No. 08-2523

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

MARY MIDGETT, Plaintiff-Appellant

v.

WASHINGTON GROUP INTERNATIONAL LONG TERM DISABILITY PLAN, et al., Defendants-Appellees

On Appeal from the United States District Court
for the Eastern District of Arkansas

No. 5:07-cv-00233-WRW
Judge William R. Wilson

Brief of the Secretary Of Labor, Hilda L. Solis, as Amicus Curiae in Support of Plaintiff-Appellant's Petition for Rehearing

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INTRODUCTION AND INTEREST OF THE SECRETARY OF LABOR

The Secretary of Labor has primary enforcement and regulatory authority for Title I of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1134, 1135. Pursuant to that authority and to ERISA section 503, 29 U.S.C. § 1133, the Secretary issued regulations, first in 1977 and most recently in 2000, that govern claims procedures applicable to benefit claims under the Act.

In this case, the panel upheld the denial of Mary Midgett's disability benefits based, in part, on peer review medical evidence developed just prior to the final denial of her claim and first revealed to her only after that denial. The panel held that this Court's previous decision in Abram v. Cargill, 395 F.3d 882, 886 (8th Cir. 2005), was no longer good law based on the panel's view that the Secretary's current claims regulation "changed the law" and effectively reversed Abram. In Abram, however, this Court correctly concluded that a claimant is denied "full and fair review" when evidence relied upon by the plan decisionmaker "is revealed only after a final decision." Id. at 886. The current claims regulation did nothing to alter this fundamental principle. The Secretary has a strong interest in ensuring that her current claims regulation, which was designed to strengthen the requirements of "full and fair review," is not read to allow plan administrators to avoid the meaningful dialogue that section 503 and the regulations contemplate.

ARGUMENT

REHEARING EN BANC IS WARRANTED BECAUSE THE PANEL'S DECISION IS INCONSISTENT WITH ABRAM V. CARGILL AND THE PANEL ERRED IN CONCLUDING THAT THE SECRETARY'S 2000 CLAIMS REGULATION CHANGED THE CORE REQUIREMENTS FOR FULL AND FAIR REVIEW RECOGNIZED BY THIS COURT IN ABRAM

ERISA is designed to promote the interests of plan participants and their beneficiaries, and to protect contractually defined benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-14 (1989). To accomplish these goals, ERISA section 503 requires plans to give claimants the specific reasons for denying a claim and an opportunity for a "full and fair review" of those reasons by the appropriate named fiduciary. 29 U.S.C. § 1133(2). As this Court has recognized, "'the persistent core requirements' of full and fair review include 'knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.'" Abram, 395 F.3d at 886 quoting Grossmuller v. International Union, United Auto. Aerospace & Agric. Implement Workers of Am., UAW, 715 F.2d 853, 858 n.5 (3d Cir. 1983).

1. In Abram, this Court reviewed the Act and supporting regulations, and correctly concluded that "ERISA [section 503] and its accompanying regulations essentially call for a 'meaningful dialogue between the plan administrators and

their beneficiaries'" including an opportunity for the claimant to examine and respond to relevant evidence. Abram, 395 F.3d at 886, quoting Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997). As the Third Circuit held, in a decision cited with approval in Abram, "full and fair review" requires a plan fiduciary to "inform the participant of what evidence he relied upon and provide him with an opportunity to examine that evidence and to submit written comments or rebuttal documentary evidence." Grossmuller, 715 F.2d at 858.

Rehearing en banc is warranted because the panel's decision creates an intra-circuit conflict with this Court's decision in Abram v. Cargill. See Fed. R. App. P. 35(b)(1)(A). After an initial denial of disability benefits, the claimant in Abram submitted a functional capacity test, which the appeals committee submitted to an independent medical examiner, Dr. Gedan, for review "after the deadline for an appeals decision had passed." 395 F.3d at 886. The review committee denied benefits based on Dr. Gedan's subsequent report, which "was sent to Abram only after the Plan issued its final denial decision." Id. Because "ERISA and its accompanying regulations, . . . essentially call for a 'meaningful dialogue between the plan administrators and their beneficiaries,'" this Court reasoned that "[t]here can hardly be a meaningful dialogue" when "[a] claimant is caught off guard when new information used by the appeals committee emerges only with the final

decision." Id. The Court correctly concluded that "[t]his type of 'gamesmanship' is inconsistent with full and fair review." Id. (citations omitted).

