit determination" in the regulation implies that the review a claim administrator must undertake is something more than simply a determination of the appeal.

Instead, the claim administrator must determine whether the claimant is entitled to the benefit. In addition, the term "determination" implies finality to a claim, not an interim decision. This textual argument was bolstered by Hartford's wording in its communications, saying that it would make a "final decision" within 45 days of an appeal.

The court also looked to the structure of the regulation and noted that the inclusion of review of newly presented evidence and lack of deference to original claim decision indicates that the process is one that should lead to a final determination of whether benefits were due.

Furthermore, the time frames of the appeal review process would be rendered meaningless if plan administrators could simply reset the clock by remanding for consideration of the claim anew.

Based on this reading, the Second Circuit concluded that because Hartford had not made a benefit determination on review within 45 days, Hartford had not complied with the regulations and thus the internal plan remedies were deemed exhausted.

Conclusion

- Claim administrators should take note of this case. It is strong authority that a claim administrator must make an actual benefits determination – either granting or denying benefits – on review within the time frames set forth in the DOL regulations, and that sending a claim back to the claims department for reconsideration is not enough to conclude review.
- This result may seem somewhat counterintuitive because the plaintiff succeeded in his internal appeal review and the denial of benefits was reversed, leading to further consideration. But the court concluded strict compliance with the regulations was required to preserve the failure to exhaust argument, and that those regulations require determination of benefits, not simply determination of the appeal.

Notes

1. McQuillin v. Hartford Life and Accident Insurance Co., No. 21-1514.
2. 29 C.F.R. § 2560.503-1.
3. See 29 C.F.R. § 2560.503-1(l)(2)(i) ("In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan. . . . Accordingly, the claimant is 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.").

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