Too Little, Too Late

When an Untimely Appeal Constitutes Failure to Exhaust Administrative Remedies Under ERISA

By Michael P. Cunningham

Courts will enforce a plan's administrative appeal deadline provided the claimant received adequate notice of the adverse benefit determination and right to appeal in accordance with ERISA's regulatory requirements.

All employee benefits plans governed by ERISA are required to provide internal procedures for the adjudication of benefit claims, including an internal appeal process. *See* 29 U.S.C. §1133(2); 29 C.F.R. §2560.503-1(h).

Internal review procedures are an integral part of ERISA, and claimants seeking to recover benefits under an ERISA plan must exhaust their administrative remedies before filing a lawsuit in court. When a claimant fails to pursue and exhaust a plan's administrative remedies before filing suit, those cases are subject to dismissal, with few exceptions.

But what happens when a claimant submits an untimely administrative appeal? Must the plan administrator consider a late-filed appeal? When might a claimant be excused from submitting a timely appeal? What, if any, traditional doctrines (*e.g.*, estoppel, waiver, equitable tolling) might preclude an administrator from enforcing an appeal deadline? May state "notice-prejudice" rules require an administrator to show prejudice to deny an untimely appeal?

This article addresses the enforceability of administrative appeal deadlines under ERISA plans and evaluates the various arguments claimants may advance to avoid the consequences of an untimely administrative appeal.

Pursuit and Exhaustion

The text of ERISA itself does not mandate exhaustion of administrative remedies as a precondition to filing a lawsuit for benefits. The courts of appeals, however, have uniformly interpreted ERISA as requiring

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the pursuit and exhaustion of administrative remedies as a prerequisite to filing suit. *See Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 610 (2013) (acknowledging plaintiff seeking ERISA plan benefits must exhaust internal review process under plan).

The exhaustion requirement is a judicially created doctrine predicated on ERISA's dual requirements that plans (1) provide adequate written notice of the reasons for adverse benefit determinations, and (2) create internal procedures for the review of those determinations. *See Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 360 (7th Cir. 2011) (referring to 29 U.S.C. §1133).

The exhaustion requirement gained widespread acceptance for several reasons. Courts recognize that a plan's internal review procedures "minimize the number of frivolous ERISA lawsuits; promote the consistent treatment of benefit claims; provide a nonadversarial dispute resolution process; and decrease the cost and time of claims settlement." *See Makar v. Health Care Corp.*, 872 F.2d 80, 83 (4th Cir. 1989).

Still further, internal review "enables plan fiduciaries to efficiently manage their funds; correct their errors; interpret plan provisions; and assemble a factual record which will assist a court in reviewing the fiduciaries' actions." *Id.* Requiring exhaustion of administrative remedies, therefore, places "primary responsibility for claim processing" on plan fiduciaries, as Congress intended, and prevents "premature judicial intervention" in the decision-making process of those fiduciaries. *See Edwards*, 639 F.3d at 361.

Exceptions to the exhaustion requirement are few. Claimants may be excused from pursuing their administrative remedies when (1) there is a lack of meaningful access to review procedures, or (2) pursuing internal plan remedies would be futile. *See Edwards*, 639 F.3d at 361; *see also Terry v. Bayer Corp.*, 145 F.3d 28, 40 (1st Cir. 1998).

A full analysis of these exceptions is beyond the scope of this article, but courts generally require plaintiffs to make a compelling showing in order to dispense with the exhaustion requirement. Conclusory allegations that a claim would have been denied on appeal, that the initial review was inadequate, or that the administrator acted in bad faith are insufficient. *See, e.g., MacLennan v. Provident Life & Acc. Ins. Co.*, 676 F. Supp. 2d 57, 66-67 (D. Conn. 2009) (rejecting futility argument absent "clear and positive showing" of futility); *see also Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 252 (3d Cir. 2002) (holding one telephone inquiry to insurer before filing suit insufficient to establish futility). Notably, a plan's refusal to hear an untimely appeal does not justify a finding of futility. *See Pieczynski v. Dril-Quip, Inc.*, 354 F. App'x 207, 211 (5th Cir. 2009).