Rather than relying on its own precedent, the panel instead relied upon the Tenth Circuit's erroneous decision in Metzger, which held that under the Secretary's 2000 claims regulation, reports generated by the plan during an appeal need not be produced until after the appeal is decided. Metzger v. Unum Life Ins. Co. of America, 476 F.3d 1161 (10th Cir. 2007). Accord Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241 (11th Cir.), cert. denied, 129 U.S. 646 (2008). However, both Metzger and Glazer misconstrued the regulation for the reasons previously recognized by this Court in Abram and elaborated upon below.[1]

In contrast to the Metzger and Glazer decisions, and in accord with Abram, other courts continue to require a full and fair claims appeals process in which claimants are permitted to challenge the evidence and rationale relied upon by the plan administrator. See Lammers v. Am. Express Disability Benefit Plan, No. 06-CV-1099, 2007 WL 2247594, at *6 (D. Minn. 2007) (well-reasoned district court decision in this Circuit adopting magistrate decision that rejects the Metzger

[1] Moreover, Metzger is inconsistent with Abram, even if Metzger is limited to cases where the medical reports generated on appeal "contain no new factual information and deny benefits on the same basis as the initial decision." 476 F.3d at 1166. In Abram, this Court concluded that the claimant had been denied full and fair review when the plan fiduciaries failed to reveal Dr. Gedan's report prior to the final denial of benefits, even though the report merely reiterated Dr. Gedan's previous conclusion that Abram could perform sedentary work despite a functional capacity test to the contrary.

analysis, concluding that the Abram analysis of "full and fair" review ought to still govern under the current regulation). For example, in a case governed by the current claims regulation, the Fifth Circuit held that a full and fair review was not provided where a plan did not provide a claimant with an opportunity to address the plan's consultation with a vocational expert during the appeal process and the consultation affected the rationale of the plan's decision. Robinson v. Aetna Life Ins. Co., 443 F.3d 389, 392-93 (5th Cir. 2006). The appeal decision disclosed to claimant that during the appeal the plan "had spoken to a vocational consultant and determined that driving was not a material duty of a sales representative." Relying in part on 29 C.F.R. 2560.503-1(h)(3)(iv), which requires 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, the Court held that "Aetna's shifting justification for its decision and failure to identify its vocational expert meant that Robinson was unable to challenge Aetna's information or to obtain meaningful review of the reason his benefits were terminated." Id. at 394.

These decisions correctly recognize that claimants are deprived of a full and fair review when claimants are prevented from responding at the administrative level to evidence developed by the plan. Because the "meaningful dialogue" contemplated by section 503 and recognized by this Court in Abram is inconsistent

with the process authorized by the panel in this case, en banc review is warranted to bring the panel's decision back in line with the Abram decision.

2. This conclusion is fully supported by the Secretary's claims regulation. Pursuant to ERISA section 503, the Secretary first promulgated a claims regulation in 1977 specifying the minimum requirements for plan procedures for the consideration and review of benefit claims. See 42 Fed. Reg. 27426 (May 27, 1977). In 2000, the Secretary promulgated a new claims regulation designed "to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims." 65 Fed. Reg. 70,246 (Nov. 21, 2000). Both regulations require that plans establish and maintain "reasonable" claims procedures (see 42 Fed. Reg. 27,426, § 2560.503-1(b) (May 27, 1977), 29 C.F.R. § 2560.503-1(b) (2008)); that the procedures not be administered in a way that unduly inhibits or hampers the initiation or processing of claims (see 42 Fed. Reg. 27,426 at § 2560.503-1(b)(3); 29 C.F.R. § 2560.503-1(b)(3)(2008); and that the claimant be allowed to appeal denials to an appropriate named fiduciary that is bound, as are all fiduciaries, by ERISA's strict duties of prudence and loyalty (see 42 Fed. Reg. 27,426, at § 2560.503-1(g)(1); 29 C.F.R. § 2560.503-1(h)(1) (2008)). Moreover, both the 1977 and 2000 regulations expressly entitle claimants to review upon request

documents, records or other information relied upon as part of a "full and fair review" process. See 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (2000 regulation replaced "pertinent" with "relevant" to expand the disclosure requirement beyond documents actually relied upon by a plan in denying benefit claim).

Nevertheless, the panel in this case concluded that the Department's amendments to the claims regulation effectively changed the law to limit the time that medical reports must be provided to the claimant to the initial administrative appeal because 29 C.F.R. § 2560.503-1(h) says that relevant materials such as medical reports must be provided to the claimant to facilitate appeal of an "adverse benefit determination," a term which refers only to the initial denial of benefits. Midgett v. Washington Group Int'l Long Term Disability Plan, 561 F.3d 887, 894-95 (8th Cir. 2009). The court also determined that 29 C.F.R. § 2560.503-1(i) supported its view, by providing that "[i]n the case of an adverse benefit determination on review, the plan administrator shall provide such access" to the relevant documents, and the use of language "on review" distinguishes review of an initial adverse benefit determination from a later appeal. Midgett, 561 F.3d at 895. Because Midgett received copies of her administrative record following the initial denial, the panel concluded that the requirements of the regulation were met. Id. Moreover, under the panel's reading of the regulations, the plan administrator

had no obligation to provide the claimant with "relevant" or even dispositive information developed after the initial denial until the administrator issues an adverse benefit determination on review.

