In the

United States Court of Appeals

For the Seventh Circuit

No. 22-1096

ERIC S. ZALL,

Plaintiff-Appellant,

v.

STANDARD INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Court for the
Western District of Wisconsin.
No. 3:21-cv-00019-slc — **Stephen L. Crocker**, *Magistrate Judge*.

ARGUED OCTOBER 24, 2022 — DECIDED JANUARY 19, 2023

Before HAMILTON, ST. EVE, and KIRSCH, *Circuit Judges*.

HAMILTON, *Circuit Judge*. Plaintiff-appellant Eric Zall worked more than twenty years as a dentist, but chronic pain and numbness in his neck and right arm made it impossible for him to keep working. In 2013, Zall filed a claim for long-term disability benefits under an insurance policy with defendant-appellee Standard Insurance Company. Standard approved his claim and began paying benefits. Six years later, Standard terminated Zall's benefits. Standard concluded that

Zall's spinal condition and associated symptoms did not satisfy policy requirements for paying disability benefits for such conditions for more than two years without additional medical findings.

Zall filed this suit under ERISA, the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq., which governs his policy with Standard. Zall contends that Standard's termination of his benefits was arbitrary and capricious on the merits. He also contends that Standard violated ERISA's procedural requirements by failing to afford him "a full and fair review … of the decision denying the claim." 29 U.S.C. § 1133. The district court granted summary judgment for Standard. *Zall v. Standard Ins. Co.*, 21-cv-19-slc, 2021 WL 6112638, at *1, *11 (W.D. Wis. Dec. 27, 2021). Zall has appealed. We agree with Zall on the procedural issue, reverse summary judgment, and remand for further proceedings. The decisive legal issue here is which version of an amended procedural regulation issued under § 1133 applies to Standard's internal administrative review of its termination of Zall's benefits. The plain language of the 2018 amendments to the regulation shows that the amended version applies, and Standard failed to comply with it.

I. *Factual & Regulatory Background*

Since the turn of the century, Department of Labor regulations have required the administrator of an employee benefit plan to give a claimant, "*upon request*," copies of "all documents, records, and other information" that the administrator has considered, generated, or relied upon in making an adverse benefit determination. 29 C.F.R. § 2560.503–1(h)(2)(iii), (m)(8)(i)–(ii) (2002) (emphasis added); 81 Fed. Reg. 92,316, 92,323 (Dec. 19, 2016) (explaining amendments). In 2018, the

Department amended the regulations to eliminate the "upon request" language and to require an administrator to provide such information "sufficiently in advance" of an adverse determination "to give the claimant a reasonable opportunity to respond" to it. § 2560.503–1(h)(4)(i); 82 Fed. Reg. 56,560-01, 56,560 (Nov. 29, 2017). In other words, under the amended regulation, a plan administrator must provide the pertinent information whether the claimant has asked for it or not. This appeal turns on which version of the regulation applies to the administrative review of the termination of Zall's benefits.

Zall filed his original claim for long-term disability benefits back in 2013, when the 2000 version of the regulations was operative, after pain and numbness forced him to stop working. Standard denied the claim initially, but Zall appealed through Standard's administrative review process. His appeal was successful. In late 2014, after considering additional medical information that Zall had submitted and consulting a board-certified orthopedic surgeon, Standard approved Zall's claim, including payment of benefits retroactive to November 2013, when Zall had filed the claim.

Less than a year after approving Zall's claim, however, Standard began reviewing his case to see if his condition might be subject to a 24-month benefit limit in the policy. That limit applies, in relevant part, to a disability "caused or contributed to by … carpal tunnel or repetitive motion syndrome" or "diseases or disorders of the cervical, thoracic, or lumbosacral back and its surrounding soft tissue." The 24-month limit does not apply, however, to a disability "caused or contributed to by … herniated discs with neurological abnormalities that are documented by electromyogram and computerized tomography or magnetic resonance imaging"

or "radiculopathies that are documented by electromyogram." The disputed issue on the merits in this lawsuit is whether Zall qualifies for that exception to the 24-month limit.

For reasons that are unclear from the record, Standard did not, during its 2015 review, ask Zall for copies of his then-recent magnetic resonance imaging and electrodiagnostic reports even though (a) consulting physicians recommended reviewing those reports and (b) such documentation was required for coverage under the policy. Also for reasons that are unclear, Standard did not immediately complete its review of Zall's claim. It continued to pay benefits for years.

