the value of that benefit in violation of the Anti-Cutback rule. (Citations omitted.)

Conclusion

In *Battoni*, the Third Circuit stated that "… it is no stretch for us to conclude that an amendment to the Local 102 Welfare Plan constructively amended the Local 102 Pension Plan." We would beg to differ. As far as we know, *Battoni* is a case of first impression as to whether an amendment to one ERISA plan can be a constructive amendment to an entirely separate ERISA plan. The *Battoni* court used language such as "forfeiting healthcare benefits" in reaching its holding and we can understand that the court felt the Local 102 trustees were being a little too cute in their rather ingenious attempt to prevent the election of lump sum payments under the pension plan by making an amendment to the welfare plan. But the fact remains that the amendment was made to the welfare plan, not the pension plan, and welfare plans are not subject to the anti-cutback rule of ERISA section 204(g)(1). We don't agree with the Third Circuit that a reading of the plain meaning of the statutory language of ERISA is "simplistic" or "robotic." In addition, the Local 102 welfare plan contained a reservation of rights provision expressly allowing changes to the benefits under that plan and the provisions of the Local 102 pension plan making a lump sum distribution available to the plan participants who were formerly participants in the predecessor Local 675 pension plan remained in place at all times. We are concerned that the *Battoni* court's development of the concept that an amendment to a welfare plan can be a constructive amendment to a pension plan may be subject to far reaching expansion in future cases with perhaps unpredictable results.

NOTES

1. Battoni v. IBEW Local Union No. 102 Employee Pension Plan, 594 F.3d 230, 48 Employee Benefits Cas. (BNA) 1833, 159 Lab. Cas. (CCH) P 10185 (3d Cir. 2010).
2. Battoni v. IBEW Local Union No. 102 Employee Pension Plan, Battoni v. IBEW Local Union No. 102 Employee Pension Plan, 594 F.3d 230, 233, 48 Employee Benefits Cas. (BNA) 1833, 159 Lab. Cas. (CCH) P 10185 (3d Cir. 2010).
3. 29 U.S.C. section § 1054(g)(1). The corollary provision in the Internal Revenue Code is 26 U.S.C. section 411(d)(6)(A).
4. In re Lucent Death Benefits ERISA Litigation, 541 F.3d 250, 44 Employee Benefits Cas. (BNA) 2185 (3d Cir. 2008).
5. 29 U.S.C. § 1002(2)(A).
6. Central Laborers' Pension Fund v. Heinz, 541 U.S. 739, 124 S. Ct. 2230, 159 L. Ed. 2d 46, 32 Employee Benefits Cas. (BNA) 2313, 2004-1 U.S. Tax Cas. (CCH) P 50260, 94 A.F.T.R.2d 2004-5071 (2004).
7. As the district court had before it, the Third Circuit also looked for support to the Treasury Regulations under the Internal Revenue Code provision that corresponds to the ERISA anti-cutback provision.

During a Claim Review, Are Disability Claimants Entitled to Rebutt Every Physician Retort?

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My Mama told my brother and me many times that it takes two to argue. But a rule can have an exception. In 2009, the Eighth Circuit and the Department of Labor (the "DOL") each appear to have engaged in internecine warfare, as if competing to be the exception to my Mama's rule.

When applying the DOL's claim regulation, courts have disagreed on whether disability claimants are entitled under ERISA to rebut all physician reports that a claim fiduciary initially obtains during an administrative appeal. On this issue in 2009, the Eighth Circuit appears to argue with the Eighth Circuit and the DOL appears to argue with the DOL. Laying out the background and opposing positions requires some detail, yet provides insights for plan administrators and lawyers faced with disability claim adjudications.

