No. _____

In The
Supreme Court of the United States

JACQUELINE AVERY,

Petitioner,

v.

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. and FCA US LLC LONG-TERM DISABILITY BENEFIT PLAN,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Under Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1133, employee benefit plans must, in accordance with the regulations of the Secretary of Labor:

1. provide adequate notice 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 participant, 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.

In turn, the Secretary of Labor's claims procedure regulations, 29 C.F.R. § 2560.503-1, precisely detail the minimum performance standards necessary to comply with the statute. However, the Sixth Circuit has ruled that violations of the claims procedure regulations may be excused under the judicial "substantial compliance" doctrine if a judge determines that plan procedures satisfy the "essential purpose" of Section 503. App. 10-12.

The question presented is: Whether the Sixth Circuit erred in holding – in conflict with the Second and Seventh Circuits – that violations of the claims procedure regulations, 29 C.F.R. § 2560.503-1, may be excused under the judicial "substantial compliance" doctrine if a judge determines that plan procedures satisfy the "essential purpose" of Section 503.

RELATED CASES

Avery v. Sedgwick Claims Management Services, No. 20-11810, U.S. District Court for the Eastern District of Michigan. Judgment entered September 21, 2022.

Avery v. Sedgwick Claims Management Services, No. 22-1960, U.S. Court of Appeals for the Sixth Circuit. Judgment entered July 24, 2023.

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INTRODUCTION

This petition presents an isolated question central to ERISA jurisprudence: Whether the Sixth Circuit erred in holding – in conflict with the Second and Seventh Circuits – that violations of the claims procedure regulations, 29 C.F.R. § 2560.503-1, may be excused under the judicial "substantial compliance" doctrine if a judge determines that plan procedures satisfy the "essential purpose" of Section 503 of ERISA, 29 U.S.C. § 1133. The claims procedure regulations are mandated by Section 503 and impose specific requirements on ERISA benefit administrators regarding the timing and content of employee benefit notices, as well as specific procedures designed to ensure participants that their claims will receive "a full and fair review." Under the Sixth Circuit "substantial compliance" test, however, a court considers all communications between a claimant and administrator to decide whether they combine "to notify the claimant of the specific reasons for a claim denial" and "to provide the claimant with an opportunity to have that decision reviewed by the fiduciary." If so, the administrator is excused from complying with the requirements of the claims procedure regulations, which are supplanted by a judge's general assessment of the purpose of ERISA. Here, the courts below determined that a claimant's letter complaining about a medical examination and an administrator's subsequent letter denying benefits incongruously combined to satisfy the "essential purpose" of Section 503, effectively denying the claimant a reasonable opportunity to appeal the adverse decision

and obtain a full and fair review. Several other circuits have addressed the propriety of the "substantial compliance" doctrine, and the Second and Seventh Circuits have rejected it in similar circumstances involving violation of the claims procedure regulations. This Court's review is now needed to provide a uniform answer to this exceptionally important question regarding ERISA jurisprudence. Sup. Ct. R. 10(a); Sup. Ct. R. 10(c).

OPINIONS BELOW

The opinion of the court of appeals (App. 1-33) is unreported but available electronically at 2023 WL 4703865 and 2023 U.S. App. Lexis 18860. The district court decision (App. 34-72) is unreported but available electronically at 2022 WL 4365707 and 2022 U.S. Dist. Lexis 170697.

JURISDICTION

The opinion and order of the court of appeals affirming the district court was entered on July 24, 2023. App. 1. The order of the court of appeals denying the petition for rehearing was entered on August 24, 2023. App. 88. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 503 of the of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1133 states:

29 U.S.C. § 1133

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice 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 participant, 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.

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The claims procedure regulations of the Secretary of Labor, 29 C.F.R. § 2560.503-1 (2000), state in relevant part:

29 C.F.R. § 2560.503-1 Claims procedure.

(a) **Scope and purpose.** In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter

referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) **Obligation to establish and maintain reasonable claims procedures.** Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

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(d) **Plans providing disability benefits.** The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) **Claim for benefits.** For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit

claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) **Timing of notification of benefit determination.**

(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. 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 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial 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 benefit determination.

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(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time,

but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic

notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant –

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures –

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

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(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) **Timing of notification of benefit determination on review.**

(1) In general.

