No. 12-729

In The
Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

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

BRIEF OF UNITED POLICYHOLDERS, AS *AMICUS CURIAE*, IN SUPPORT OF PETITIONER

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BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS

INTEREST OF *AMICUS CURIAE*[1]

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP is concerned about the implementation and application of laws and rules under the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*., because a substantial percentage of the insurance market is governed by ERISA.

UP's work is divided into three program areas: *Roadmap to Recovery* (claim assistance), *Roadmap to Preparedness* (promoting insurance/financial literacy) and *Advocacy and Action* (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no person or entity other than the *amici curiae*, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office in accordance with Supreme Court Rule 37.3(a).

Advancing the interests of policyholders through participation as *amicus curiae* in insurance-related cases throughout the country is an important part of UP's work. UP's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth*, 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.*, 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including *TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as *amicus curiae* include: *US Airways v. McCutchen*, 133 S. Ct. 1537 (2013); *Hardt v. Reliance Standard Life Insurance Co.*, 130 S. Ct. 2149 (2010); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004); and *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). UP also was granted leave to file an *amicus* brief in *Skinner v. Northrop Grumman Retirement Plan B*, No. 10-55161 (Doc. 53) (9th Cir. 2012).

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

SUMMARY OF THE ARGUMENT

ERISA's internal claims procedure for disability benefit claims is often a time-consuming process, necessitated by numerous factors governing the assessment of disability and the good faith exchange of information between participants and plan administrators. The time periods in ERISA's implementing regulations provide flexible deadlines, such that the internal claim and appeal process, which claimants must exhaust before they can file a lawsuit, may not be completed within a set period of time and can vary widely on a case-by-case basis. The realities of the claims course and the need for claimants and administrators to have the opportunity to resolve claims before litigation without the ticking of an accrual of any contractual limitations period is essential to maintaining the integrity of the process.

The "bright-line" rule that accrual of a limitations period starts at a final denial of a benefits claim – at the point at which the claim becomes live – will provide certainty to participants and administrators across the board. Any rule short of one that provides a clearly ascertainable statute of limitations is unworkable and will only serve to increase litigation costs and hamper participants' access to ERISA's civil enforcement scheme, in direct contradiction to one of ERISA's stated goals.

ARGUMENT

I. Accrual of a Statute of Limitations at Final Denial Protects the Internal Claims Procedure Required by Section 503 of ERISA and Its Implementing Regulations.

A. The Internal Claims Procedure for Disability Claims.

ERISA sets forth basic procedural safeguards that govern the administration of employee welfare benefit plans. 29 U.S.C. § 1133. Every employee benefit plan must: (1) provide adequate notice in writing to any participant whose claim for benefits has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. *Id*. With respect to the administration of disability claims, ERISA's implementing regulations provide certain minimum requirements for a participant's initial claim for benefits and for an appeal of an adverse determination. *See* 29 C.F.R. § 2560.503-1, *et seq*.

The regulations require that a plan render a decision on a benefit claim within a reasonable period of time, but not later than 45 days after the plan receives the claim. 29 C.F.R. § 2560.503-1(f)(3). However, the plan may extend the period to make a decision for up to 30 days if the administrator determines

that, due to matters beyond the plan's control, a decision cannot be rendered within that extension period. *Id*. The plan may take two 30-day extensions following the initial 45-day deadline, provided that it issues a notice which explains the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. *Id*. The participant then has *at least* 45 days within which to provide the specified information. *Id*. The deadlines by when a plan administrator must render a determination are tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. 29 C.F.R. § 2560.503-1(f)(4). The deadlines provided by the regulations are not absolute, in certain situations providing only a floor on the time that a claimant must provide certain information. As such, a plan's initial determination on a claim may occur as quickly as 45 days following a plan's receipt of the claim or many months later.

For example, if a participant files a disability claim on January 1, the first 45-day deadline for the plan administrator to render a decision falls on February 15. The plan administrator may determine on February 10 that it requires additional information to make a decision, notifies the claimant of such, and extends the time to render a decision by the first 30-day permissible extension. The claimant must be given *at least* 45 days, to provide the plan with the

requested information before it may deny the claim. Assuming that the claimant furnishes the requested information on day 45, or March 27, the plan now has until April 26 to render a determination.