Indeed, the failure to file a timely administrative appeal is one of the ways claimants "may fail to exhaust [their] administrative remedies." *Gallegos v. Mount Sinai Med. Ctr.*, 210 F.3d 803, 808 (7th Cir. 2000). Consistent with ERISA's implementing regulations, plans typically provide claimants 180 days to appeal an adverse benefit determination involving healthcare or disability benefits, and 60 days to appeal all other adverse benefit determinations. *See* 29 C.F.R. §2560.503-1(h)(3)(i) (healthcare benefits); 29 C.F.R. §2560.503-1(h)(4) (disability benefits); 29 C.F.R. §2560.503-1(h)(2)(i) (other benefits).

When a plan provides an internal review procedure consistent with ERISA, and the claimant receives adequate written notice of the right to appeal, courts are not hesitant to strictly enforce the plan's administrative appeal deadlines. *See, e.g., Edwards*, 639 F.3d at 362 (affirming dismissal of ERISA claim for failure to exhaust where administrative appeal submitted 11 days late); *Gayle v. UPS*, 401 F.3d 222, 230 (4th Cir. 2004) (affirming dismissal of ERISA claim for failure to exhaust where administrative appeal submitted two months late); *Wilson v. Bellsouth Telecomms., Inc.*, 97 F. App'x 36, 37–38 (6th Cir. 2004) (affirming dismissal for failure to exhaust where administrative appeal submitted approximately three weeks late); *Terry*, 145 F.3d at 40–41 (affirming summary judgment against claimant on the basis of late-filed administrative appeal).

Enforcing administrative appeal deadlines is consistent with the requirement that ERISA plan fiduciaries administer claims "in accordance with the documents and instruments governing the plan[s]." *See* 29 U.S.C. §1104(a)(1)(D); *see also Heimeshoff*, 134 S. Ct. at 612 (collecting cases recognizing the "particular importance of enforcing plan terms as written" and giving effect to plan's limitations provision). A plan fiduciary "must implement and follow the plain language of the plan," provided the plan terms are consistent with ERISA and its regulations. *See Edwards*, 639 F.3d at 362. Administrative appeal deadlines under an ERISA plan are no exception. *See Gayle*, 401 F.3d at 226 ("[I]nternal appeal limitations periods in ERISA plans are to be followed just as ordinary statutes of limitations.").

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Still further, one of the principal purposes of ERISA is to promote "efficiency, predictability, and uniformity" in the administration of employee benefit plans. *See Conkright v. Frommert*, 559 U.S. 506, 517–18 (2010). The "haphazard waiver" of appeal deadlines should be avoided because it would lead to "inconsistent results where one claimant is held to the limitation, and another is not." *Terry*, 145 F.3d at 40. Similarly, permitting appeals beyond the limitations period imposed by the plan would "only increase the cost and time of the settlement process." *Id.* Courts, therefore, recognize that ERISA plans "have an interest in 'finality of decisions' regarding claims for benefits that militates against reopening a plan's administrative claim process willy-nilly." *See Edwards*, 639 F.2d at 362.

Triggering the Appeal Clock

Whether a plan involves healthcare, disability, or other benefits, the event triggering the appeal deadline clock is the claimant's "receipt of a notification of an adverse benefit determination." *See* 29 C.F.R. §2560.503-1(h). Notice of an adverse

benefit determination is itself subject to still further regulation. ERISA requires that every plan provide "adequate" written notice "setting forth the specific reasons" for any claim denial "written in a manner calculated to be understood by the participant." 29 U.S.C. §1133(1).

The ERISA regulations interpreting §1133(1) require that notice of an adverse benefit determination (1) specify the reason for the denial; (2) reference the specific plan provisions on which the decision is based; (3) describe any additional information necessary for the claimant to perfect the claim; and (4) describe the plan's review procedures and the applicable appeal deadlines. 29 C.F.R. §2560.503-1(g).