(i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 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 a hearing) require an extension of time for processing the claim. 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 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial 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.

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(3) Disability claims.

(i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

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(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) **Manner and content of notification of benefit determination on review.** The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits –

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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(l) Failure to establish and follow reasonable claims procedures. 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.

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(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

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(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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STATEMENT OF THE CASE

This petition presents an isolated question central to ERISA jurisprudence: Whether the Sixth Circuit erred in holding – in conflict with the Second and Seventh Circuits – that violations of the claims procedure regulations, 29 C.F.R. § 2560.503-1, may be excused

under the judicial "substantial compliance" doctrine if a judge determines that plan procedures satisfy the "essential purpose" of Section 503 of ERISA, 29 U.S.C. § 1133. The facts necessary for the Court's decision are not in dispute, and there can be no doubt that Respondent Sedgwick Claims Management Services violated the claims procedure regulations in the course of processing Petitioner Jacqueline Avery's claim. Ms. Avery was not provided 180 days to appeal her adverse claim decision as promised in the regulation, and Sedgwick issued a "final decision" of Ms. Avery's "appeal" without actually receiving an appeal from Ms. Avery.

However, the courts below looked at whether they believed Sedgwick was in "substantial compliance" with the "essential purpose" of Section 503 rather than requiring adherence the detailed procedures established as minimum performance standards in 29 C.F.R. § 2560.503-1. To accomplish this, the court of appeals construed Ms. Avery's July 28, 2014 letter protesting a medical examination, App. 131-36, as though it was an appeal of Sedgwick's subsequent August 20, 2014 benefit denial letter. App. 137-39. As incongruous as this may seem, it permitted the court of appeals to approve Sedgwick's September 12, 2014 "final decision" denying Ms. Avery's appeal without affording her the 180 day appeal period mandated by 29 CFR § 2560.503-1(h)(3)(i), (h)(4).

The question of whether this judicial "substantial compliance" doctrine may excuse violations of the claims procedure regulations is crucial to maintaining the integrity of ERISA's remedial scheme. The Sixth

Circuit decision conflicts with decisions of the Second and Seventh Circuits, and this case presents an appropriate vehicle for deciding the issue. Therefore, it would be appropriate for the Court to grant the writ at this time.

A. Factual Background

The facts necessary for the Court's decision are not in dispute. Ms. Avery was a participant in the FCA US LLC Long-Term Disability Benefit Plan, for which Sedgwick serves as claims administrator, when she first became disabled on July 15, 2011. App. 2. Sedgwick approved Ms. Avery's claim for disability on the basis of "totally disabling condition(s) of Right Lower Extremity Neuropathy & reflex sympathetic dystrophy lower extremity" as confirmed in clinical examinations with two independent neurologists. App. 3. Ms. Avery continuously furnished medical records from her treating physicians to substantiate her disability, and Sedgwick repeatedly approved Ms. Avery's long-term disability benefits through early 2014. App. 3.

Beginning on April 14, 2014, however, Chrysler's corporate investigations unit conducted surveillance on Ms. Avery on five occasions, mistakenly drawing the conclusion that, "[a]lthough not confirmed, it appears that she may be running some sort of business out of her home." App. 121-22. The surveillance apparently spotted a "woman who shows up at Avery's home the same time every day," and rather than identifying

this woman as one of Ms. Avery's medical caregivers, the investigation unit surmised that she may be running a business. *Id*. Chrysler and Sedgwick then came up with a plan to coordinate additional surveillance with an independent medical examination to be scheduled for Ms. Avery with Dr. Joel Shavell. App. 124-28. Dr. Shavell is not a neurologist, the specialty appropriate for evaluating Ms. Avery's condition, but he nonetheless determined that Ms. Avery could return to work. App. 4-5. Based on Dr. Shavell's opinion, Sedgwick sent a letter on July 21, 2014 requesting Ms. Avery to "report to your plant medical department for a determination of your ability to return to work." App. 129.