In 2018 Standard resumed its review in earnest. Standard finally requested copies of Zall's diagnostic reports for his electromyography and magnetic resonance imaging. Zall provided them. After consulting with physicians who had studied Zall's medical file, Standard concluded that his condition was subject to the 24-month limit, and it stopped paying benefits at the end of 2019. By that time, as we discuss below, the Department of Labor's amendments to the regulations had taken effect for cases like Zall's. See 82 Fed. Reg. 56,560-01, 56,560 (Nov. 29, 2017) (setting amendments' applicability date as April 1, 2018). Zall again appealed through Standard's administrative review process.

During the administrative review process, Standard consulted with another physician, Dr. Michelle Alpert. Dr. Alpert reviewed Zall's medical file and summarized her findings in a report dated August 3, 2020. She disagreed with Zall's own physicians' readings of his diagnostic reports. Her interpretations supported the conclusion that his condition was subject to the 24-month benefits limit. On August 20, 2020, Standard notified Zall that his file had been reviewed "by a physician

who had not previously reviewed" it—presumably Dr. Alpert—and that Standard "require[d] additional time to review" the physician's "medical review report." Standard did not provide Zall with a copy of that report.

Nine days later, Standard notified Zall that it was rejecting his appeal and would in fact be terminating his benefits. Based substantially on Dr. Alpert's report, Standard had determined that Zall's condition was subject to the 24-month benefit limit. Although the denial letter summarized Dr. Alpert's findings, Standard did not attach a copy of her report. The letter noted, however, that Standard would, upon "request," provide Zall "with copies of all documents, records and other information relevant to the claim."

II. *Procedural History*

Having exhausted his administrative appeals, Zall filed this suit against Standard. He alleged that Standard had violated ERISA by arbitrarily and capriciously conducting the review of his benefits claim and wrongfully refusing to continue paying him long-term disability benefits. Zall sought both payment of retroactively owed benefits and a declaration that Standard continues to owe him benefits.

Zall presented three principal challenges in the district court. First, Standard had "denied him a full and fair review" by failing to give him a copy of Dr. Alpert's report. See *Zall*, 2021 WL 6112638, at *6. That failure, Zall contended, meant that he never had an "opportunity to respond" to Dr. Alpert's findings before Standard made its final decision to terminate his benefits. Second, Zall argued that Standard's conclusion that his condition was subject to the 24-month limit was "not rationally supported by the medical evidence." Finally, Zall

argued that, by paying him benefits for more than six years after Standard claims his benefits should have ended, Standard waived its right to terminate those benefits.

The district court was not persuaded. The court read the 2018 amendments to the regulations as applying only to claims first *filed* after April 1, 2018. *Id.* at *7. Under that view, the old regulation applied and Standard had not been "obliged to produce Dr. Alpert's report to Dr. Zall before issuing its final decision," so Zall's "full and fair review" claim must fail. *Id*.

In terms of the medical evidence, because Standard's determination needed only to be "rationally supported by record evidence," Standard "was entitled to credit the opinions of its consulting physicians," including those of Dr. Alpert, over those of Zall's own physicians. *Id.* at *8, quoting *Black v. Long Term Disability Ins.*, 582 F.3d 738, 745 (7th Cir. 2009) (deferring to "Standard's choice between competing medical opinions"). Standard's determination that Zall's condition fell within the 24-month benefit limit was neither arbitrary nor capricious, the court said, because Dr. Alpert's interpretations of Zall's 2014 diagnostic reports provided rational support for the denial. *Id.* at *8–9, *11. The district court also rejected Zall's waiver argument: "ERISA does not prohibit a plan administrator from performing a periodic review of a beneficiary's disability status." *Id.* at *11, quoting *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758, 767 (7th Cir. 2010). On cross-motions for summary judgment, the district court therefore ruled against Zall and entered judgment for Standard. *Id.* at *1, *11.

On appeal, Zall has abandoned the waiver argument, but he continues to argue that (1) Standard did not afford him a "full and fair review" because it failed to provide him with

Dr. Alpert's report before reaching a final benefit determination, and (2) Standard arbitrarily and capriciously concluded that Zall's condition was subject to the 24-month benefit limit.