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"Substantial compliance" with the notice requirements under ERISA and its regulations is all that is required. *See Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006); *Lacy v. Fulbright & Jaworski Ltd. Liab. P'ship Long Term Disability Plan*, 405 F.3d 254, 257 (5th Cir. 2005) (collecting cases); *Hickman v. Gem Ins. Co.*, 299 F.3d 1208, 1215 (10th Cir. 2002); *Terry*, 145 F.3d at 39. Thus, a claimant's administrative appeal deadline is triggered when a claimant receives written notice of an adverse benefit determination that substantially complies with the requirements of 29 U.S.C. §1133 and 29 C.F.R. §2560.503-1(g). *See, e.g.*, *Lacy*, 405 F.3d at 257; *Terry*, 145 F.3d at 39–41; *see also McGowan v. New Orleans Emp'rs Int'l Longshoremen's Ass'n*, 538 F. App'x 495, 498 (5th Cir. 2013) (termination of benefits letter substantially complied with regulation by referencing pertinent pages of summary plan description regarding 180-day appeal deadline).

By contrast, when notice of an adverse benefit determination fails to substantially comply with ERISA requirements, the usual time limits for submitting an administrative appeal will not be enforced. *See, e.g., White v. Aetna Life Ins. Co.*, 210 F.3d 412, 414 (D.C. Cir. 2000). Thus, where the claim administrator failed to specify one of the reasons the claim was denied (*i.e.*, lack of physician certification of disability) and failed to inform the claimant of the additional information necessary to perfect her claim (*i.e.*, physician certification), the plan's appeal deadline was not triggered by the defective denial notice. *See id.* at 417–18.

Similarly, a plan's appeal deadline was not triggered when the notice provided only an unsupported conclusion regarding the claimant's ineligibility for benefits, failed to specify the plan provisions on which the denial was based, and failed to inform the claimant of the type of information needed to perfect his claim. *See White v. Jacobs Eng'g Group Long Term Disability Benefit Plan*, 896 F.2d 344, 350 (9th Cir. 1989); *see also Epright v. Envtl. Res. Mgmt., Inc. Health & Welfare Plan*, 81 F.3d 335, 342 (3d Cir. 1996) (denial letter that failed to explain proper steps for requesting internal review failed to trigger administrative appeal deadline).

In these cases, the courts refused to enforce the administrative appeal deadline because the claim administrator's conduct arguably impeded the claimant's ability to pursue a timely appeal. The remedy in these cases, however, is not to dispense with the exhaustion requirement, but remand to the administrator for an out-of-time appeal. *See Counts v. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105, 108 (11th Cir. 1997); *see also White v. Aetna*, 210 F.3d at 419 (ordering remand and directing administrator to consider merits of appeal); *Jacobs Eng'g*, 896 F.2d at 352 (same).

What Constitutes an Appeal?

One recurring issue in cases involving untimely appeals is the "inadequate appeal." These cases typically involve a claimant's request for documents from the plan and vague assertions about the possibility of filing an appeal before the appeal deadline expired. Thinking about an appeal, however, is not an appeal.

In *Edwards*, a letter from the claimant to the plan requesting documents and stating the claimant would "decide whether or not to appeal" after receiving the documents, was not an appeal. *See Edwards*, 639 F.3d at 364. A subsequent letter from claimant's counsel to the plan requesting plan documents and indicating the claimant would bring an appeal "soon," may have expressed an intention to appeal, but was not itself an appeal. *See id.* Affirming summary judgment in favor of the plan, the court held the claimant failed to exhaust her administrative remedies because she failed to submit a timely administrative appeal. *See id.*; *see also ADA v. Wellpoint Health Networks, Inc.*, 494 F. App'x 43, 46 (11th Cir. 2012) (holding plaintiff failed to initiate administrative appeal where letter to insurer did not challenge partial denial of benefits or request any kind of review, but merely sought information about claim decision); *Swanson v. Hearst Corp. Long Term Disability Plan*, 586 F.3d 1016, 1018–19 (5th Cir. 2009) (holding plaintiff failed to exhaust administrative remedies where letter to plan that "merely expressed an 'intention to appeal'" was not itself an appeal).

