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ERISA's Silence: Standards of Review in Deemed Denial Employment Benefit Claims

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ERISA'S SILENCE: STANDARDS OF REVIEW IN DEEMED DENIAL EMPLOYMENT BENEFIT CLAIMS

INTRODUCTION

Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA") to protect participants' employee benefits and to establish uniform requirements for employers who provide these benefits.[1] Although Congress intended to provide a framework for the distribution and enforcement of participants' benefits,[2] ERISA does not set the judicial standard of review of an administrator's decision to deny benefits.[3]

In *Firestone Tire & Rubber Co. v. Bruch*, the Supreme Court held that the standard of review is *de novo* unless the plan administrator has discretion to award benefits, in which case the standard of review is arbitrary and capricious.[4] Under the *de novo* standard, a court does not defer to the plan administrator's decision. Under the arbitrary and capricious standard, however, a court does defer to the administrator's decision unless it is arbitrary and capricious. Circuits are split not only as to when to apply the *de novo* standard, but also as to whether a court may consider evidence outside of the administrator's record when applying the standard of review.[5]

This paper examines the recent Tenth Circuit's holding in *Finley v. Hewlett-Packard.*[6] In *Finley,* the Tenth Circuit used an "arbitrary and capricious" standard to review a plan administrator's "deemed denial" of a participant's benefits.[7] A "deemed denial" occurs when an administra-

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1. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in 29 U.S.C. §§ 1001–1461 and in scattered sections of Titles 5, 18, 26, 31, and 42 U.S.C.).

2. Robert Mason Hogg, Note, *The Evidentiary Scope of De Novo Review in ERISA Benefits Litigation After* Firestone Tire & Rubber Co. v. Bruch, 78 MINN. L. REV. 1575, 1578 (1994) ("[E]RISA brought employee benefit plans under federal regulatory authority. ERISA regulates pension plans and aspects of 'employee welfare benefit plans,' which include health, disability, and death benefit plans.").

3. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989) ("[E]RISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations.").

4. *Bruch*, 489 U.S. at 115.

5. *Compare, e.g.*, Hall v. UNUM Life Ins. Co., 300 F.3d 1197, 1202–03 (10th Cir. 2002) (holding that evidence outside the administrator's record could not be examined in *de novo* review); S. Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir. 1993) *with* Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1026 (4th Cir. 1993) (holding that evidence outside the administrator's record may be examined under *de novo* review when the court deems it necessary); Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989) (holding that evidence outside the administrator's record can always be reviewed under *de novo* review for ERISA cases).

6. Finley v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan, 379 F.3d 1168 (10th Cir. 2004).

7. *Finley*, 379 F.3d at 1174.

tor fails to notify the participant of its decision to deny benefits within ERISA's timeframes.

Part I of this paper examines ERISA's history and the federal courts' interpretations of ERISA. Part II examines the scope of employee benefits under ERISA and the provisions providing the framework of an administrator's internal review and the availability of judicial review. Part III examines judicial standards of review. Part IV examines federal circuit splits over "deemed denial" cases commencing with the Tenth Circuit's holding in *Finley*. Part V analyzes the Tenth Circuit's reasoning in *Finley* and recommends a consistent standard in "deemed denial" cases that reflects other circuits and the legislative intent behind ERISA.

I. HISTORICAL ANALYSIS

Congress enacted ERISA in 1974 after escalating concerns of employer abuse of workers' benefit plans.[8] Examples of abuse include breach of fiduciary duty, funding failures, and wrongfully denied benefits.[9] Congress intended to establish a framework that would provide a comprehensive and consistent set of federal regulations to govern employment benefit plans.[10] To provide consistent laws, ERISA pre-empts all state laws relating to "any employment benefit plan."[11]

ERISA states that a plan participant or beneficiary has a right to federal court review for termination and denial of benefits claims.[12] Further, Congress intended federal common law to develop under ERISA.[13] ERISA, however, is silent on the appropriate standard of review.[14]

II. THE SCOPE OF EMPLOYEE BENEFITS UNDER ERISA

Because ERISA's preemption clause was drafted broadly enough to exclude most state claims, a claim under the federal statute usually provides the only relief for a participant or beneficiary.[15] ERISA authorizes

8. Enzio Cassinis, *Employment Law: The Tenth Circuit's Stance on the Evidentiary Scope of a "De Novo" Review in ERISA Benefits Suits*, 80 DENV. U. L. REV. 529, 532 (2003).