III. *Analysis*

A. *Standard of Review*

We review a grant of summary judgment de novo, showing no deference to the district court's legal analysis. *Weitzenkamp v. Unum Life Ins. Co. of America*, 661 F.3d 323, 329 (7th Cir. 2011). The default rule under ERISA is that courts apply de novo review to denials of benefits, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), but most benefit plans give the administrator "discretionary authority" to interpret the plan and to decide claims for benefits, as permitted by *Firestone*. The plan here does just that. Courts review exercises of such discretionary authority under the deferential arbitrary-and-capricious standard. *Hennen v. Metropolitan Life Ins. Co.*, 904 F.3d 532, 539 (7th Cir. 2018).[1]

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[1] Because Standard is both the adjudicator and payor of his claim, Zall argues that Standard is susceptible to a structural conflict of interests, so that we should "apply special skepticism" in reviewing Standard's decision to terminate benefits. That is, Zall would have us accord Standard's decision less deference than we would if there were no conflict. The Supreme Court addressed this problem under ERISA in *Metropolitan Life Ins. Co. v. Glenn*, teaching that "a conflict should 'be weighed as a factor in determining whether there is an abuse of discretion.'" 554 U.S. 105, 115 (2008), quoting *Firestone*, 489 U.S. at 115 (cleaned up). Such a conflict of interest does not take the standard of review outside the otherwise applicable "arbitrary-and-capricious" standard. *Conkright v. Frommert*, 559 U.S. 506, 512 (2010); *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 482 (7th Cir. 2009). Under *Glenn*, however, that standard must be applied with awareness of and giving some weight to the conflict of interest. "In evaluating whether the administrator's decision was arbitrary and capricious,"

Arbitrary-and-capricious review "turns on whether the plan administrator communicated 'specific reasons' for its determination to the claimant, whether the plan administrator afforded the claimant 'an opportunity for full and fair review,' and 'whether there is an absence of reasoning to support the plan administrator's determination.'" *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009), quoting *Leger v. Tribune Co. Long Term Disability Benefit Plan*, 557 F.3d 823, 832–33 (7th Cir. 2009).

B. *The 2018 Regulatory Amendments*

Whether Standard failed to provide Zall with the "full and fair review" ERISA requires, 29 U.S.C. § 1133, depends on which version of the Department of Labor's regulations for claims procedures applied to Zall's claim. The requirements are contained in 29 C.F.R. § 2560.503–1.

Under the 2002 version of the regulation, when a claimant appealed an adverse benefit determination, a "full and fair review" required the plan to provide the claimant, "*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." § 2560.503–1(o)(1), (h)(2)(iii), (h)(4) (2002) (emphasis added). "A document, record, or other information" was "considered 'relevant' to a claimant's claim if" the plan administrator had "relied upon [it] in making the

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we consider, "among other factors, the administrator's structural conflict of interest." *Weitzenkamp*, 661 F.3d at 329. How much weight we give that factor remains a case-by-case determination. But we need not dwell further on these nuances in this appeal. Because we reverse on the procedural issue, which is a question of law that we review de novo, we need not decide what weight to give Standard's conflict of interest.

benefit determination" or it had been "submitted, considered, or generated in the course of making the benefit determination, without regard to whether" the plan administrator had "relied upon [it] in making the benefit determination." § 2560.503–1(m)(8)(i)–(ii).

As amended in 2018, the regulations demand more of a plan administrator. In an appeal of an adverse benefit determination, a "full and fair review" now requires that, "before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim." § 2560.503–1(h)(2), (h)(4)(i). Any "such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided … to give the claimant a reasonable opportunity to respond prior to that date." *Id.* at (h)(4)(i).

As the district court read them, the 2018 amendments did not apply, so Standard would have needed to provide Zall with a copy of Dr. Alpert's report only if he had requested it. Zall did not request the report until after Standard finally denied his appeal, so he was afforded all the process legally required. We disagree with that reading of the 2018 amendments.