However, the plan may determine on April 25 that it again requires additional information to make a decision and notifies the claimant of the information that she must submit. The claimant must be given *at least* 45 days, or until June 9, to provide the requested information. The claimant may need additional time beyond 45 days and any plan administrator, engaging in good faith, would grant any reasonable request for an extension. Assuming that the claimant seeks and obtains an extension for a total of 60 days to furnish the requested information, or June 24, the second 30-day extension for the plan to render a decision falls on July 24. The plan issues a written denial on that date.

The regulations require that a plan give a claimant *at least* 180 days following notification of an adverse benefit determination within which to appeal such determination. 29 C.F.R. § 2560.503-1(h)(3)(i) and (h)(4). Upon the plan's receipt of the claimant's appeal, it has 45 days to render a determination. *Id*. at (i)(1)(i); (i)(3). However, if special circumstances prevent a plan from making a determination within 45 days, it may take an additional 45 days if it notifies the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. *Id*. at (i)(1)(ii);

(i)(3). If a plan extends the period of time within which it has to make a benefit determination on review due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. *Id*. at (i)(4).

Continuing with the above example, the claimant's appeal is due *at least* 180 days following receipt of the claim denial letter. If the claimant received the denial letter on July 24, her appeal is due by January 20, more than one year since the claimant's initial claim filing. The claimant may require additional time beyond 180 days to submit an appeal and nothing in the regulations requires that a claimant must submit an appeal within 180 days – it is a *minimum* period of time. Indeed, a plan engaging in good faith in the review process will grant a claimant any reasonable request for an extension of time. The claimant may have a medical test scheduled 60 days after the deadline which would aid the administrator in making a decision. The claimant may require an additional 60 days following the test for follow up diagnostic testing and to gather medical records. For purposes of this example, the claimant required an additional 120 days to submit all of the necessary information with her appeal, or until May 20. The plan's first 45-day deadline begins to run at that time. However, the plan determines on day 40, or June 29,

that there is still more information it needs to render a decision. It sends written notice to the claimant informing her of its need for additional information. The regulations permit tolling of the period for making a benefit determination on review until the claimant responds to the request for additional information.

If the claimant responds to the request for information within 45 days, or by August 13, the plan may take the remainder of the first 45-day period (five days in this example since the tolling period started at day 40), plus an additional 45 days, making a final determination not due until October 2. In this example, with only relatively modest extensions of time not prohibited by the regulations, an adverse claim and appeal decision took approximately 21 months from the filing of the claim. The date of the final written denial, provided that it was issued by the statutory deadline, is the absolute earliest date that the claimant may be found to have exhausted administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing suit under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

However, a plan may require that a participant exhaust not just one, but two levels of internal appeals, before she can file suit. *See* 29 C.F.R. § 2560.503-1(i)(3)(i); *see also Bernikow v. Xerox Corp. Long-Term Disability Income Plan*, 517 F. Supp. 2d 646, 653 (W.D.N.Y. 2007) (dismissing the plaintiff's Complaint with prejudice where the plaintiff did not exhaust the plan's second level of administrative appeal).

A mandatory second level of appeal could easily extend the claim and appeal process by an additional year for a total of nearly three years to exhaust administrative remedies.

B. Why a Full and Fair Review May – and Should – Extend the Internal Claims Procedure.

ERISA imposes "higher-than-marketplace quality" standards on plan administrators. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008). It underscores the particular importance of accurate claims processing by insisting that administrators provide a "full and fair review" of claim denials. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113, (1989) (quoting § 1133(2)).

As the Petitioner identifies, only a small fraction of the hundreds of thousands of disability claims filed each year end up in federal court. Brief of Petitioner at 9. The internal claims procedure described above provides the flexibility necessary for participants and administrators to work together in resolving claims short of litigation. There are a number of reasons why an internal claims procedure may extend for significant periods of time while a plan administrator is deciding a claim or reviewing an appeal of a denied claim.