9. Colleen E. Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L.J. 1, 5 (2000).

10. Karla S. Bartholomew, Note, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131, 1137 (1999).

11. *See* 29 U.S.C. § 1144(a) (2004) (stating that ERISA preempts state law); Jayne Elizabeth Zanglein, *Employee Benefits for General Practitioners: Ten Rules That Every Attorney Should Know About ERISA*, 26 TEX. TECH L. REV. 579, 580 (1995); Cassinis, *supra* note 8, at 532.

12. *See* 29 U.S.C. § 1132(a) (2004).

13. Cassinis, *supra* note 8, at 532 (citing Scott v. Gulf Oil Corp., 754 F.2d 1499, 1502 (9th Cir. 1985)); 29 U.S.C. § 1144(a).

14. Chambers v. Family Health Plan Corp., 100 F.3d 818, 824–25 (10th Cir. 1996).

15. Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1090–91 (2001).

> [T]o the extent ERISA's preemption clause is construed broadly to restrict and preempt other State tort and contractual causes of action, more emphasis is obviously placed on ERISA's federal causes of action which then may be the sole or predominant cause of action and provide the only form of remedy for the participant/beneficiary.

Id.

an individual to bring only certain types of suits in federal court.[16] Scholars have criticized the limitations of ERISA remedies as a "shield for plan fiduciaries and insurers to limit their liability," which is contrary to the legislative intent of ERISA to protect employee benefit plan participants.[17]

A. Claims Under § 1132(a)(1)(B)

ERISA authorizes plan participants to sue in federal court for denial of benefits and breach of fiduciary duty.[18] A participant may sue for denial of employee benefits under 29 U.S.C. § 1132(a), which provides:

> A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.[19]

ERISA authorizes three different causes of action under § 1132(a).[20] The first claim (relevant to *Finley* and this paper), under § 1132(a)(1), "affords a cause of action for the participant/beneficiary to request recovery of plan benefits, enforcement of plan rights or clarification of plan rights."[21] Section 1132(a)(1) provides for both legal[22] (i.e., monetary) and equitable (i.e., injunctive or declaratory) relief.[23]

B. Plan Level Review

Under ERISA, employee benefit plans are subject to an "internal claim-review procedure."[24] The enforcement rules are codified at 29 U.S.C. § 1133, which provides:

> In accordance with regulations of the Secretary [of Labor], every employee benefit plan shall—(1) provide adequate notice[25] in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the par-

16. 29 U.S.C. § 1132(a).
17. Kennedy, *supra* note 15, at 1091.
18. JAMES F. JORDEN ET AL., HANDBOOK ON ERISA LITIGATION, § 3.05[A], 3-107 (2d ed. Supp. 2004) (outlining the statutory relief and right of civil action).
19. 29 U.S.C. § 1132(a).
20. *Id.*
21. Kennedy, *supra* note 15, at 1092.
22. *Id.* (citing Pane v. RCA Corp., 868 F.2d 631, 636 (3d Cir. 1989); Novak v. Andersen Corp., 962 F.2d 757, 759 (8th Cir. 1992)).
23. *Id.* (citing DAN B. DOBBS, LAW OF REMEDIES (2d ed. 1993)).
24. Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 21 (1992).
25. "Notice" is defined by the regulation as "[t]he delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 C.F.R. § 2520.104b–1(b) as appropriate with respect to material required to be furnished or made available to an individual." 29 C.F.R. § 2560.503–1(m)(5) (2004).

> ticipant, and (2) 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.[26]

Before a participant or beneficiary can sue, he must exhaust the internal remedies provided in § 1133.[27] All circuits enforce these internal limitations.[28] The ERISA Handbook on Litigation states that these internal requirements ensure that a plan participant who appeals an administrator's denial of benefits decision will "be able to address the determinative issues and have a fair chance to present his case."[29]

III. JUDICIAL STANDARDS OF REVIEW

The judicial standard of review under ERISA benefits suits is unclear and has caused conflict since the inception of ERISA.[30] ERISA requires a participant to exhaust all the internal remedies before suing.[31] The administrator's handling of the patients benefit claims, and all documents involved in the process, form a detailed administrative record.[32]

A. Review of the Plan Administrator's Decision

ERISA gives plan participants an express private right of action to recover benefits due to them under the terms of their plan regardless of whether other claims are available.[33] However, as mentioned above, ERISA does not set forth any standard of review in adjudicating denial of benefit claims.[34]

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26. 29 U.S.C. § 1133 (2004); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987).