1. *The Applicable Text*

The Department of Labor included these provisions for effective dates for the 2018 amendments to 29 C.F.R. § 2560.503–1:

> (p) Applicability dates and temporarily applicable provisions.
>
> (1) Except as provided in paragraphs (p)(2), (p)(3) and (p)(4) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.
>
> (2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.
>
> (3) Paragraphs (b)(7), (g)(1)(vii) and (viii), (j)(4)(ii), (j)(6) and (7), (*l*)(2), (m)(4)(ii), and (o) of this section shall apply to claims for disability benefits filed under a plan after April 1, 2018, in addition to the other paragraphs in this rule applicable to such claims.
>
> (4) With respect to claims for disability benefits filed under a plan from January 18, 2017 through April 1, 2018, this paragraph (p)(4) shall apply instead of paragraphs (g)(1)(vii), (g)(1)(viii), (h)(4), (j)(6) and (j)(7).

29 C.F.R. § 2560.503–1(p)(1)–(4).

We "begin our interpretation of the regulation with its text." *Green v. Brennan*, 578 U.S. 547, 553 (2016). Only where

the text is unclear must we "turn to other canons of interpretation." *Id.* at 554. We think the text of the amended regulation is clear as applied to this case, so in this case our analysis can begin and end with that text.

Paragraph (p)(1) establishes a general rule of applicability: "this section shall apply to claims filed under a plan on or after January 1, 2002." Because Zall filed his original claim in 2013, paragraph (p)(1) encompasses his case, so the new version governs unless an exception applies.

Paragraph (p)(1) identifies three exceptions, which are stated in paragraphs (p)(2), (p)(3), and (p)(4). The (p)(2) exception applies only "to claims filed under a group health plan," so it does not apply to Zall's claim for disability insurance benefits. The (p)(3) exception identifies nine provisions—"(b)(7), (g)(1)(vii) and (viii), (j)(4)(ii), (j)(6) and (7), (*l*)(2), (m)(4)(ii), and (o)"—as applicable only to claims for disability benefits filed after April 1, 2018.

Critically, sub-paragraph (h)(4)(i), which eliminated the "upon request" language and upon which Zall relies to argue that he was not afforded a "full and fair review," is not among those paragraphs identified in paragraph (p)(3).

Finally, the (p)(4) exception renders five provisions—"(g)(1)(vii), (g)(1)(viii), (h)(4), (j)(6) and (j)(7)"—inapplicable to claims filed between January 18, 2017 and April 1, 2018. While paragraph (h)(4) with its removal of the "upon request" language is among the provisions identified in paragraph

(p)(4), the exception does not apply to Zall's appeal since he filed his claim before this carve-out period began.[2]

Accordingly, by the regulation's plain text, no exception applies to Zall's claim, so the 2018 amendments applied to his administrative appeal of the benefit termination decision.

To avoid this straightforward reading of the controlling text, Standard makes three arguments. First, Standard points to evidence from the rule-making process to argue that the applicability dates in the text of subsection (p) are incorrect. Second, Standard argues that Zall waived his procedural-violation argument by failing to make it during his administrative appeal. Finally, Standard argues that the 2018 amendments cannot be read to apply to claims filed as far back as 2002 because that reading would make the amendments impermissibly retroactive. These arguments are not persuasive and cannot overcome the text of the regulation.

2. *Extratextual Evidence*

Standard argues that, despite the clear meaning of the regulation's text, the 2018 amendments were not meant to apply to any claims filed before April 1, 2018. As evidence of the Department of Labor's purported intent, Standard directs our

[2] We have wondered why the date of Zall's original claim for benefits should control the applicable regulation as applied to Standard's 2018 move to terminate benefits he had already been receiving for several years. The regulation is written in terms that fit an application for new benefits better than a termination of existing benefits. If the relevant time were Standard's notice of termination of benefits or Zall's appeal of that decision, the 2018 amendments would certainly apply. For reasons explained in the text, we reach the same result even if the relevant date is Zall's original application date, so we need not choose here between the two approaches.

attention to the "summary" statement the Department issued when announcing the final rule. That statement said that "the applicability of a final rule amending the claims procedure requirements applicable to ERISA-covered employee benefit plans that provide disability benefits" would be April 1, 2018. 82 Fed. Reg. 56,560-01, 56,560 (Nov. 29, 2017).