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Background as to the Claim Regulation and Physician Reports

ERISA § 503[1] requires plans to give plan participants adequate notice of the specific reasons a claim is denied and a "reasonable opportunity for a full and fair review" by a fiduciary that decided the claim. The Secretary of Labor promulgated a detailed regulation that "sets forth minimum requirements for" plan claim procedures.[2] Originally promulgated in 1977, the Department of Labor amended this claim regulation in 2000, essentially restating it, with the amendments effective as to some claims as of January 1, 2002, and applicable to all claims filed after at least January 1, 2003.[3]

To comply with ERISA's mandate of a full and fair review, the 2000 claim regulation requires disability benefits plans to "[p]rovide claimants the opportunity to provide written comments, documents, records, and other information relating to the claim for benefits … [and p]rovide 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."[4]

In addition, plan claim procedures do not provide a "full and fair review" unless, during an appeal of an adverse benefit determination, they "[p]rovide 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."[5] "A document, record, or other information shall be considered 'relevant' to a claimant's claim if such document, record or other information" either was "relied upon" or was "submitted, considered, or generated in the course of making the benefit determination … ."[6]

For plans providing disability benefits, if an initial benefit determination required a health care professional to be consulted, the claim fiduciary in the denial notice must either explain the medical judgment or state that such an explanation will be provided free upon request.[7] The medical expert consulted also must be identified.[8] Other than the requirement [9] "that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all [relevant] documents," the 2000 claim regulation does not expressly require a claim fiduciary to furnish documents to the claimant before a decision on appeal.

If deciding an appeal requires medical judgment, the claim fiduciary must consult with a new health care professional, who is independent of the one who was consulted in making the initial benefit determination.[10] In an appeal denial notice, the claim fiduciary must also either explain the medical judgment or state that such an explanation will be provided free upon request.[11] The plan administrator is also required, "as is appropriate," to provide claimants with copies of documents describing any such medical judgments.[12]

Typically, plans comply with the claim regulation by furnishing claimants with copies of reports from physicians (or whatever medical experts were consulted). These physician reports also are the means by which claim fiduciaries document medical judgments in the administrative record. Normally, claim fiduciaries for disability plans obtain two reports or sets of reports from physicians: (1) during the initial determination and (2) during the claim appeal. Under the claim regulation, upon request, claimants are expressly entitled to these physician reports after an initial claim denial and after an appeal.

Courts have divided on the question of whether the regulations require the plan to provide physician reports during the claim review process prior to the fiduciary's final decision. This would allow claimants to respond to those reports before the final appeal decision is made. A subtle variation of the issue is whether, *after requesting a copy*, claimants are entitled to review the reports under consideration before the final appeal decision is made.

The Eighth Circuit Says Claimants Are Entitled to Respond During an Appeal

In *Abram v. Cargill, Inc.*[13], the Eighth Circuit held that, under the 1977 claim regulation, a claimant was entitled to a copy of a physician's

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report during an appeal.[14] The *Abram* opinion did not indicate that the claimant requested the report before a final decision was made, suggesting that claimants were always entitled to such reports.[15]

In *Abram*, the plaintiff's claim was initially denied based on the report of a consulting physician, who examined the plaintiff and concluded the plaintiff could work.[16] The plaintiff appealed the decision, submitting a treating physician's report that opined she could not work.[17] This treating physician's report was sent to the same consulting physician (an independent consulting physician was not required until after the claim regulation was amended in 2000).[18] The consulting physician again concluded that the plaintiff could work.[19] On the basis of the consulting physician's second report, the plaintiff's appeal was denied. The claim fiduciary supplied the plaintiff with a copy of the consulting physician's second report with the appeal denial letter.[20]

The Eighth Circuit held that the plaintiff was denied a full and fair review under ERISA. It concluded that the claim fiduciary should have permitted the plaintiff to respond to the consulting physician's second report and remanded the case to the claim fiduciary for further consideration.[21] The court reasoned that "full and fair review" requires "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."[22] Because "ERISA and its accompanying regulations essentially call for a meaningful dialogue" between insurers and insureds, "[p]lan procedures cannot be 'full and fair' without providing for this communication."[23] "Without knowing what inconsistencies the plan was attempting to resolve or having access to the report the Plan relied on, [the plaintiff] could not meaningfully participate in the appeals process."[24]