27. *See* 29 U.S.C. § 1133(1) (requiring written notice to a participant of a denied claim); JAMES F. JORDEN ET AL., *supra* note 18, § 4.03[A], at 4–8; Whitman F. Manley, *Litigation Under ERISA: Civil Actions Under ERISA Section 502(a): When Should Courts Require That Claimants Exhaust Arbitral or Intrafund Remedies?*, 71 CORNELL L. REV. 952, 972 (1986) ("[C]ourts should require claimants seeking section 502(a)(1)(B) judicial review of benefit denials to exhaust administrative procedures before bringing suit, regardless of whether those procedures consist of internal review by plan administrators or binding arbitration pursuant to a collective bargaining agreement.").

28. *See, e.g.*, Lindemann v. Mobil Oil Corp., 79 F.3d 647, 650 (7th Cir. 1996); Variety Children's Hosp., Inc. v. Century Med. Health Plan, 57 F.3d 1040, 1042 (11th Cir. 1995); Hickey v. Digital Equip. Corp., 43 F.3d 941, 945 (4th Cir. 1995); Communications Workers of Am. v. AT&T, 40 F.3d 426, 431 (D.C. Cir. 1994); Costantino v. TRW, Inc., 13 F.3d 969, 974 (6th Cir. 1994); Simmons v. Willcox, 911 F.2d 1077, 1081 (5th Cir. 1990); Curry v. Contract Fabricators, Inc. Profit Sharing Plan, 891 F.2d 842, 846 (11th Cir. 1990); Leonelli v. Pennwalt Corp., 887 F.2d 1195, 1199 (2d Cir. 1989); Drinkwater v. Metro. Life Ins. Co., 846 F.2d 821, 826 (1st Cir. 1988).

29. JAMES F. JORDEN ET AL., *supra* note 18, § 4.03[D], at 4–15; *see also* Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 236–37 (4th Cir. 1997); Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997); Wolfe v. J.C. Penney Co., 710 F.2d 388, 392 (7th Cir. 1983).

30. Hogg, *supra* note 2, at 1576.

31. *See* 29 U.S.C. § 1133; Kennedy, *supra* note 15, at 1091–92 (citing Amato v. Bernard, 618 F.2d 559, 568 (9th Cir. 1990)).

32. Kennedy, *supra* note 15, at 1092.

33. JAMES F. JORDEN ET AL., *supra* note 18, § 4.04[C], at 4-48; *see* 29 U.S.C. § 1132(a)(1)(B).

34. JAMES F. JORDEN ET AL., *supra* note 18, § 4.04[C], at 4-48.

After ERISA was enacted, the courts "almost uniformly" applied an arbitrary and capricious standard to review an administrator or fiduciary's benefit decision, giving great deference to the plan decision-makers.[35] This highly deferential standard drew criticism,[36] especially in cases where the administrator was "not necessarily impartial in the determination of benefit eligibility or construction of plan terms."[37] Further, some scholars have stated that the adoption of the arbitrary and capricious standard of review indicated "little regard for the language of ERISA."[38]

B. Firestone Tire & Rubber Co. v. Bruch

The United States Supreme Court in *Firestone Tire & Rubber Co. v. Bruch* addressed the issue of the appropriate standard of review in denial of benefit cases under § 1132(a)(1)(B).[39] The Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[40] The Court set forth the following principles:

- Unless the language of a plan gives a fiduciary discretion to determine eligibility or construe the terms of a plan, a claims decision by a fiduciary should be reviewed under a *de novo* standard;

- If the plan language gives the fiduciary discretion to determine eligibility or construe the terms of a plan, a court should not disturb the decision unless it constituted an abuse of discretion; and

- If a plan fiduciary could gain from denying a claim, the potential conflict of interest should be taken into account in determining whether there has been an abuse of discretion.[41]

Post *Firestone*, most circuits use one of two standards to review employee benefit claims: *de novo* or the more deferential abuse of discretion standard.[42] A plan administrator's decision to deny benefits is gener-

35. *Id.*; *see* George L. Flint, *ERISA: The Arbitrary and Capricious Rule*, 39 CATH. U. L. REV. 133, 139 (1989); Kennedy, *supra* note 15, at 1108–09.

36. *See* Struble v. N.J. Brewery Employees' Welfare Trust Fund, 732 F.2d 325, 333–34 (3d Cir. 1984); Harm v. Bay Area Pipe Trades Pension Plan Trust Fund, 701 F.2d 1301, 1305 (9th Cir. 1983); Dennard v. Richards Group Inc., 681 F.2d 306, 314–15 (5th Cir. 1982).