As a general rule, of course, where the text of the regulation itself is clear, we need not consider extratextual evidence of the kind Standard presents. See *Green*, 578 U.S. at 553–54; see also *Beeler v. Saul*, 977 F.3d 577, 590 (7th Cir. 2020) ("When text is clear and unambiguous, 'the court must give it effect and should not look to extrinsic aids for construction.'"), quoting *In re Robinson*, 811 F.3d 267, 269 (7th Cir. 2016). More specific to the issue in this case, it is not at all unusual for a *summary* of a rule to gloss over detailed nuances in the rule itself. (Consider under ERISA, for example, the relationship between a plan summary and the detailed terms of the benefit plan itself.) Zall's argument relies on the details in the governing rule itself, whether or not all of those details were reflected accurately in the published summary.

Even taking the Department of Labor's summary statement into account, we find no conflict between the announced applicability date and the text of the amendments. All the applicability date means is that until April 1, 2018, the old procedures governed, and after that date, the new procedures governed. Standard sees a conflict between the summary statement and the regulations merely because Standard believes (erroneously) that the new rules apply only to claims that were *filed* after the applicability date.

This is the critical flaw in Standard's argument. Once the procedures became operative, they applied to all active

claims, as long as they were first filed after January 1, 2002. On April 1, 2018, Standard had not even begun its administrative appeal review of Zall's claim. It would be 18 months before Standard would terminate his benefits, more than 24 months before Zall would appeal, and more than 27 months before Dr. Alpert would write her report. For purposes of Standard's argument, it does not matter that Zall *filed* his original claim in 2013 when the earlier claims procedures were in place. What matters is that when the new claims procedures under the amended regulation took effect, Standard had not yet reached an adverse benefit determination and Zall had not yet begun his administrative appeals.[3]

3. *Waiver*

If a "plan fails to strictly adhere to all" of the procedural requirements "with respect to a claim, the claimant is deemed to have exhausted the administrative remedies under the plan." 29 C.F.R. § 2560.503–1(*l*)(2)(i). "It is at this point in the claims process that 'the claimant is entitled to pursue any available remedies … 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.'" *Dragus v. Reliance Standard*

[3] Our view does not conflict with other cases cited by Standard. In *Mayer v. Ringler Assocs. Inc.*, 9 F.4th 78, 81, 83 (2d Cir. 2021), the Second Circuit considered a claim that had been filed in late 2015 and was finally denied in late 2017. The court naturally concluded that the pre-2018 regulations applied to the claim, so the administrator was not required "to produce documents developed or considered while [the] claim was under review prior to a final determination." *Id.* at 86–87, 88. And in *Jette v. United of Omaha Life Ins. Co.*, 18 F.4th 18, 20, 25 & n.11 (1st Cir. 2021), the claim had been filed in 2013 and benefits finally denied in 2016, both long before the 2018 amendments became operative. Moreover, the parties in *Jette* had in fact stipulated that the 2002 regulations applied. *Id.* at 25 & n.11.

Life Ins. Co., 882 F.3d 667, 672 (7th Cir. 2018), quoting § 2560.503–1(*l*)(2)(i).

According to Standard, the regulations governing its appeal process are "not designed to permit Zall to sabotage the administrative review process by remaining silent on a purported regulatory violation, pursuing the allegedly deficient administrative proceedings to conclusion, and then utiliz[ing] the claimed regulatory violation to prevail in court and demand a second administrative appeal." In other words, Standard argues, Zall cannot now challenge Standard's failure to provide him with a copy of Dr. Alpert's report because he did not raise the issue with Standard at the correct time during the administrative review process.

The problem is that Standard first notified Zall of Dr. Alpert's review and report just nine days before denying his appeal, without providing him a copy of the report. The regulations require an administrator to "provide the claimant … with any new or additional information considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination … as soon as possible and *sufficiently in advance*" of the adverse determination "to give the claimant a reasonable opportunity to respond prior to" the administrator's final decision. 29 C.F.R. § 2560.503–1(h)(4)(i) (emphasis added). What might be a reasonable opportunity will depend on the circumstances of the particular case. We are confident that in this case, nine days advance notice of the existence of such a critical document was not a reasonable opportunity for Zall to respond substantively to the new evidence against his claim, such as by seeking to obtain updated diagnostic scans, to learn the results of those scans, and to

communicate them to Standard before it made its final decision.

Standard committed the procedural error in the very last stage of Zall's administrative appeal. Only after Standard announced its final decision could Zall have known that Standard had failed to abide by the required procedures. Zall never had "a reasonable opportunity to respond *prior to*" the final decision. § 2560.503–1(h)(4)(i) (emphasis added). Just as a party cannot be expected to object to, let alone to appeal, a judge's erroneous decision until after the decision has been made, so too Zall could not object to Standard's failure until after that failure became apparent.