Similarly, where claimant's counsel sent a letter to the insurer's benefit management services department rather than the appeal unit, failed to outline any issues on appeal as directed, requested "any and all medical records," and stated counsel "will be reviewing" information "for [the] client's appeal," the court concluded the insurer reasonably construed the letter to be a mere request for documents rather than an appeal. *See Reindl v. Hartford Life & Accident Ins. Co.*, 705 F.3d 784, 788 (8th Cir. 2013). Affirming summary judgment for the insurer, the court held counsel's subsequent letter to the insurer's appeal unit requesting reversal of the claim decision was late and, therefore, claimant failed to exhaust her administrative remedies. *See id.* at 786, 788.

Although courts ordinarily require a definitive written statement from the claimant that the adverse benefit determination is being appealed, the appeal submission need not be entirely complete. Thus, where a letter from claimant's coun-

sel to the insurer clearly stated the claimant was appealing the insurer's decision and outlined the general basis of the appeal, the court concluded the letter was sufficient to constitute an appeal, despite counsel's further request for documents and a 60-day extension to present additional information. *See Kellogg v. Metropolitan Life Ins. Co.*, 549 F.3d 818, 826-27 (10th Cir. 2008).

Estoppel

Estoppel may preclude a plan administrator or insurer from asserting the claimant's failure to exhaust as a defense "where that failure results from the claimant's reliance on written misrepresentations" by the plan administrator or insurer. *See Gallegos*, 210 F.3d at 810. While the precise elements necessary to establish estoppel vary from circuit to circuit, to invoke estoppel, a claimant generally must show the administrator knowingly misrepresented or concealed a material fact and the claimant reasonably relied on the misrepresentation or concealment to his detriment. *See, e.g., Schorsch v. Reliance Std. Life Ins. Co.*, 693 F.3d 734, 739 (7th Cir. 2012).

Estoppel arguments obviously fail absent a misrepresentation by the plan or an administrator of the plan. *See, e.g., Swanson*, 586 F.3d at 1019 (rejecting estoppel argument absent evidence insurer affirmatively misled claimant and where termination of benefits letter properly apprised claimant of appeal deadline). Moreover, even if a misstatement were made, estoppel cannot be established without showing claimant's reliance on that misstatement prevented a timely administrative appeal. *See, e.g., Schorsch*, 693 F.3d at 739–41 (rejecting estoppel argument because claimant failed to follow insurer's instructions for seeking administrative review and failed to show she relied on alleged misstatement regarding appeal deadline); *Chorosevic v. MetLife Choices*, 600 F.3d 934, 942–43 (8th Cir. 2010) (rejecting estoppel argument absent evidence claimant relied on insurer's letter to his detriment by failing to file second appeal within 60-day deadline); *Gallegos*, 210 F.3d at 811 (rejecting estoppel argument because plaintiff did not rely on insurer's misleading statements in deciding not to appeal within applicable deadline).

If, however, the claimant can show he relied on the defendant's misleading words and conduct, and that reliance prevented him from timely pursuing the plan's appeal process, then the defendant may be estopped from asserting the failure to exhaust administrative remedies as a defense to an ERISA claim. *See Bourgeois v. Pension Plan for the Emps. of Santa Fe Int'l Corps.*, 215 F.3d 475, 481 (5th Cir. 2000) ("We agree that the lack of information and the behavior of various officials of the company led [plaintiff] on a wild goose chase, effectively extinguishing his time to apply for benefits.").

Waiver

Waiver is commonly defined as "an intentional relinquishment and abandonment of a known right or privilege." *See Chapman v. Choicecare Long Island Term Disability Plan*, 288 F.3d 506, 510 (2d Cir. 2002) (citing *United States v. Olano*, 507 U.S. 725, 733 (1993)). In *Chapman*, plaintiff argued the insurer of a long-term disability plan waived any argument that her administrative appeal was untimely because the insurer considered and ruled on the merits of her appeal. Rejecting the waiver argument, the Second Circuit held the insurer "properly preserved" the untimeliness issue because it noted the late-filed appeal as additional grounds for upholding the claim denial in its appeal decision. *See id.* at 511.