This reading does not follow from the language of the regulation, and is undercut by the regulation's express goal to ensure "full and fair review" by clarifying and expanding, rather than narrowing, the protective requirements of the original claims regulation. See 65 Fed. Reg. 70,246 (Nov. 21, 2000) (explaining that the new regulation is designed, among other things, to "improve access to information on which a benefit determination is made"). Subsection (h) broadly regulates the entire process for "full and fair review" of the "claim" and "adverse benefit determination" extending from the initial denial of benefits until the issuance of an "adverse benefit determination on review." See 29 C.F.R. § 2560.503-1(h)(1) (2008) ("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 a plan and under which there will be a full and fair review of the claim and adverse benefit determination."); Price v. Xerox Corp., 445 F.3d 1054, 1057 (8th Cir. 2006) (concluding that subsection (h)'s requirement of "full and fair review" applies not only to review of the initial denial, but to a second-level internal appeal, which followed a first appeal that had sustained the denial).

Nothing in subsection (h) suggests that the claimant can be denied reasonable access to information relevant to her claim for benefits during the critical period of review between the "adverse benefit determination" and the final "adverse benefit determination on review." Instead, the regulation simply provides that "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 an adverse benefit determination unless the claims procedures. . . (iii) provide that a claimant 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." 29 C.F.R. § 2560.503-1(h)(2) (2008). Moreover, the regulation expands the scope of required disclosure by creating a broad definition of "relevant," which clearly encompasses the medical peer review evidence developed and relied upon by the administrator in this case. See 29 C.F.R. § 2560.503-1(m)(8) (2008) (providing that information is "relevant" if "it was relied upon in making the benefit determination" or "was submitted, considered, or generated in the course of the benefit determination," even if not relied upon).

Thus, under the terms of 29 C.F.R. § 2560.503-1(h), Ms. Midgett was entitled "upon request and free of charge" to see the relevant evidence prior to the final decision on review. A claimant is not provided "reasonable access" to relevant evidence, as the regulation requires, and is precluded from engaging in the

"meaningful dialogue" that section 502 and the regulation require, if the evidence is provided to her only after the decision is rendered and it is too late for her to respond. Under subsection (h)(2)(iii) Ms. Midgett should have been given "reasonable access" to the records, and permitted to offer rebuttal evidence under subsection (h)(2)(ii) (requiring plans to give claimants the opportunity to submit written comments, documents, and information).

Although the primary purpose of the 2000 regulation was to expand the scope of disclosure and promote a meaningful dialogue, the panel's decision instead endorses a process that unreasonably prevents the participant from responding to evidence, not only at the administrative stage, but also on judicial review, which is typically based on the administrative record. See, e.g., Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998) (citations omitted) (judicial review is on the record, and "additional evidence gathering is ruled out on deferential review"). Consistent with the Department's intent in promulgating the regulation, subsection (h) is most logically read to require that the claimant be provided with such relevant information throughout the process.[2]

[2] The panel also notes that 29 C.F.R. § 2560.503-1(h)(3)(iii) provides that, on review, the plan fiduciary is required to consult with health care professionals in cases involving the exercise of medical judgment, but does not specifically require the opportunity to review and rebut the professional's opinion. As explained in the text, however, subsection 2560.503-1(h)(2)(iii) creates a disclosure rule that covers

Subsection (i)(5) does not undercut this reading of the regulation. Instead, subsection (i)(5) simply specifies that "[i]n the case of an adverse benefit determination on review," the administrator must provide the claimant "as is appropriate" with access to and copies of documents, records and other information "described in paragraphs (j)(3), (j)(4), and (j)(5)" (relating to appeal rights and the legal and factual basis for the decision). 29 C.F.R. § 2560.503-1(i)(5) (2008). The provision, by its terms, is not focused on the disclosure of relevant evidence during the critical period between initial denial and the final determination on review, but rather on how the claimant should be notified of a final determination on review after it has been rendered. It is simply one more example of the inclusive nature of the disclosures mandated by the regulation, and in no way cuts back on the disclosures required prior to final determination.

The panel's policy concerns about the position advocated in this brief are also misplaced. First, the panel suggests that the rationale for the regulation's specification of "relevant" documents was merely to ensure that the claimant has the "information necessary to determine whether to pursue further appeal." Midgett, 561 F.3d at 896 (citing 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000)). In the panel's view, this purpose is not served by pre-determination disclosure. As

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the entire claims period, and requires reasonable access to all relevant evidence throughout that period.

noted above, however, the regulation is aimed at ensuring "reasonable access" to relevant evidence in order to promote the dialogue between the claimant and the plan at all stages, not merely in ensuring that the claimant receives sufficient information at the end of the process to decide whether to seek judicial review.