37. Kennedy, *supra* note 15, at 1109.

38. Paul O'Neil, *Protecting ERISA Health Care Claimants; Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 723, 746 (1994) ("[C]onflict of interest almost always exists between ERISA benefits plans and benefits claimants. Incongruously, and with little regard for the language of ERISA, the courts initially adopted the arbitrary-and-capricious rule as the appropriate standard for review . . . .").

39. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

40. *Bruch*, 489 U.S. at 115.

41. JAMES F. JORDEN ET AL., *supra* note 18, § 4.04[C], at 4-50.

42. Kennedy, *supra* note 15, at 1130.

ally reviewed under the *de novo* standard.[43] The *de novo* standard of review affords less deference to the administrator's decision because it allows the courts to "second guess" the decision.[44] But if the plan gives the administrator or fiduciary discretion to determine eligibility for benefits or to construe the terms of the plan, then an arbitrary and capricious standard of review is applied.[45] Arbitrary and capricious is synonymous with abuse of discretion.[46] In the Tenth Circuit, the abuse of discretion standard is generally known as the arbitrary and capricious standard.[47]

IV. DEEMED DENIALS

This paper examines the Tenth Circuit's decision in *Finley v. Hewlett-Packard*, which applied a more deferential standard of review—arbitrary and capricious—to an administrator's "deemed denial" of benefits. As the court noted in *Finley*, the circuits are split on this issue.[48]

A. Tenth Circuit: Finley v. Hewlett-Packard[49]

1. Background

Ms. Finley was an employee of Hewlett-Packard Corporation from 1969 to 1996.[50] In 1996, she suffered from right thoracolumbar scoliosis.[51] Ms. Finley's employee benefit plan (the "Plan") was sponsored by Hewlett-Packard and administered by Voluntary Plan Administrators,

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43. *See* Hall v. UNUM Life Ins. Co., 300 F.3d 1197, 1201 (10th Cir. 2002).

44. Kennedy, *supra* note 15, at 1094.

45. *See Bruch*, 489 U.S. at 115.

46. "All the circuits affirm that there are two applicable judicial standards of review in ERISA benefit denial claims—the *de novo* standard and the more deferential standard—abuse of discretion." Kennedy, *supra* note 15, at 1130. "The Fourth, Fifth, Eighth, Ninth, and Tenth Circuits prefer the abuse of discretion standard over the *de novo* standard." *Id.* at n.249.

47. Chambers v. Family Health Plan Corp., 100 F.3d 818, 825 (10th Cir. 1996).

48. The *Finley* court noted the following circuit splits on this issue in footnote five of the opinion:

> *Compare* Jebian v. Hewlett-Packard Emp. Ben. Org. Income Protection Plan, 349 F.3d 1098, 1107- 08 (9th Cir.2003) (holding that the administrator's failure to communicate with plaintiff until 119 days into the 120-day review period triggers *de novo* review); Gritzer v. CBS, Inc., 275 F.3d 291, 295-96 (3d Cir. 2002) (extending no deference to a plan administrator's post hoc justification, issued only after commencement of litigation, for a deemed denial of benefits); with McGarrah, 234 F.3d at 1030-31 (holding that an ERISA plan fiduciary's failure to respond to beneficiary's request for administrative review does not trigger heightened scrutiny absent showing of extreme procedural irregularities); Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir.1993) ("In our view, the standard of review is no different whether the claim is actually denied or is deemed denied."); Daniel v. Eaton Corp., 839 F.2d 263, 267 (6th Cir.1988) (same).

Finley v. Hewlett-Packard Employee Benefits Org. Income Prot. Plan, 379 F.3d 1168, 1173 n.5 (10th Cir. 2004).

49. *Finley*, 379 F.3d at 1168.

50. *Id.* at 1170.

51. *Id.*

Inc. ("VPA").[52] VPA operates as an independent third-party administrator and is compensated solely by a flat fee.[53]

On November 29, 1996, Ms. Finley left her job and shortly thereafter applied to VPA for short-term disability benefits.[54] VPA denied these benefits and paid only after Ms. Finley "administratively appealed with the help of an attorney."[55]

Later in July of 1997, Ms. Finley applied for long-term benefits under the Plan.[56] According to the Plan, a member is only eligible for long-term benefits after their short-term benefits have expired if the member is permanently "unable to perform any occupation for which he or she is or may become qualified."[57] Thus, Ms. Finley was required to show by "objective medical evidence" that she was unable to perform any job for which she was or could become qualified.[58]