Ms. Avery obtained a copy of Dr. Shavell's report, and on July 28, 2014, she wrote a letter to Sedgwick "to appeal my recent return to work decision." App. 131-36. Ms. Avery provided a detailed refutation of the assertions contained in Dr. Shavell's report and requested Sedgwick "to reverse the return to work authorization." App. 136. Sedgwick subsequently sent a letter dated August 20, 2014 to Ms. Avery that cited "the results of your recent IME examination, in which you were found able to work," and stated:

> Based upon this information we are requesting that you report to your Human Resource for a determination of your ability to return to work. Your benefits may be terminated effective July 21, 2014 pending the outcome of the ability to work examination.

App. 137. The August 20, 2014 letter also explained that Ms. Avery could "appeal this decision by sending a written request within 180 calendar days of the date you receive this letter." App. 138. Nevertheless, Sedgwick did not wait for the 180-day appeal period to expire before sending Ms. Avery its September 12, 2014 letter stating Sedgwick had "completed our review of your claim and appeal under your employer's Long-Term Disability Benefit Plan." App. 140. Ms. Avery had not submitted an appeal of the August 20, 2014 decision, and there was no communication with Ms. Avery between sending the August 20, 2014 letter and issuing the September 12, 2014 appeal decision. Still, Sedgwick informed Ms. Avery: "The decision is the Claim Administrator's final decision. You have the right to bring a civil action under ERISA 502(a)." App. 141.

During the district court proceedings, it came to light that Sedgwick had sent a letter nearly a *year* later to Ms. Avery's former address (she had moved after her benefits were stopped and never received the letter) after Ms. Avery consulted with a local attorney who scolded Sedgwick for terminating Ms. Avery's benefits. App. 143. The July 8, 2015 letter stated in full:

> Your file is under re-review. If you have any additional medical information for the re-review, the deadline to submit additional medical information is July 28, 2015.

App. 143. The letter was sent solely to Ms. Avery's former address, not to the attorney who had scolded Sedgwick. *Id*. The letter clearly did not comply with the notice requirements of the claims procedure regulations, did not explain the "re-review" process, and did not offer the required 180-day period to submit an appeal. *Id*. On September 30, 2015, Sedgwick completed its "re-review" and upheld the termination of Ms. Avery's benefits.

B. Proceedings Below

Ms. Avery filed this action in the district court for the Eastern District of Michigan, which had jurisdiction pursuant to 29 U.S.C. § 1132(e)(1) and 28 § U.S.C. § 1331, seeking recovery of her long term disability benefits pursuant to Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). Understanding that Sedgwick's July 21, 2014 letter was being treated as a benefit determination letter, Ms. Avery filed a procedural challenge in district court complaining that the July 21, 2014 letter did not comply with the requirements of the claims procedure regulations. This procedural challenge was rejected by the district court, which noted:

> It is undisputed that the July 21 letter did not provide a detailed determination of Defendants' decision to deny Plaintiff further disability benefits and did not include any information on how an appeal could be filed. Defendants factually dispute whether this letter constituted a benefits determination or

> merely communicated the findings of Dr. Shavell's IME. And Defendants point to Sedgwick's detailed August 20, 2014 letter – which more closely hewed to the requirements of 29 C.F.R. § 2560.503-1(g) – as the document meant to notify Plaintiff of final benefits determination.

App. 82 (citations to record omitted). Obviously, if Sedgwick's admittedly defective July 21, 2014 letter did not constitute a benefits determination, then Ms. Avery's July 28, 2014 letter protesting Sedgwick's "return to work decision" could not constitute an appeal of a benefits determination. App. 131-36. The district court avoided this anomaly by reasoning:

> The court need not wade into this factual dispute because the Sixth Circuit found in *Kent v. United of Omaha Life Ins. Co.* that an insurer "*substantially complied* with E.R.I.S.A.'s procedural requirements" when the claimant was provided with two consecutive letters that collectively complied with ERISA's notification requirement. 96 F.3d 803, 807 (6th Cir. 1996) (emphasis added). In *Kent*, the insurer's notification procedures "were technically deficient because the [contents of the] first letter did not meet the requirements of the statute and regulation, and the second letter was untimely (it being issued more than 90 days after the decision to deny the claim)." *Id*. But the court determined that "when viewed in light of the myriad of communications between claimant, her

> counsel and the insurer, [the letters] were sufficient to meet the purposes of Section 1133 in insuring that the claimant understood the reasons for the denial of the claim as well as her rights to review of the decision." *Id*.
>
> In the present case, Defendants' substantial compliance with the notification requirements is even more readily apparent, because unlike in *Kent*, even if the court assumes that, as Plaintiff alleges, both letters were attempts at notifying Plaintiff of a final benefit determination, Sedgwick's second letter provided a timely correction undisputedly within the ninety-day notification window required by the regulation. Therefore, any alleged "procedural failures" with regards to the notification letters cannot plausibly said to be "substantial" under Sixth Circuit case law because the alleged procedural violations "did not prevent [Plaintiff] from gaining information necessary to contest [her] denial of benefits." *Putney* [*v. Med. Mut. of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004)].