Far from undercutting the Secretary's reasonable view of her regulation, the preamble to the regulation fully supports what the regulations require: that the claimant be given access to "relevant" information requested at all stages of the decisionmaking process. For instance, the preamble explains that the Secretary adopted the definition of "relevant" in subsection 2560.503-1(m)(8), not in order to address the timing of the required disclosure or to depart from the 1977 regulation, but as a "specification of the scope of the required disclosure." 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (emphasis added). Moreover, contrary to the panel's reasoning, allowing "[a]ccess to documents during the course of an administrative decision," Midgett, 561 F.3d at 896, is also entirely consistent with the interest in ensuring that a claimant can reasonably assess whether to appeal a benefit denial. Providing such information before the final decision would certainly allow a claimant to assess whether to pursue an appeal in the event of an adverse decision, while additionally serving other important purposes such as allowing the claimant to develop and submit information necessary to evaluating

the claim by generally "improv[ing] access to information on which a benefit determination is made." 65 Fed. Reg. 70,246 (Nov. 21, 2000).[3]

Second, relying on the Tenth Circuit's decision in Metzger, the panel expressed concern about the potential "circularity of review" if the position advocated here is accepted. The potential for "an endless loop of opinions" is limited, however, by claimants' ability to generate new evidence requiring further review by the plan. Such submissions ordinarily become repetitive in short order, and are further circumscribed by the limited financial resources of most claimants. Moreover, if a claimant's assertions do not include new factual information or medical diagnoses, a plan need not generate report after report rather than relying on the reports it already has in hand. The circularity issue necessarily resolves itself when the plan has enough evidence to properly decide the claim. Certainly, administrative proceedings of all types commonly provide the elementary safeguard of permitting claimants to see and respond to all of the evidence, without creating endless proceedings or infinite loops of evidence.

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[3] Indeed, although the regulation generally shortens the time limits applicable to disability and health care claims, it also adds provisions allowing the decisionmaker to extend the time limits for both the initial determination and the adverse determination on review in order to "enable a plan to take sufficient time to make an informed decision on what may be a complex matter," noting "the plan will be required to keep the claimant well informed as to the issues that are retarding decisionmaking and any additional information the claimant should provide" and may not simply proceed without the back-and-forth that the claims regulation contemplates. 65 Fed. Reg. 70,246, 70,249 (Nov. 21, 2000).

Finally, even if the Secretary's preferred reading of her regulation were not the only possible reading, the Secretary's reasonable interpretation of her own regulation is entitled to significant deference. Auer v. Robbins, 519 U.S. 452, 461-63 (1997); see also Long Island Care at Home v. Coke, 127 S. Ct. 2339, 2349-51 (2007); Yellow Trans. Inc. v. Michigan, 537 U.S. 36, 45 (2002). But this reading of the regulation is not just permissible, it is the most consistent with the statutory entitlement to "full and fair review" of a claim denied by an ERISA fiduciary, who, as such, is bound by strict duties of prudence and loyalty. Claims procedures preventing claimants from addressing evidence upon which a plan fiduciary's benefit determination is based are unreasonable and violate these core principles of full and fair review by which plan fiduciaries are bound, as this court recognized in Abram. See 395 F.3d 882, 886, quoting Grossmuller, 715 F.2d at 858 n. 5.

As is well-established in the administrative context, "full and fair review" at a minimum "must provide a claimant with knowledge of the opposing party's contentions and a reasonable opportunity to meet them." Grossmuller, 715 F.2d at 858 n. 5 citing Robbins v. United States Retirement Railroad Board, 594 F.2d 448 (5th Cir. 1979); Morgan v. United States, 304 U.S. 1, 18-19 (1938). This Court should not assume that the Secretary meant to depart from these well established principles that are reflected in the statutory requirement for "full and fair review." For both plans and the courts, the claimant's opportunity to review and address

evidence used to deny the claim helps ensure that the final decision is based upon a complete and accurate record – the underlying premise that supports both the deferential standard of review and the exhaustion of administrative remedies requirement. The exhaustion requirement assists the courts in resolving litigated controversies by presenting them with fully considered decisions, Amato v. Bernard, 618 F.2d 559, 568 (9th Cir. 1980) and also promotes "a nonadversarial dispute resolution process." Kinkead v. Southwestern Bell Corp. Sickness and Accident Disability Plan, 111 F.3d 67, 68 (8th Cir. 1997) (quotation omitted). These purposes are ill-served if an administrator may decide a benefit claim without the "meaningful dialogue" required by section 503, based on evidence that the claimant did not have an opportunity to address at the plan administration level.

Respectfully submitted,

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Dated: May 29, 2009

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CERTIFICATE OF SERVICE

I hereby certify that on May 29, 2009, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

s/
James L. Craig, Jr.