After Ms. Finley was examined by her doctors, as well as those of VPA, she sent the required reports to VPA in September 1997.[59] VPA denied long-term benefits on March 11, 1998.[60] VPA stated that Ms. Finley was "capable of performing sedentary work for which she may become qualified."[61] Ms. Finley appealed VPA's denial of long-term benefits on May 12, 1998.[62] Under ERISA's provisions in 1998, an appeal from a denial of benefits must be resolved within sixty days.[63] Similarly, the Plan provided that an appeal must be resolved within sixty days unless an extension has been granted.[64]

On July 14, 1988, after a series of exchanges, VPA agreed to make a decision within sixty days.[65] On October 9, 1998, VPA denied the appeal.[66]

2. Procedural Facts

Ms. Finley sued "under 29 U.S.C. § 1132(a)(1)(B), seeking recovery of her long-term benefits, and under 29 U.S.C. § 1133, seeking dam-

52. *Id.* at 1170–71.
53. *Id.* at 1171.
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *Id.*
63. *Id.* at 1171–72 (citing that later amendments to this provision did not take effect until January 1, 2002 so the court applied the older regulation).
64. *Id.* ("Section 8(c) of the benefits document mimics this regulation, stating: 'In no event shall the decision of the Claims Administrator be rendered more than one hundred twenty (120) days after it receives the request for review.'").
65. *Id.* at 1171.
66. *Id.*

ages for VPA's alleged failure to provide full and fair review of her claims."[67] The district court held that VPA's response to Ms. Finley's administrative appeal was due on September 12, 1998—sixty days after VPA's July 14 letter.[68] VPA, however, denied the appeal on October 9—twenty-seven days late.[69] Thus, Ms. Finley's administrative appeal was "deemed denied" under ERISA. The district court granted summary judgment for the VPA using an arbitrary and capricious standard of review.[70] Both parties appealed, and the Tenth Circuit affirmed summary judgment.[71]

3. Decision

The Tenth Circuit affirmed summary judgment for the plan using the arbitrary and capricious standard of review to examine the Plan administrator's "deemed denied" decision.[72] In *Finley,* the Tenth Circuit applied the *Firestone* holding that a denial-of-benefits claim under § 1132(a)(1)(B) requires a *de novo* standard *unless* the administrator of the plan has discretionary authority to determine eligibility of benefits.[73] In this case, the court held that the Plan administrator had full discretion to determine eligibility of benefits and granted more deference to the administrator's decision.[74] Further, the court stated that because the Plan administrator had no financial or other incentive to deny claims and that the benefits were paid out of the Plan's trust funds, there was no conflict of interest triggering a less deferential *de novo* standard of review.[75]

The Tenth Circuit rejected the plaintiff's contention that the court owes no deference to the administrator's decision because it was "deemed denied."[76] The court held that Ms. Finley's administrative appeal falls into an exception to the general use of *de novo* review for "deemed denials" because she failed to "provide meaningful new evidence or raise significant new issues . . . and the delay does not undermine confidence in the integrity" of the decision making process.[77] The court held that the plan administrator had "substantially complied" with the deadline and the delay was "inconsequential" and "in the context of

67. *Id.* at 1172.
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.* at 1170.
73. *Id.* at 1172 (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)); Jones v. Kodak Medical Assistance Plan, 169 F.3d 1287, 1291 (10th Cir. 1999).
74. *Id.* at 1173.
75. *Id.* at 1175.
76. *Id.* at 1173.
77. *Id.* at 1174.

an on-going, good-faith exchange."[78] The Tenth Circuit affirmed the district court's granting of summary judgment for the defendant.[79]

B. Ninth Circuit: Jebian v. Hewlett-Packard[80]

1. Background

In *Jebian,* the plaintiff was a Hewlett-Packard engineer who suffered from a multitude of orthopedic impairments and was given short-term disability benefits by the plan administrator—VPA.[81] After the plaintiff had exhausted his short-term disability benefits, he applied and was denied long-term benefits by VPA.[82] He appealed the denial of benefits, and sued the plan administrator after it failed to reply within ERISA's timeframe.[83] The district court reviewed VPA's denial of long-term benefits under the abuse-of-discretion (arbitrary and capricious) standard, and granted summary judgment for the plan administrator.[84]

2. Decision

The Ninth Circuit reversed, holding that the appropriate standard of review was *de novo.*[85] The Ninth Circuit held as a matter of first impression that the "[d]eemed denials are not exercises of discretion."[86] Thus, the Ninth Circuit held that "deemed denials" are "undeserving of deference under *Firestone,* and a *de novo* standard of review applies."[87] Further, the court held that the plan administrator's 119 days of "radio silence" to the claimant's appeal triggered *de novo* review.[88] The Ninth Circuit did note, however, that using *de novo* review in certain "deemed denial" claims may be "tempered" where there is "substantial compliance."[89]

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78. *Id.* at 1173–74.