The Eighth Circuit suggested that the claim fiduciary's failure to provide the plaintiff with the second physician's report prior to reaching a final determination, as the sort of "gamesmanship [that] is inconsistent with full and fair review."[25] As the Eighth Circuit explained, "[t]here can hardly be a meaningful dialogue between the claimant and the Plan administrators if evidence is revealed only after a final decision. A claimant is caught off guard when new information used by the appeals committee emerges only with the final denial."[26]

One might question whether the *Abram* rule is the best means to address the Eight Circuit's concerns. The problem identified in *Abram* is that the claim fiduciary relied on "new information" and "new reasons for the claim denial" for the administrative appeal that were not part of the initial claim denial and as to which the claimant had no opportunity to respond, which the Eighth Circuit called "gamesmanship" and "sandbagging" that prevented "meaningful dialogue." *Abram* requires claim fiduciaries to supply ***all*** disability claimants physician reports initially obtained during an administrative appeal so the claimant has an opportunity to rebut every report. Yet, it would seem a rule requiring claim fiduciaries to give disability claimants physician reports initially obtained during an administrative appeal whenever such reports include ***new information, new reasons or new diagnosis*** would have adequately and less woodenly addressed the problem in *Abram*.

The Tenth Circuit Says Claimants Are Not Entitled to Respond During an Appeal

In *Metzger v. UNUM Life Ins. Co*,[27] the Tenth Circuit held that a claimant was not entitled to a copy of a physician's report during an appeal, even after the claimant specifically requested to review and to respond to any new physician reports.[28] The Tenth Circuit commented that it found *Abram* unpersuasive and also distinguished *Abram* on the ground that the claim in *Abram* arose under the 1977 claim regulation and the claim in *Metzger* arose under the 2000 claim regulation.[29]

The Tenth Circuit affirmed, holding that the plaintiff's reading of the claim regulation "set[s] up an endless loop of opinions rendered" by consulting physicians, "followed by rebuttal from

Plaintiff's experts, followed by more opinions …, and so on." [30]The Tenth Circuit explained as follows:

> **Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal – even when those reports contain no new factual information and deny benefits on the same basis as the initial decision – would set up an unnecessary cycle of submission, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which, under the regulations, should normally be completed within 45 days. Moreover, such repeating cycles of review within a single appeal would unnecessarily increase cost of appeals.[31]**

To avoid "an endless loop of opinions," the Tenth Circuit in *Metzger* ruled that, unless the claim fiduciary obtained a physician report with new information or reasoning, a claimant was not entitled to a copy of a physician's report during an administrative appeal, even after the claimant specifically requested to review and to respond to any new physician reports.

The Tenth Circuit's concern about an "endless loop of opinions" strikes the author as overstated. Under the rule in *Metzger*, unless the new physician "reports contain no new factual information and deny benefits on the same basis as the initial decision," the claimant is entitled to physician reports initially obtained during an administrative appeal, so the claimant can rebut such a report. Walking through possible scenarios helps one think about *Metzger*'s focus on avoiding an "endless loop of opinions." First, assume a claimant responds to the physician report from the initial denial. If that claimant response results in the claim fiduciary's obtaining a new physician report that has new information, reasons or diagnosis, the claimant is entitled to that physician report and to respond. The claimant's rebuttal then either changes the result or at least continues the "meaningful dialogue." If, on the other hand, the claim fiduciary obtained an additional physician report on review that does not have new information, reasons or diagnosis, the claimant can be given a copy of the physician report, but presumably would not have any additional response. Even in the rare circumstance in which the claimant had a new rebuttal to a physician report that had no new information, reasons or diagnosis, the dialogue would be expected quickly to become no longer meaningful. In other words, unless the claim fiduciary obtains a physician report that adds something new, the loop of opinions should end.

The Tenth Circuit also construed the Department of Labor's description of the 2000 amendments of the claim regulation as providing for disclosure of physician reports in two phases: first after the initial denial and then after the denial of an administrative appeal.[32] Accordingly, the Tenth Circuit concluded that "[s]o long as appeal-level reports analyze evidence already known to the claimant and contain no new factual information or novel diagnoses, this two-phase disclosure is consistent with 'full and fair review.'"[33] While the Tenth Circuit's analysis of the 2000 claim regulation makes sense, it does not really provide a basis for distinguishing *Abram* as much as it provides a basis for arguing that *Abram* was unpersuasive.