Chapman serves as a reminder that whenever a plan or claims administrator considers an untimely appeal on the merits, any appeal decision upholding the initial denial ought to reflect that the untimely appeal constitutes one of the reasons for upholding the initial claim decision. Indeed, failing to raise the untimeliness issue in the appeal decision may result in a waiver of this important defense. *See, e.g., Robertson v. Nat'l Asbestos Workers Pension Fund*, 2011 WL 672057 (S.D. W. Va. Feb. 14, 2011); *Orgeron v. Moran Towing Corp.*, 1995 WL 708688 (S.D.N.Y. Nov. 30, 1995).

A slightly different waiver issue was addressed in *Malke v. Metropolitan Life Insurance Co.*, 2012 WL 6738250 (D. Mass. Dec. 27, 2012). In *Malke*, the claimant argued the plan administrator waived the deadline for filing a "second level" administrative appeal, when it previously considered the claimant's untimely "first level" appeal. The court found the administrator's willingness to excuse the prior appeal deadline did not constitute a waiver of the second appeal deadline because it "explicitly warned" the claimant about the time limitation relating to the "second level" appeal. *See id.*

Thus, a claimant's administrative appeal deadline is triggered when a claimant receives written notice of an adverse benefit determination that substantially complies with the requirements of 29 U.S.C. §1133 and 29 C.F.R. §2560.503-1(g).

Equitable Tolling

Equitable tolling allows courts to "extend a statute of limitations on a case-by-case basis to prevent inequity." *Viti v. Guardian Life Ins. Co. of Am.*, 817 F. Supp. 2d 214, 227 (S.D.N.Y. 2011). "To warrant equitable tolling, a petitioner must demonstrate '(1) that he has been pursuing his rights diligently, and (2) that some extraordinary circumstance stood in his way and prevented timely filing.'" *Id.* (quoting *Lawrence v. Florida*, 549 U.S. 327, 336 (2007)). Equitable tolling may be warranted, for example, when a claimant's physical or mental health prevented him from pursuing his rights in a timely manner. *See id.*

The Supreme Court has recognized that equitable tolling might be applied to toll the contractual limitations period under an ERISA plan. *See Heimeshoff*, 134 S. Ct. at 615. Whether equitable tolling may be applied to toll a plan's administrative appeal deadline, which is technically not a

limitations period, is perhaps less clear. *See Viti*, 817 F. Supp. 2d at 227 (noting Second Circuit has never "'squarely held that [equitable tolling] applies to time limits that are specified in [ERISA] plan provisions'").

In *Gayle v. UPS*, 401 F.3d 222, 226 (4th Cir. 2005), the Fourth Circuit considered this precise issue, noting that "[e]quitable tolling, while rare, does allow for exceptions to the strict enforcement of deadlines," including administrative appeal deadlines. The court observed that equitable tolling has been permitted where a claimant actively pursued judicial remedies by filing a timely but defective pleading, or where the claimant has been induced or tricked into allowing a filing deadline to pass. *See id*. (citing *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 96 (1990)). The court held neither exception applied because the claimant failed to submit a timely appeal due to her attorney's negligence. *See id*. Attorney negligence is not an "extraordinary circumstance" justifying equitable tolling and, therefore, the court dismissed claimant's ERISA claim, with prejudice, for failing to exhaust administrative remedies. *See id*. at 227, 230.

Moreover, state notice-prejudice rules have only been applied in the context of initial claim denials.

In other courts where equitable tolling was considered, plaintiffs have been unsuccessful in extending the time to file administrative appeals. *See, e.g.*, *MacLennan*, 676 F. Supp. 2d at 65 (rejecting equitable tolling argument based on mental illness because plaintiff failed to show he was so incapacitated he could not submit an appeal during three year period); *Viti v. Guardian Life Ins. Co. of Am.*, 2013 WL 6500515 (S.D.N.Y. Dec. 11, 2013) (finding plaintiff failed to establish extraordinary circumstances and reasonable diligence where, despite his mental condition, plaintiff had been able to pursue social security benefits).