79. *Id.* at 1173.

80. Jebian v. Hewlett-Packard Employee Benefits Org. Income Prot. Plan, 349 F.3d 1098 (9th Cir. 2003).

81. *Jebian,* 349 F.3d at 1101.

82. *Id.*

83. *Id.* at 1102.

84. *Id.* ("We conclude that the proper standard of review of VPA's decision in this case is *de novo,* and remand for reconsideration of Jebian's claim accordingly.").

85. *Id.* at 1103 ("The primary question before us, of first impression in this circuit, is whether a plan administrator's discretion, otherwise within the administrator's discretion, can be accorded judicial deference when the purported final, discretionary decision is not made until after the claim is . . . already automatically deemed denied on review. We conclude that where, according to plan and regulatory language, a claim is 'deemed . . . denied' on review . . . there is no opportunity for the exercise of discretion and the denial is usually to be reviewed *de novo.*").

86. *Id.* at 1106; *see also* Gritzer v. CBS, Inc., 275 F.3d 291, 295 (3d Cir. 2002) (holding that the administrator's failure to exercise discretion and communicate with the plaintiffs prior to litigation subjected them to *de novo* review).

87. *Jebian,* 349 F.3d at 1106.

88. *Id.* at 1107.

89. *Id.*

C. Fifth Circuit: Southern Farm Bureau Life Ins. Co. v. Moore[90]

1. Background

In *Moore,* the plaintiff sought to recover accidental death benefits under ERISA.[91] The plaintiff was employed by Southern Farm Bureau Life Insurance Company and had coverage for herself and her husband.[92] Plaintiff's husband suffered a brain tumor and fatally crashed his vehicle.[93] The plaintiff attempted to recover benefits from Southern Farm Life, the plan administrator.[94] Southern Farm Life filed for a declaratory judgment, asking the court to hold that the plaintiff's policy did not require it to pay under a policy exception.[95] Southern Farm Life did not communicate the denial of the plaintiff's claim to her before asking for the declaratory judgment.[96] The plaintiff counterclaimed for alleged deemed denial of benefits.[97] The district court applied *de novo* review and found for the plaintiff.[98] The administrator of the plan appealed.[99]

2. Decision

The Fifth Circuit held that "[i]n our view, the standard of review is no different whether the claim is actually denied or is deemed denied."[100] The court held that the district court erred in using the *de novo* standard of review for factual determinations under ERISA and instead applied the abuse of discretion standard.[101] Thus, the court rejected plaintiff's contention that the failure to provide a written denial within the timeframes required under ERISA elevates the standard of review from abuse of discretion to *de novo.*[102] However, the Fifth Circuit held that "under *Firestone,* we review the plan administrator's *interpretation* of the policy de novo."[103]

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90. Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98 (5th Cir. 1993).
91. *Moore,* 993 F.2d at 99.
92. *Id.*
93. *Id.*
94. *Id.*
95. *Id.* at 100.
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.* at 101.
101. *Id.* ("For factual determinations under ERISA plans, the abuse of discretion standard of review is the appropriate standard; that is, federal courts owe due deference to an administrator's factual conclusions that reflect a reasonable and impartial judgment.").
102. *Id.* ("Failure to provide a written denial does not mean that the abuse of discretion standard announced in *Pierre* is not applicable.").
103. *Id.* (emphasis added).

D. Eighth Circuit: McGarrah v. Hartford Life Insurance Company[104]

1. Background

In *McGarrah,* the plaintiff sued the plan administrator under ERISA for terminating his benefits.[105] The plaintiff was a truck driver for Wal-mart.[106] After slipping on ice and suffering a herniated cervical disk, he applied for and received long-term disability benefits.[107] Two years later, Hartford (the employee benefit plan administrator) discontinued benefits after learning that the plaintiff's physical condition had significantly improved.[108] The plaintiff appealed the denial but did not receive a response from Hartford.[109] The plaintiff sued for the denied benefits under § 1132(a)(1)(B).[110] The district court—using the arbitrary and capricious standard—granted summary judgment for Hartford.[111]