App. 82-83. Here, the district court viewed it as Ms. Avery's duty to obtain the information necessary to contest her denial of benefits, rather than recognizing Sedgwick's duty to provide her with proper notice in compliance with Section 503 and the claims procedure regulations. Notably, neither the July 21, 2014 letter nor the August 20, 2014 letter actually notified Ms. Avery that her benefits were terminated. The July 21, 2014 letter notified Ms. Avery that her "benefits may be suspended effective July 22, 2014 pending

the outcome of the ability to work examination." App. 129-30. The August 20, 2014 letter similarly instructed Ms. Avery to report "for a determination of your ability to return to work," and notified Ms. Avery that: "Your benefits may be terminated effective July 21, 2014 pending the outcome of the ability to work examination." App. 137. Ms. Avery was not properly put on notice that her benefits were terminated, and although she was promised that she could "appeal this decision by sending a written request within 180 calendar days of the date you receive this letter," App. 138, Sedgwick did not grant Ms. Avery that appeal period, instead issuing its final decision terminating her benefits on September 12, 2014. App. 140. As a result, Ms. Avery was not provided with a reasonable opportunity to respond to the August 20, 2014 letter with comments or additional records, but the district court rejected Ms. Avery's procedural challenge based on the "substantial compliance" doctrine and its view that Ms. Avery's July 28, 2014 letter constituted an appeal of Sedgwick's August 20, 2014 adverse benefit decision. App. 82-83.

The district court granted defendants' motion for judgment on the administrative record, and denied plaintiff's motion for judgment, despite the myriad procedural irregularities in the case. App. 34-72. Among other things, Ms. Avery argued that the *de novo* standard of review should be applied because Sedgwick failed to comply with the Department of Labor claims procedure regulations. App. 54. The district court noted that "the Sixth Circuit has not issued a

clear guidance on whether the *de novo* standard applies in a case involving procedural deficiencies, but at least two district courts' opinions, which were highly regarded on appeal, have adopted this rule," elaborating in a footnote:

> In *Bustetter v. Standard Ins. Co.*, 529 F. Supp. 3d 693 (E.D. Ky. 2021), the Eastern District of Kentucky noted the lack of clear guidance from the Sixth Circuit and said that "until the Sixth Circuit provides additional guidance, . . . [it] will follow the prevailing view in the circuits and apply de novo review for violation of the 2002 version of the regulations." *Id*. at 703. The Sixth Circuit affirmed Bustetter and applauded it as a "notably thorough and well-reasoned opinion." *Bustetter v. Standard Ins. Co.*, No. 21-5441, 2021 WL 5873159, at *1 (6th Cir. Dec. 13, 2021). In *Myers v. Iron Workers Dist. Council of S. Ohio & Vicinity Pension Tr.*, No. 2:04-CV-966, 2005 WL 2979472, at *6 (S.D. Ohio Nov. 7, 2005), the Southern District of Ohio also applied the *de novo* standard of review "[c]onsidering the conflicting and potentially changing law on the subject of what standard of review applies in a case involving the procedural deficiencies." *Id*. at *6. The Sixth Circuit adopted the reasoning in Myers' "comprehensive and well-reasoned opinion." *Myers v. Iron Workers Dist. Council of S. Ohio & Vicinity Pension Tr.*, 217 F. App'x 526 (6th Cir. 2007).

App. 54-55. Nevertheless, the district court engaged in an analysis of the law-of-the-case doctrine and

concluded that, because Ms. Avery had not prevailed in her procedural challenge seeking discovery, she could not now assert procedural errors as a basis for seeking *de novo* review. App. 55-56. Reviewing the case under the arbitrary and capricious standard of review, the district court granted judgment in favor of defendants on September 21, 2022. App. 59-72.