While there do not appear to be any reported cases extending a plan's administrative appeal deadline based on equitable tolling, the doctrine has been invoked on multiple occasions and it appears only a matter of time before a case presents sufficient facts and circumstances warranting application of the doctrine.

Notice-Prejudice

In some circumstances, a state notice-prejudice rule may require the administrator of a fully insured ERISA plan to show prejudice in order to deny a claim based on a claimant's failure to give timely notice. Indeed, the Supreme Court held California's notice-prejudice rule, which precludes an insurer from avoiding liability based on an untimely claim unless the insurer shows actual prejudice, is a law which regulates insurance and, therefore, is saved from preemption under ERISA, 29 U.S.C. §1144(b)(2)(A). *See Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 373 (1999).

In the case of self-funded plans, however, state notice-prejudice rules will not be "saved." ERISA's "deemer clause" prohibits states from deeming a self-funded plan "to be an insurance company or … engaged in the business of insurance" for purposes of state regulation. *See* 29 U.S.C. §1144(b)(2)(B). The Supreme Court has interpreted the deemer clause as exempting "self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the savings clause." *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Thus, even state insurance regulations are preempted by ERISA to the extent they apply to self-funded plans. *See id.* at 64–65; *see also Unum Life,* 526 U.S. at 367 n.2 (noting self-insured plans are "generally sheltered from state insurance regulations"). Accordingly, if an untimely administrative appeal relates to a self-funded plan, then any state notice-prejudice rule will be preempted by ERISA.

Although state notice-prejudice rules may be saved from preemption in the case of fully insured plans, their applicability to administrative appeal deadlines is doubtful. Some state notice-prejudice rules or statutes govern only certain types of third-party insurance, such as "liability insurance," which is typically not part of an ERISA plan. The Wisconsin notice-prejudice statute at issue in *Edwards*, for example, applied only to "liability insurance"—not the disability benefits at issue in that case. *See Edwards*, 639 F.3d at 363 (rejecting application of notice-prejudice statute in context of untimely appeal); *see also Tetreault v. Reliance Std. Life Ins. Co.*, 2011 WL 7099961, at *9 (D. Mass. Nov. 28, 2011) (rejecting application of notice-prejudice rule to untimely ERISA appeal because disability insurance is not "liability insurance").

Moreover, state notice-prejudice rules have only been applied in the context of initial claim denials. *See Edwards*, 639 F.3d at 363. As the Ninth Circuit observed, "[t]here is no… federal case that has applied a notice-prejudice rule outside the initial review context" and "[t]o extend the notice-prejudice rule to ERISA appeals would extend the rule substantially beyond its previous uses." *Chang v. Liberty Life Assurance Co. of Boston*, 247 F. App'x 875, 878 (9th Cir. 2007). Federal courts, therefore, have been reluctant to extend notice-prejudice rules beyond the context of initial claim denials. *See, e.g., Edwards*, 639 F.3d at 363 ("[W]e are 'not inclined to make such a significant and unprecedented extension of the rule.'"); *Tetreault*, 2011 WL 7099961, at *10 (declining to extend notice-prejudice rule to ERISA appeals).

Conclusion

Courts will enforce a plan's administrative appeal deadline provided the claimant received adequate notice of the adverse benefit determination and right to appeal in accordance with ERISA's regulatory requirements. Although claimants may invoke the doctrines of waiver, estoppel, and equitable tolling to avoid the consequences of a late-filed appeal, facts supporting the application of these traditional doctrines are often difficult to establish. Administrators and insurers of ERISA plans must not overlook a plan's administrative appeal deadlines and, even when a decision is made to consider an untimely appeal on the merits, the untimeliness issue should be preserved in the appeal decision. Indeed, a claimant's failure to exhaust administrative remedies due to an untimely appeal may be a dispositive defense in any subsequent litigation.