Standard also argues that Zall waived his argument about the amended regulation in the district court "by failing to allege it" in his complaint. This argument reflects a deep and too-common misunderstanding of federal pleading requirements. We have made this point repeatedly: "The Federal Rules of Civil Procedure do not require a plaintiff to plead legal theories." *Chessie Logistics Co. v. Krinos Holdings, Inc.*, 867 F.3d 852, 859 (7th Cir. 2017), quoting *Vidimos, Inc. v. Laser Lab Ltd.*, 99 F.3d 217, 222 (7th Cir. 1996), accord, e.g., *Johnson v. City of Shelby*, 574 U.S. 10, 10–11 (2014) (per curiam) (summarily reversing dismissal based on failure to identify legal theory in complaint); *Skinner v. Switzer*, 562 U.S. 521, 529–30, 537 (2011) (reversing dismissal); *Zimmerman v. Bornick*, 25 F.4th 491, 492–94 (7th Cir. 2022) (allowing amendment of complaint); *Beaton v. SpeedyPC Software*, 907 F.3d 1018, 1023 (7th Cir. 2018) ("As the Supreme Court and this court constantly remind litigants, plaintiffs do not need to plead legal theories."). Also, when a complaint does present legal theories,

those theories may later be altered or refined. *Chessie Logistics*, 867 F.3d at 859.

Zall's complaint alleged broadly that Standard "did not perform a 'full and fair review' of" Zall's claim. Dkt. 1 ¶30. Zall properly honed that argument as the parties proceeded toward summary judgment. "When a new argument is made in summary judgment briefing," the district court may "refuse to consider [any] new factual claims," but if the new argument merely "changes the complaint's … legal theories," then the district court should exercise its discretion to hear the argument so long as doing so will not "'cause unreasonable delay,' or make it 'more costly or difficult' to defend the suit." *Id*. at 860, quoting *Vidimos*, 99 F.3d at 222; see also *Whitaker v. T.J. Snow Co.*, 151 F.3d 661, 663 (7th Cir. 1998) (where "both parties squarely address[ ]" a legal theory "in their summary judgment briefs, the complaint [is] constructively amended" to incorporate the refined claim); *Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073, 1078 (7th Cir. 1992) ("Later documents" may "refine the claims" and "supply the legal arguments that bridge the gap between facts and judgments."). Here, the district court properly addressed Zall's argument at summary judgment, and we may review that decision on appeal.

4. *Retroactivity*

"Retroactivity is not favored in the law. Thus, congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). Likewise, "a statutory grant of legislative rulemaking authority will not, as a general matter, be understood to

encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms." *Id.*

Standard argues that the 2018 amendments cannot be read as applying to Zall's claim without violating these general principles. The power to promulgate retroactive rules, Standard contends, is beyond the authority Congress has bestowed on the Department of Labor, for nothing in sections 1133 or 1135 of ERISA expressly conveys such power.

If the regulation's 2018 amendments had substantive import, Standard's argument might need further consideration. But this is a purely procedural rule, aptly titled "Claims procedure." 29 C.F.R. § 2560.503–1. The amendments at issue in this case merely altered the procedural interactions between a plan administrator and a claimant. Where previously the burden had been on a claimant like Zall to request a copy of a document like Dr. Alpert's report, under the 2018 amendments the burden falls on an administrator like Standard to give the claimant a copy without being asked and "sufficiently in advance" of the adverse determination "to give the claimant a reasonable opportunity to respond" to it. § 2560.503–1(h)(4)(i).

"Changes in procedural rules may often be applied in suits arising before their enactment without raising concerns about retroactivity." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 275 (1994). This is so because applying the new procedural rule "usually 'takes away no substantive right but simply changes'" the process through which substantive rights are adjudicated. *Id.* at 274, quoting *Hallowell v. Commons*, 239 U.S. 506, 508 (1916). "Because rules of procedure regulate secondary rather than primary conduct, the fact that a new procedural rule was instituted after the conduct giving rise to the

suit does not make application of the rule … retroactive." *Id.* at 275. Unless there is a "retroactive effect" that "would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed[,]" we are unconcerned with whether Congress expressly provided for retroactive application. *Id.* at 280. Here, it would have been easy for Standard to comply with the new procedural requirement without any prejudice to its interests. All it had to do was send Zall Dr. Alpert's report and give him a reasonable opportunity to respond to it. Standard's retroactivity argument does not apply to the procedural rule at issue in this case.