The court of appeals affirmed in a decision issued on July 24, 2023. App. 1-33. The court of appeals concluded that "Sedgwick substantially complied with ERISA claims procedures," and provided this summary of the judicial "substantial compliance" doctrine in the context of the claims procedure regulations:

> ***ERISA Procedural Requirements***
>
> We begin with a brief overview of the ERISA regulations that govern employee benefit claims procedures. ERISA ensures that fiduciaries administer employee benefit plans "solely in the interest of the participants and beneficiaries." 29 U.S.C. §§ 1104(a)(1), 1001(b). Under ERISA, the Secretary of Labor has the authority to enact regulations that govern the administration of employee benefit claims. Id. §§ 1133, 1135. Section 1133 provides that every employee benefit plan must:
>
> > (1) provide adequate notice 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 participant, 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.
>
> *Id*. § 1133. We have held that the "essential purpose" of these requirements is twofold: "(1) to notify the claimant of the specific reasons for a claim denial, and (2) to provide the claimant with an opportunity to have that decision reviewed by the fiduciary." *Wenner v. Sun Life Assurance Co. of Can.*, 482 F.3d 878, 882 (6th Cir. 2007) (emphasis and citation omitted).
>
> In deciding whether a plan has satisfied the requirements of § 1133, we employ a "substantial compliance" test. *Id*. Under this test, all communications between the claimant and the administrator are considered. "If the communications between the administrator and participant as a whole fulfill the twin purposes of § 1133, the administrator's decision will be upheld even where the particular communication does not meet those requirements." Id. (internal quotation marks omitted).

App. 10-12. The court of appeals then applied the "substantial compliance" doctrine to excuse Sedgwick's procedural violations:

We need not resolve whether Sedgwick's July 21, 2014, letter was in fact a formal benefit determination, because Sedgwick's collective communications with Avery substantially complied with ERISA's procedural requirements. See *Kent*, 96 F.3d at 807 (holding that, despite technical deficiencies in the insurer's denial letters, "when viewed in light of the myriad of communications between claimant, her counsel and the insurer, [the letters] were sufficient to meet the purposes of Section 1133 in insuring that the claimant understood the reasons for the denial of the claim as well as her rights to review of the decision"). Although Sedgwick's July 21, 2014, letter undoubtedly fell short of meeting the requirements articulated in § 2560.503-1(h), its August 20, 2014, denial letter corrected any deficiencies. Avery was made aware of the reasons for Sedgwick's benefits denial (i.e., the results of Dr. Shavell's independent medical examination) and of her appeal rights. Collectively, therefore, Sedgwick's communications with Avery satisfied the dual purposes behind (and plain text of) Section 1133. See *Wenner*, 482 F.3d at 882; *Putney v. Med. Mut. of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004) (finding that an administrator's failure to satisfy ERISA notice requirements was "neither significant nor outcome determinative" where the "procedural failures did not prevent [the claimant] from gaining information necessary to contest his denial of benefits").

App. 14-15. Thus, the court of appeals incongruously viewed Ms. Avery's July 28, 2014 letter as the appeal of Sedgwick's subsequent August 20, 2014 adverse benefit decision. App. 15. The court of appeals coupled this with the fact that Sedgwick "effectively afforded Avery a second appeal by voluntarily re-reviewing her claim in 2015." App. 15. In essence, although Sedgwick "undoubtedly fell short of meeting the requirements articulated in § 2560.403-1(h)," the "substantial compliance" doctrine acted to excuse these regulatory violations. It did not matter that Sedgwick's so-called re-review itself violated the regulations, so long as judge could conclude the combination of the communications met the court of appeals view of Section 503's essential purpose. App. 11-12.

Ms. Avery also contended once again that Sedgwick's procedural violations should result in having the claim reviewed *de novo*, citing *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), but the court of appeals expressly rejected the *Halo* analysis in a footnote:

> Relying on the Second Circuit's opinion in *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), Avery argues that the *de novo* standard of review should apply to our review of the administrator's decision to terminate benefits *because* Sedgwick allegedly failed to comply with the claims procedure regulation. Appellant's Br. at 25. In *Halo*, the Second Circuit held that "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. However, this circuit has yet to adopt such a rule, and we decline to do so here.