The Eighth Circuit Flip-flops and Says Claimants are Not Entitled

Arguably disagreeing with itself and flip-flopping, in *Midgett v. Washington Group International Long Term Disability Plan*,[34] the Eighth Circuit followed *Metzger* and distinguished *Abram*. In *Midgett*, the Eighth Circuit held that *Abram* was not binding due to the change in the law resulting from the 2000 amendments to the claim regulation, identifying three ways in which the currently applicable regulations differ from the 1977 regulations that governed the *Abram* decision.[35]

First, the Eighth Circuit said, when *Abram* was decided, the regulations "failed to specify when a claimant was entitled to 'review pertinent documents.'"[36] By contrast, under the current regulations, the Department of Labor substituted "relevant" for "pertinent" and "set forth specific stages in the claims process at which a claimant

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is entitled to review the materials 'relevant to his or her claim.'" [37]

Second, current 29 C.F.R. § 2560.503-1(h)(3)(iii), requires that "in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, … the appropriate named fiduciary shall consult with a health care professional." [38]According to the Eighth Circuit, "Conspicuously absent from § 2560.503-1(h)(3)(iii) is any requirement that the claimant be given the opportunity to review and rebut the health care professional's conclusion."[39]

Third, the Eighth Circuit relied on the Department of Labor's explanation for the definition of "relevant" in 29 C.F.R. § 2560.503-1(m)(8). According to the Department of Labor, the 2000 amendments clarified what to disclose to claimants and provided "claimants with adequate access to the information necessary to determine whether to pursue further appeal." 65 Fed. Reg. 70246, 70252 (emphasis added)." The Eighth Circuit, citing *Metzger*, commented that providing claimants with physician reports during an appeal would not help claimants decide whether to appeal.[40]

The Eighth Circuit's analysis of the 2000 claim regulations has its merits, but in the author's view its distinguishing *Abram* based on *Abram*'s having been based on the 1977 claim regulation is not persuasive. It's hard to understand how the DOL's substitution of the word "pertinent" for the word "relevant" became outcome determinative. How the other aspects of the 2000 claim regulation might lead to a different rule than the 1977 claim regulation are also hard to see, since the 1977 claim regulation just was not as detailed and did not address the issues before the court.

To sum up, the Tenth Circuit first in *Metzger* and the Eighth Circuit then in *Midgett* appear to have understood the DOL, with the 2000 claim regulation, as having said that the rule in *Abram* was wrong. Assuming this reading of the DOL's 2000 claim regulation is correct, the courts in *Metzger* and *Midgett* agree with the DOL and disagree with *Abram* by holding that claimants are not entitled to rebut a physician report initially obtained during an administrative appeal, unless it has new information, reasons or diagnosis.

The DOL Says Claimants Are Entitled to Respond During an Appeal

If the Eighth Circuit performed a flip-flop from *Abram* to *Midgett*, the DOL urged the Eighth Circuit to flop-flip on rehearing in *Midgett*. The Department of Labor filed an *amicus* brief in *Midgett* supporting the plaintiff/appellant's petition for rehearing (which was denied without a hearing).[41]

The Secretary disagrees with the Eighth Circuit's *Midgett*, particularly with what the Secretary describes as *Midgett's* holding 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 claim regulation 'changed the law' and effectively reversed *Abram*."[42] The Secretary argues at length that *Abram* correctly stated the law, that the 2000 amendments to the claim regulation did not change the law, and that the claim regulation requires claim fiduciaries to provide physician reports to claimants whenever requested, including during an appeal.[43] *cf. Auer v. Robbins*[44] (Secretary's reasonable interpretation of her own regulation is entitled to significant deference).[45] In other words, not only does the DOL indicate that the Eighth Circuit was correct in *Abram*, but also posits that the Eighth Circuit was wrong to argue with itself and reject *Abram* in *Midgett*.