2. Decision

The Eighth Circuit affirmed the district court's use of the arbitrary standard and the judgment for the defendant.[112] The court held that "[i]n general, the abuse-of-discretion standard applies, if, as in this case, the plan expressly gives the administrator discretion to determine eligibility for benefits and to construe the terms of the plan."[113] The court responded to the plaintiff's claim that "procedural irregularities" should entitle him to a less deferential review of the administrator's decision by conceding that Hartford's failure to respond is "troubling" and a "serious procedural irregularity."[114] The Eighth Circuit, however, set forth a "rigorous standard" that a participant must meet to get *de novo* review: the irregularity must "raise[s] serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim . . . or where procedural irregularities are so egregious that the court has a total lack of faith in the integrity of the decision making process . . . ."[115]

The Eighth Circuit held that the "mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential

104. McGarrah v. Hartford Life Ins. Co., 234 F.3d 1026 (8th Cir. 2000).
105. *McGarrah*, 234 F.3d at 1027.
106. *Id.*
107. *Id.*
108. *Id.*
109. *Id.* at 1029.
110. *Id.* at 1027.
111. *Id.* at 1027–28.
112. *Id.* at 1028.
113. *Id.* at 1030 (citing *Bruch*, 489 U.S. at 115).
114. *Id.* at 1031.
115. *Id.*

standard of review."[116] The court affirmed summary judgment for the defendant.[117]

V. ANALYSIS AND RECOMMENDATION

In *Gilbertson v. Allied Signal Inc.*, decided before *Finley*, the Tenth Circuit reversed the district court's use of arbitrary and capricious in a "deemed denied" case.[118] In *Gilbertson*, the plaintiff appealed the administrator's denial of long-term benefits.[119] Later, the administrator extended the time for providing additional medical information in considering the plaintiff's appeal.[120] But the administrator neither replied to the appeal within ERISA's required timeframe nor contacted the plaintiff again.[121] Thus, the court held that the plaintiff's appeal was "deemed denied."[122] The Tenth Circuit reversed the district court's use of the arbitrary and capricious standard in granting summary judgment for the defendant and remanded for a *de novo* review.[123]

The Tenth Circuit noted in *Finley* that a court should use *de novo* review in a "deemed denied" case: "[w]hen the administrator fails to exercise his discretion within the required timeframe, the reviewing court must apply *Firestone's* default *de novo* standard."[124] However, the Tenth Circuit distinguished *Gilbertson*, stating that the administrator "made no decision to which a court may defer" requiring a *de novo* review.[125]

The Tenth Circuit further attempted to qualify *Gilbertson* by stating that its decision to apply *de novo,* instead of the arbitrary and capricious standard, is not "a hair-trigger rule" resulting in less deference if the administrator's decision is "rendered the day after the deadline." [126]

In *Finley*, the Tenth Circuit held that there was a limited exception (*McGarrah* exception) to the *de novo* standard if the "delay was a mere procedural irregularity that did not undermine its confidence in the integrity of the administrator's decision making process."[127] The Tenth Circuit

116. *Id.*

117. *Id.* at 1030–31 ("In these circumstances, Hartford's failure to respond to McGarrah's appeal, while wrong, does not undermine our confidence in the integrity of its decision-making process.").

118. Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 631–32 (10th Cir. 2003).

119. *Gilbertson*, 328 F.3d at 629.

120. *Id.*

121. *Id.* at 636.

122. *Id.*

123. *Id.* at 636–37.

124. Finley v. Hewlett-Packard Employee Benefits Org. Income Prot. Plan, 379 F.3d 1168, 1173 (10th Cir. 2004) (quoting *Gilbertson*, 328 F.3d at 631–32).

125. *Id.* (quoting *Gilbertson*, 328 F.3d at 631–32).

126. *Id.* at 1173 (quoting McGarrah v. Hartford Life Ins. Co., 234 F.3d 1026, 1031 (8th Cir. 2000)).

127. *Id.* at 1174 (citing the district court's reliance on the Eight Circuit's decision in *McGarrah*, 234 F.3d at 1026, forwarding this exception to using *de novo* review in "deemed denial" cases).

applied the arbitrary and capricious standard because the plaintiff failed to "provide meaningful new evidence or raise significant new issues [on administrative appeal]."[128] Also, the Tenth Circuit held that the delay did "not undermine [the court's] confidence in the integrity of [the administrator's] decision-making process."[129]

The Tenth Circuit reiterated in *Finley* that the goal of ERISA is to "promote accurate, cooperative, and reasonably speedy decision-making based upon a good faith exchange of information between the administrator and the claimant."[130] Further, the court said that failure by the plan administrator to respond under the required timeframes can still be deemed "substantial compliance" if the delay is: "(1) inconsequential; and (2) in the context of an on-going, good-faith exchange of information between the administrator and the claimant."[131]

In *Finley*, the Tenth Circuit adopted the "substantial compliance rule" of *Gilbertson* and held that VPA had substantially complied with the deadline, albeit late.[132] However, the substantial compliance rule in "deemed denial" cases fails to "protect the reasonable expectations of the participants."[133] Thus, when an administrator fails to comply with ERISA's deadlines and a claim is deemed denied, no deference should be granted.