To sum up, by the plain text of the regulation, the 2018 amendments applied to Zall's claim. Standard therefore violated the operative regulation when it failed to provide Zall with a copy of Dr. Alpert's report "sufficiently in advance" of its final determination to allow Zall an "opportunity to respond" to its contents. This simply was not the "full and fair review" ERISA requires.

C. *Prejudice to Zall's Claim*

Zall argues that this procedural violation—the failure to afford him an opportunity to respond to Dr. Alpert's report—was prejudicial to the substance of his benefits claim. Standard has not responded to this argument, and the district court did not address it because it found no procedural violation.

The First Circuit recently dealt with this same scenario in *Jette v. United of Omaha Life Ins. Co.*, 18 F.4th 18 (1st Cir. 2021). The court chose to reach the question of prejudice because it could be easily answered "at this stage on the basis of the administrative record before" the court. *Id.* at 32. *Jette* found that

the claimant had indeed been prejudiced by the administrator's failure to provide a copy of a consulting physician's report that it relied upon to deny benefits. *Id.* at 23, 32–33. The record here reveals facts similar to those that were decisive in *Jette*.

Standard submitted Zall's file to Dr. Alpert for review, and Dr. Alpert's medical conclusions contradicted those of Zall's own physicians. In particular, Dr. Alpert disagreed with how Zall's physicians had read the 2014 MRI and EMG reports and noted that Zall "had not had an updated MRI" in the six intervening years. Summarizing her findings and responding to Standard's particular inquiries regarding conditions subject to the 24-month limit, Dr. Alpert emphasized that the 2014 diagnostic reports could not support Zall's benefits claim, writing that Zall had provided "no medical evidence to support" his claim as of January 2020.

Because Zall was unaware of the report until just nine days before Standard made its final decision to terminate his benefits, and because Standard gave Zall a copy of the report only after his attorney requested one in September 2020, Zall was never afforded a meaningful opportunity to respond to the report's contents while his claim was still undergoing administrative review. But Standard relied on that undisclosed report "to uphold its decision to terminate" the long-term disability benefits. *Jette*, 18 F.4th at 32. Like the First Circuit, we therefore find that the failure to provide that report before rendering a final adverse determination was prejudicial to Zall's claim. *Id.* at 33.[4]

[4] Our focus on the issue of prejudice is on Dr. Alpert's report, which, according to Standard, played an important role in its decision denying

D. *Whether Zall's Condition Was Subject to the 24-Month Limit*

Because of the procedural violation, we cannot say reliably whether Standard acted arbitrarily and capriciously in terminating Zall's benefits. If Zall had "been afforded the full and fair review to which [he] was entitled," including access to Dr. Alpert's report, he would have had the opportunity to respond to that report. *Jette*, 18 F.4th at 33.

We cannot know whether Zall's response would have helped his claim, but it is certainly possible that he might have tried to provide updated diagnostic tests and imaging. If Zall were to provide new objective test results, we do not know what they would show. The administrator might ultimately arrive at the same adverse determination. But Standard could not ignore such updated diagnostic reports if they showed that Zall's condition falls within an exception to the 24-month limit.

Like the First Circuit therefore, "we will not review" Standard's "substantive decision at this time." *Jette*, 18 F.4th at 33. Rather, Zall must be allowed to "go back to the administrative stage, where [he] will have the opportunity to 'submit written comments, documents, records, and other information relating to [his] claim,' 29 C.F.R. § 2560.503–1(h)(2)(ii), before [Standard] makes a new determination based on the thus supplemented record." *Jette*, 18 F.4th at 33; 29 C.F.R. § 2560.503–1(h)(2)(iv) (A review must consider all information "without regard to whether such information was

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Zall's appeal. As noted, Standard did not argue the issue of prejudice in this appeal at all, let alone argue that Dr. Alpert's report did not add new information to the case.

submitted or considered in the initial benefit determination.").

We REVERSE the entry of summary judgment in favor of Standard and REMAND to the district court with instructions to REMAND Zall's case to Standard for a full and fair review of his claim.