Contrary to the Tenth Circuit's and the Eighth Circuit's reading of the DOL's 2000 claim regulation, the Secretary asserts that her position is that all physician reports should be disclosed during an administrative appeal. One might try to harmonize *Metzger* and *Abram* by limiting *Metzger* to cases where the physician's report for the appeal "contain no new factual information and deny benefits on the same basis as the initial decision."[46] Nonetheless, the Secretary rejects this reading, arguing that *Abram* was correctly decided and holds that "the claimant had been denied full and fair review when the [claim] fiduciary failed to reveal [the consulting physician]'s report prior to the final denial of benefits, even

though the report merely reiterated" the consulting physician's "previous conclusion." [47]

In her *amicus* brief, the Secretary argues that the 2000 amendments to the claim regulation were intended to expand the scope of disclosure, not limit it, with the disclosure obligations applying during the entire claims period, not just at two phases.[48] She emphasizes a claimant's right to "reasonable access" to all evidence "upon request and free of charge."[49] Furthermore, she points out that, if a claimant is not allowed to make an argument during the administrative appeal, the claimant may be foreclosed from making that argument on judicial review.[50]

Despite the DOL's *amicus* brief, the Eighth Circuit in *Midgett* denied the plaintiff's petition for rehearing without any opinion. Based on how heavily the *Midgett* opinion relied on the Eighth Circuit's understanding of the DOL's regulatory position, one might think the Eighth Circuit might have provided some explanation. On the other hand, if the Eighth Circuit was not going to go back to the rule in *Abram*, what could it say? It might not be politic for the Eighth Circuit to tell the DOL that the DOL took one position in the 2000 claim regulation and with its *amicus* brief now was just unpersuasively arguing with itself.

Several Concluding Comments

Several concluding comments are offered in order to put the courts' and the DOL's pronouncements on this issue in perspective.

First, if one steps back, under what circumstances would the difference between the *Abram* rule and *Metzger/Midgett* rule make any difference? If a claim fiduciary obtains a physician report during an administrative appeal but the physician report does not have new information or reasoning,[51] why would a claimant need the physician report or why would the claim fiduciary not give the physician report to a claimant that requested it? Hopefully, parties could normally avoid litigating such issues.

To illustrate this point, in *Metzger*, [52], the district court before the appeal to the Tenth Circuit had remanded the disability claim to the claim fiduciary for a new administrative appeal because the plaintiff had not had an opportunity to respond to a physician report initially obtained during the first administrative appeal. During the new administrative appeal, the plaintiff requested to see any new physician reports before a final decision. The claim fiduciary did not comply with that request. The plaintiff filed a Motion to Show Cause based on that failure. The district court held that the physician report did not have any new information and that the plaintiff was not entitled to it.[53] One might ask why the parties put so much effort into litigating an issue that was only procedural and not substantive, should not have helped the plaintiff on the merits, and could have been avoided by the claim fiduciary's simply providing a copy of the physician report to the plaintiff.

Second, under current case law, whether disability claimants are entitled to physician reports during an administrative appeal might depend on several considerations. It might depend on whether the physician report presents new information, new reasons, or new diagnoses. It might depend on whether the claimant requested an opportunity to respond to the physician report before a final decision. Most likely, it might depend on what court makes the decision as to whether the claimant was entitled to the physician report. If advising a claim fiduciary, the best practice would seem to be for a claim fiduciary to give a claimant the physician report, even if the claimant does not request it, if it has new information or reasoning, and for a claim fiduciary to give the claimant the physician report if the claimant requests it, even if it does not have new information or reasoning.