App. 9-10. After the court of appeals issued its opinion, Ms. Avery sought rehearing, but the petition for rehearing was denied on August 24, 2023. App. 88.

REASONS FOR GRANTING THE WRIT

The question presented is narrow but exceptionally important to ERISA jurisprudence, and it would be appropriate for the Court to grant the writ at this time for the following reasons.

a. The Question Presented Has Divided the Circuits

While the court of appeals applied a very broad rendering of the "substantial compliance" doctrine in this case, other circuits have taken a different path. As acknowledged by the court of appeals, the Second Circuit has required stricter compliance with the specific terms of the claims procedure regulation, and

failure to comply will result in having the claim reviewed *de novo* by the court:

> As the Department [of Labor] explained in the preamble to the 2000 regulation, "[i]nasmuch as the regulation makes substantial revisions in the severity of the standards imposed on plans, we believe that plans should be held to the articulated standards as representing the minimum procedural regularity that warrants imposing an exhaustion requirement on claimants." 65 Fed. Reg. at 70,256.
>
> In other words, if plans comply with the regulation, which is designed to protect employees, the plans get the benefit of both an exhaustion requirement and a deferential standard of review when a claimant files suit in federal court – protections that will likely encourage employers to continue to voluntarily provide employee benefits. But if plans do not comply with the regulation, they are not entitled to these protections. That result is not unnecessarily harsh, as those in favor of the substantial compliance doctrine have contended. The failure to comply does not result in any oppressive consequence; plans will have to pay the claim only if it is a meritorious claim, which they are already contractually obligated to do. They will simply lose the benefit of the great deference afforded by the arbitrary and capricious standard. In short, this regulatory approach balances the competing interests of employers and employees and, accordingly, ERISA's dual congressional purposes.

Halo, 819 F.3d at 56. The Seventh Circuit, while not expressly adopting the *Halo* analysis, has recognized that a court that excused violations of deadlines contained in the claims procedure regulations "would upset the careful balance that the regulations strike between the competing interests of administrators and claimants." *Fessenden v. Reliance Standard Life Ins. Co.*, 927 F.3d 998, 1004 (7th Cir. 2019). The Seventh Circuit specifically addressed the "substantial compliance" doctrine as follows:

> We acknowledge that some of our sister circuits have been willing to apply the substantial compliance exception to blown deadlines. See *Gilbertson* [*v. Allied Signal, Inc.*, 328 F.3d 625, 634-35 (10th Cir. 2003)] (applying the substantial compliance doctrine to an administrator's untimely decision under the pre-2002 regulation); *Jebian* [*v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1108 (9th Cir. 2003)] ("Absent unusual circumstances, an administrator engaged in a genuine, productive, ongoing dialogue that substantially complies with a plan's and the regulations' timelines should remain entitled to whatever discretion the plan documentation gives it."); see also *Becknell v. Severance Pay Plan of Johnson & Johnson*, 644 F. App'x 205, 213 (3d Cir. 2016) (conducting deferential review because "[the plan administrator's] late decision does not rise to the level of a severe procedural violation"). These circuits have seen no difference between forgiving

> tardiness and forgiving violations of other procedural requirements.
>
> We disagree. As an initial matter, it is worth noting that many of the circuits currently applying the exception to missed deadlines have relied on precedent that predates the 2002 version of the regulations. The earlier version offered a much less nuanced approach to balancing the competing interests at stake, which subjected the goals of ERISA to different kinds of gamesmanship and perverse incentives. See *Gilbertson*, 328 F.3d at 634-35; see *id.* at 629 n.3, 631 n.4. For example, because the old regulations did not include tolling provisions to stop the clock while the administrator was waiting on information from the claimant, "claimants might [have been] encouraged to delay a final decision by suggesting that they intend[ed] to produce additional information, only to pull the plug and demand de novo review in federal court on the [last] day." *Id*. at 635. The substantial compliance doctrine allowed courts the flexibility to police such gamesmanship and avoid results that would be "antithetical to the aims of ERISA." *Id.* But the amendments reflected in the 2002 regulations address the incentives concern head-on by including more detailed and balanced provisions on timing and tolling. Thus, the oft-invoked rationale for applying the exception to missed deadlines no longer exists.