The Tenth Circuit in *Finley* appears determined to grant deference to a plan administrator's decision to deny benefits. If we re-examine the purpose and spirit of ERISA—to provide a constructive framework in order to prevent employer abuses of participants' benefit plans—an administrator's failure to respond to a participant or beneficiary's appeal for denial of benefits is not an acceptable exercise of discretion. Accordingly, the Ninth Circuit held in *Jebian* that "[d]eemed denials are not exercises of discretion."[134] Congress's intent to "protect employees"[135] should not be construed in "deemed denial" cases to allow administrators of an employee benefit plan yet another tactic to stall decisions or frustrate the process.[136] A plan administrator's failure to respond to an appeal within the prescribed ERISA timeframes indicates a lack of acting pru-

128. *Id.* (quoting *Gilbertson*, 328 F.3d at 633).
129. *Id.* (quoting *McGarrah*, 234 F.3d at 1031).
130. *Id.* at 1173 (quoting *Gilbertson*, 328 F.3d at 635).
131. *Id.* at 1174 (citing *Gilbertson*, 328 F.3d at 635).
132. *Id.* at 1173–75.
133. George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 995, 1050 (1995).
134. Jebian v. Hewlett-Packard Employee Benefits Org. Income Prot. Plan, 349 F.3d 1098, 1106 (9th Cir. 2003).
135. *See* 29 U.S.C § 1001(a) (2004).
136. Flint, *supra* note 133, at 1048 ("The policy that ERISA seeks to further is to protect the reasonable expectations of the participants.").

dently or in "good faith" and courts should not accord deference to the administrator's decision.[137]

In contrast, the Fifth Circuit treats all denials the same: "[i]n our view, the standard of review is no different whether the claim is actually denied or is deemed denied."[138] Although the Fifth Circuit prefers the abuse of discretion for all factual determination reviews, a blanket application affords the same deference to an administrator's decision whether or not it complied with the timeframes provided for under ERISA.

Although the silence of ERISA on an appropriate standard of review was intentional in order to develop federal common law, a standard of review for "deemed denials" is necessary to provide participants, beneficiaries, and employers consistent guidelines for compliance.[139] Further, a consistent approach will promote ERISA's goals of "fairness, disclosure, and due process to participants" with similar claims.[140] Otherwise, as a scholar has noted, "the method of review chosen by the courts will determine the *fairness* by which a plan administrator administers an employee benefit plan."[141]

Applying *de novo* review in "deemed denial" cases encourages administrators to "protect the reasonable expectations of the participants."[142] Plan administrators will follow ERISA's provisions more closely and act more prudently if they lose the "defendant's shield"[143] of arbitrary and capricious review in "deemed denial" cases.

VI. CONCLUSION

ERISA's silence has resulted in the current circuit split regarding the appropriate standard of review of an administrator's "deemed denied" decision. The Tenth Circuit grants more deference than other circuits to an administrator's decision by using an arbitrary and capricious standard in "deemed denial" cases when the administrator has substantially complied with ERISA's timeframes. But to comply with ERISA's purpose and spirit *to protect employees*, however, courts should apply the less deferential standard of *de novo* in "deemed denial" cases. Applying

137. *Jebian*, 349 F.3d at 1103.

138. Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir. 1993).

139. *See* 120 CONG. REC. 29933 (1974) (statement of Sen. Javits) ("It is also intended that a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans."); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (stating that a federal common law is sought for ERISA provision interpretation).

140. Kennedy, *supra* note 15, at 1175.

141. George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Seige*, 39 CATH. U. L. REV. 133, 133 (1989) (emphasis added).

142. Flint, *supra* note 133, at 1048.

143. Paul O'Neil, *Protecting ERISA Health Care Claimants; Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 723, 724 (1994).

the more deferential arbitrary and capricious standard in "deemed denial" cases provides plan administrators no incentives to comply with ERISA.

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