Third, for claim fiduciaries generally (not just for disability plans), this body of case law and regulatory guidance offers several lessons. One, just because information or reasons were not considered as part of an initial denial does not mean that the claim fiduciary cannot consider the information or those reasons during an administrative appeal. Whether presented by a claimant or otherwise coming to the attention of a claim fiduciary, a claim fiduciary should consider all relevant information and reasoning during an administrative appeal. Two, if a claim fiduciary considers new information or reasoning on appeal other

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than what the claimant submitted and the claim is to be denied, the claim fiduciary should make sure the claimant has an opportunity to rebut the new information or reasons before the claim fiduciary makes a final decision. Otherwise, a court might find that the claim procedure was not the required full and fair review and that the claim fiduciary engaged in gamesmanship and sandbagging, preventing meaningful dialogue. Three, even claim fiduciaries who do their best may want to recognize that courts are unpredictable, with courts even at times arguing with themselves.

NOTES

1. 29 U.S.C. § 113.3.
2. 29 C.F.R. § 2560.503-1(a).
3. 42 Fed. Reg. 27,426 (1977 claim regulation); 46 Fed. Reg. 5882 (1981 amendments to 1977 claim regulation); 65 Fed. Reg. 70,264 (2000 claim regulation); 29 C.F.R. § 2560.503-1(o)(2) (effective dates for 2000 claim regulation).
4. 29 C.F.R. § 2560.503-1(h)(2)(ii) & (iv).
5. 29 C.F.R.§ 2560.503-1(h)(2)(iii).
6. 29 C.F.R. § 2560.503-1(m)(8).
7. 29 C.F.R. § 2560.503-1(g)(1)(v)(B).
8. 29 C.F.R. § 2560.503-1(h)(3)(iv); *see* 29 C.F.R. § 2560.503-1(h)(4) (providing that 29 C.F.R. § 2560.503-1(h)(2)(ii)-(iv) & (3)(i)-(v) apply to disability plans).
9. In 29 C.F.R. § 2560.503-1(h)(2)(iii).
10. 29 C.F.R.§ 2560.503-1(h)(4) (indicating that (h)(3)(iii) & (v) apply to disability plans).
11. 29 C.F.R.§ 2560.503-1(j)(5)(ii).
12. 29 C.F.R.§ 2560.503-1(i)(5) & (j)(5)(ii).
13. Abram v. Cargill, Inc., 395 F.3d 882, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
14. Abram v. Cargill, Inc., 395 F.3d 882, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005). The *Abram* decision has been followed by a number of district courts. *E.g.*, Smith v. Continental Cas. Co., 616 F. Supp. 2d 1286, 41 Employee Benefits Cas. (BNA) 2511 (N.D. Ga. 2007); Lammers v. American Express Long Term Disability Benefit Plan, 2007 WL 2247594 *6 (D. Minn. 2007); Harris v. Aetna Life Ins. Co., 379 F. Supp. 2d 1366, 1374 (N.D. Ga. 2005).
15. One reported decision, which pre-dated *Abram*, held that the plaintiff was entitled to statutory penalties under ERISA § 502(c), 29 U.S.C. § 1132(c), for a claim fiduciary's failure to furnish physician reports, in addition to holding that such documents are required to be provided by the claim regulation. Hamall-Desai v. Fortis Benefits Ins. Co., 370 F. Supp. 2d 1283, 1313-1314 (N.D. Ga. 2004), aff'd without opinion, 164 Fed. Appx. 963 (11th Cir. 2006); *but see* Brucks v. Coca-Cola Co., 391 F. Supp. 2d 1193, 1211-1212 n. 16 (N.D. Ga. 2005) (expressly rejecting *Hamall-Desai* on this statutory penalty issue); Montgomery v. Metropolitan Life Ins. Co., 403 F. Supp. 2d 1261, 1265-1266 (N.D. Ga. 2005) (following *Brucks* and rejecting *Hamall-Desai*); *cf.* Byars v. Coca-Cola Co., 517 F.3d 1256, 1270, 43 Employee Benefits Cas. (BNA) 1310 (11th Cir. 2008) ("the regulations that [the plaintiff] relied on as authority for her request do not apply to [§ 502(c)], but rather apply to [§ 503], which establishes the types of claims procedures that administrators are required to maintain").
16. Abram v. Cargill, Inc., 395 F.3d 882, 883-884, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
17. Abram v. Cargill, Inc., 395 F.3d 882, 885, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
18. Abram v. Cargill, Inc., 395 F.3d 882, 885, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
19. Abram v. Cargill, Inc., 395 F.3d 882, 885, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
20. Abram v. Cargill, Inc., 395 F.3d 882, 885, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).
21. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005). "Remand to the [claim] administrator for full and fair review is usually the appropriate remedy when the administrator fails to substantially comply with the procedural requirements of ERISA." *Lafleur v. Louisiana Health Service & Indemnity Co.*, 563 F.3d 148, 157-58 (5th Cir. 2009) (citing cases from several circuits and also discussing modifying the standard of review, striking evidence, and awarding benefits as alternative remedies for failing to provide a full and fair review); *see Miller v. United Welfare Fund*, 72 F.3d 1066, 1074 (2d Cir. 1995) ("Because district courts are required to limit their review to the administrative record, it follows that, if upon review a district court concludes that the [claim fiduciary's] decision was arbitrary and capricious, it must remand to the [claim fiduciary] with instructions to consider additional evidence unless no new evidence could produce a reasonable decision permitting denial of the claim or remand would otherwise be a useless formality.") (internal quotation marks and citation omitted).
22. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005). The discussion in *Abram* arguably supports claimants' submitting arguments