Fessenden, 927 F.3d at 1005-06. The holdings of *Halo* and *Fessenden* differ starkly from the Sixth Circuit

in this case. Therefore, it would be appropriate for the Court to grant the writ to resolve the district split at this time.

b. The Question Presented is Exceptionally Important to ERISA Jurisprudence and Requires a Uniform National Answer

This Court has previously explained the importance of complying with the claims procedure regulations as part of ERISA's two-tiered remedial scheme:

> The first tier of ERISA's remedial scheme is the internal review process required for all ERISA disability-benefit plans. 29 CFR § 2560.503-1. After the participant files a claim for disability benefits, the plan has 45 days to make an "adverse benefit determination." § 2560.503-1(f)(3). Two 30-day extensions are available for "matters beyond the control of the plan," giving the plan a total of up to 105 days to make that determination. Ibid. The plan's time for making a benefit determination may be tolled "due to a claimant's failure to submit information necessary to decide a claim." § 2560.503-1(f)(4).
>
> Following denial, the plan must provide the participant with "at least 180 days . . . within which to appeal the determination." §§ 2560.503-1(h)(3)(i), (h)(4). The plan has 45 days to resolve that appeal, with one 45-day extension available for "special circumstances (such as the need to hold a hearing)."

> §§ 2560.503-1(i)(1)(i), (i)(3)(i). The plan's time for resolving an appeal can be tolled again if the participant fails to submit necessary information. § 2560.503-1(i)(4). In the ordinary course, the regulations contemplate an internal review process lasting about one year. Tr. of Oral Arg. 22. If the plan fails to meet its own deadlines under these procedures, the participant "shall be deemed to have exhausted the administrative remedies." § 2560.503-1(l). Upon exhaustion of the internal review process, the participant is entitled to proceed immediately to judicial review, the second tier of ERISA's remedial scheme.

Heimeshoff v. Hartford Life & Accident Ins. Co., 571 U.S. 99, 110-11, 134 S. Ct. 604, 613 (2013). Sedgwick did not provide "at least 180 days . . . within which to appeal the determination." *Id*. The court of appeals' application of the judicial "substantial compliance" doctrine simply obviates the regulatory requirements altogether, supplanting them with the determination of a judge as to whether communications as a satisfied the "essential purpose" of Section 503, which itself is a reduction of the requirements of the statute. App. 11 ("the 'essential purpose' of these requirements is twofold: '(1) to notify the claimant of the specific reasons for a claim denial, and (2) to provide the claimant with an opportunity to have that decision reviewed by the fiduciary.'"). But Section 503 requires more, and the best evidence of the essential purpose of a statute should be the text of the statute. Section 503 also mandates the Secretary of Labor to

adopt implementing regulations, 29 U.S.C. § 1133, and those regulations should be followed by the courts. Therefore, to ensure the integrity of the two-tiered ERISA remedial scheme, the Court should grant the writ in this case.

c. This Case Presents an Appropriate Vehicle for Deciding the Question Presented

Despite the fact that the court of appeals' decision is unreported, this case presents an excellent vehicle for deciding the question presented. The regulatory violations at issue and the circuit court split are clear. The issue is narrow but essential to ERISA jurisprudence. Moreover, the distinction between reported and unreported decisions has been blurred in recent years. For example, the court of appeals' decision below cites several unreported decisions as authority for its conclusions. App. 15, citing *Putney v. Med. Mut. of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004); App. 24, citing *Gilewski v. Provident Life and Accident Ins. Co.*, 683 F. App'x 399, 406 (6th Cir. 2017); App. 27-28, citing *Morris v. Am. Elec. Power Long-Term Disability Plan*, 399 F. App'x 978, 986 (6th Cir. 2010) and *Leffew v. Ford Motor Co.*, 258 F. App'x 772, 779 (6th Cir. 2007); App. 29, citing *Hurse v. Hartford Life & Accident Ins. Co*., 77 F. App'x 310, 318 (6th Cir. 2003).

Particularly given the broad application of the judicial "substantial compliance" doctrine announced in the court of appeals' decision, there can be no doubt

that this analysis will serve as authority for future decisions. Therefore, the Court should grant the writ in this case to provide a uniform answer to the question presented.

CONCLUSION

For all of these reasons, Petitioner Jacqueline Avery requests this Honorable Court to grant her a writ of certiorari in this case.

Respectfully submitted,

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