and evidence in response to physician reports initially obtained during an administrative appeal, but two courts have held that *Abram* only gives claimants the right to submit arguments. *See* Toppins v. The Hartford Life and Acc. Ins. Co., 657 F. Supp. 2d 1107 (W.D. Mo. 2009) (applying *Abram* to claim arising under 1977 claim regulation and holding that *Abram* does not give a claimant the right to respond with new medical evidence); *Lammers v. Am. Express Disability Long Term Benefit Plan,* 2007 WL 2247594 *2 (D. Minn. Aug. 2, 2007) (interpreting *Abram* as not giving a claimant the right to submit new medical evidence in response to physician reports disclosed during administrative appeal).

23. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).

24. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005).

25. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005) (quotations and citations omitted).

26. Abram v. Cargill, Inc., 395 F.3d 882, 886, 34 Employee Benefits Cas. (BNA) 1569 (8th Cir. 2005). Numerous cases hold that a fair review necessarily requires an opportunity to review and rebut the basis of the denial determination. *E.g.*, Crocco v. Xerox Corp., 137 F.3d 105, 108, 8 Employee Benefits Cas. (BNA) 1137 (2d Cir. 1998) (holding that "full and fair review" was not provided); Grossmuller v. International Union, United Auto., Aerospace and Agr. Implement Workers of America, UAW, Local 813, 715 F.2d 853, 857-858, 4 Employee Benefits Cas. (BNA) 2082 (3d Cir. 1983) (stating that full and fair review requires that claimant be presented with all relevant evidence and be afforded an opportunity to respond to that evidence); *see also* Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 974, 38 Employee Benefits Cas. (BNA) 2262 (9th Cir. 2006) (finding that "an administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA" and that such a "procedural violation must be weighed by the district court in deciding whether [administrator] abused its discretion").

27. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007). Several courts have followed *Metzger*. *E.g.*, Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241,1245-1246, 44 Employee Benefits Cas. (BNA) 1392 (11th Cir. 2008), cert. denied, 129 S. Ct. 646, 172 L. Ed. 2d 614, 45 Employee Benefits Cas. (BNA) 2888 (2008) (following *Metzger*, without indicating whether the claimant had requested an opportunity to respond to the physician reports); Kao v. Aetna Life Ins. Co., 2009 WL 2601104 *13-14 & n. 31 (D. N.J. Aug. 25, 2009) (following *Metzger*, expressly not considering what the result would have been if "new information or novel diagnoses" had been involved); Rizzi v. Hartford Life and Acc. Ins. Co., 613 F. Supp. 2d 1234, 1247 (D.N.M. 2009) (following *Metzger*, without indicating whether the claimant had requested an opportunity to respond to the physician reports).

28. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1164, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

29. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1167-1168 n.3, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

30. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1167-1168 n.3, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

31. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1166-1167, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007) (citations omitted) .

32. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1166-1167, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

33. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1166-1167, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

34. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 893-896, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009).

35. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894-896, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009).

36. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009) (citing 29 C.F.R. § 2560.503-1(g)(1)(ii) (2000).

37. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894-895, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009) (citing 29 C.F.R. § 2560.503-1(h)(2)(ii), for after the initial denial to decide whether to appeal, and citing 29 C.F.R. § 2560.503-1(i)(5), for following the denial of an appeal).

38. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009) (quoting 29 C.F.R. § 2560.503-1(h)(3)(iii).

39. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894, 46

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Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009) (quoting 29 C.F.R. § 2560.503-1(h)(3)(iii).

40. Midgett v. Washington Group Intern. Long Term Disability Plan, 561 F.3d 887, 894, 46 Employee Benefits Cas. (BNA) 2229 (8th Cir. 2009) (quoting 29 C.F.R. § 2560.503-1(h)(3)(iii).

41. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010).

42. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010), at 1.

43. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010); at 2-15.

44. Auer v. Robbins, 519 U.S. 452, 461-463, 117 S. Ct. 905, 137 L. Ed. 2d 79, 3 Wage & Hour Cas. 2d (BNA) 1249, 133 Lab. Cas. (CCH) P 33490 (1997).

45. *See* Brian C. Gilmore, *ERISA's Full and Fair Review: Access to Appeal-Level Documents During the Course of an Administrative Appeal*, 43 U. S.F. L. Rev. 383 (2008) (arguing that the Department of Labor should amend the claim regulation to resolve this issue).

46. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1166, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

47. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010), at 4 n.1.

48. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010), at 9-11 & n.2.

49. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010), at 9.

50. *See* http://www.dol.gov/sol/media/briefs/midgett(A)-5-29-2009.pdf (the Secretary's brief, available April 16, 2010), at 10.

51. Granted, under the *Metzger/Midgett* rule, another issue to litigate might be what a court would consider to be new "factual information" entitling a claimant to the physician report and to respond to the physician report before a final decision on appeal. *Cf. Forrester v. Metro. Life Ins. Co.*, 232 F. App'x 758, 760 (10th Cir. 2007) ("*Metzger* indicated that ERISA review obligations *could require disclosure* of consultant reports if they 'analyze evidence not already known to the claimant' and thus interject 'new factual information or novel diagnoses' into the case at the administrative-appeal level") (quoting *Metzger*, 476 F.3d at 1167) (emphasis added); *Peterson v. Principal Financial Group*, 2008 WL 4630576 *8 (D. Colo. Oct. 17, 2008) (following *Metzger* and explaining that "medical opinions generated – as here – by review of an employee's existing records do not contain 'new factual information' and therefore need not be disclosed to the employee during the course of her administrative appeal").

52. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1164, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

53. Metzger v. UNUM Life Ins. Co. of America, 476 F.3d 1161, 1164, 39 Employee Benefits Cas. (BNA) 2865 (10th Cir. 2007).

Tenth Circuit Holds that It Already Held that a PPA Amendment was Retrospective

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We're not sure exactly which of our major character flaws accounts for our fascination with *Dobbs v. Anthem Blue Cross and Blue Shield*.[1] The underlying subject of the case—a statutory amendment to articulate the circumstances under which plans maintained by Indian tribes are covered by ERISA—is not one that has had, or is likely to have, much impact on our practices. The case presents a common ERISA preemption issue, but it's one that we, like the Tenth Circuit, view as relatively easy to resolve.

What really hooked us on the case was the fact that it produced an opinion and dissent, both argued in detail and mostly diametrically opposed. We're less interested in which opinion is right in its analysis—although we will express views—than with the intricacy of the issues presented by what seems such a simple claim. Much of that intricacy results from the majority's dogged insistence on treating the main substantive question as having been resolved in an earlier appeal in the same case and thus as binding on the current panel. If you get that far into our recounting of the decision, you'll see what we mean, but this twist forces a

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