First, courts generally discourage attorneys from participating in the claims process. *See Rego v. Westvaco Corp.*, 319 F.3d 140 (4th Cir. 2003). The congressional purpose of ERISA, which emphasized

promotion of "the soundness and stability of plans with respect to adequate funds to pay promised benefits," (29 U.S.C. § 1001(a)) encourages participants to resolve their claims on their own without legal counsel. Courts have recognized this purpose of ERISA in refusing to award attorneys' fees for work done during the claims and appeal process because "some claimants and some plans may use informal internal review procedures, accomplished by nonlawyers, perhaps union or other employee representatives and plan representatives; a nonliteral reading of the statute which exposed the loser to the prevailing party's attorneys' fees might undermine such a process." *Cann v. Carpenters' Pension Trust Fund for N. California*, 989 F.2d 313, 317 (9th Cir. 1993).

For lay persons, and those whose life has been transformed by disability, the intricacies of ERISA and the requirements necessary to establish a disability claim are unknown and daunting. The regulations implementing ERISA's full and fair review process recognize the necessary back and forth exchange of information by permitting the tolling of deadlines to render a decision. "In simple English, what [the regulations call] for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).

Second, in the disability claims context, there are a countless number of scenarios that justify an extended internal claims procedure with sometimes indefinite periods of tolling. For example, a diligent

administrator may be required to toll the period of time to make a benefit determination pending a response to multiple requests for medical records from a claimant's treating physician which is necessary to process the claim. *See Evans v. American Express Financial Corp. Long-Term Disability Plan*, No. 3:01-1501, 2003 WL 23126327 at *7-8 (M.D. Tenn. Nov. 5, 2003) (finding time limits for responding to claim were tolled pending the administrator's receipt of all medical information necessary to process plaintiff's claim where administrator made numerous requests to the plaintiff's treating physicians). As courts are recognizing the relevance of a finding of disability by the Social Security Administration ("SSA") (*see, e.g., Glenn*, 554 U.S. at 106; *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 635 (9th Cir. 2009), claimants may seek to toll a decision on their disability claim pending an award of benefits by the SSA or an administrator may request a claimant's SSA file for consideration. A process which encourages the consideration of more information, rather than less, maintains the integrity of a benefit review procedure. Indeed, this Court has recognized that a benefit determination is considered to be a fiduciary act. *Glenn*, 554 U.S. at 111. Administrators should be encouraged to take the time they need to make benefits determinations in accordance with their fiduciary duties to act for the "exclusive purpose of . . . providing benefits to participants . . . [and] in accordance with the documents and instruments governing the plan. . . ." ERISA § 404; 29 U.S.C. § 1104. Stifling the benefits determination process with a threat of the

sunset of an accrual period will lead to unnecessary litigation on a subpar claims record.

Third, claimants intending to appeal a denied claim may seek an attorney for assistance and may need additional time beyond the 180-day minimum time period to appeal. Given the importance of the administrative record to a claimant's benefit claim,[2] administrators should and typically do grant reasonable extensions of time to appeal while a claimant is seeking representation. *See*, *e.g.*, *Duncan v. Hartford Life and Acc. Ins. Co.*, No. 2:11-cv-01536-GEB-CKD, 2013 WL 506465 at *2 (E.D. Cal. Feb. 8, 2013) (granting plaintiff's request for a 90-day extension for her appeal to "obtain an attorney").

As it is reasonable to expect that a disabled claimant may be overwhelmed by the amount of documentation she must obtain and submit to prove her claim, including relying on medical providers to respond to requests for information, an administrator should not be encouraged to quickly render a determination on the merits of a claim until it has all of the necessary records in order to parlay a later argument that a claimant had a reasonable amount of

[2] Depending on the applicable judicial standard of review of a denied benefits claim under 29 U.S.C. § 1132(a)(1)(B), a reviewing court is generally limited to the claim record developed during the course of administrative exhaustion. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 969-70 (9th Cir. 2006) (collecting circuit cases limiting a district court to the administrative record on abuse of discretion review).

time post-exhaustion to file a lawsuit prior to the expiration of a statute of limitations period that began accruing before it made a final decision.

II. A "Reasonableness" Standard Applied in this Context Is Unworkable and Will Create More Litigation and Uncertainty.

In lieu of a bright-line rule that accrual of a statute of limitations start no earlier than at a final benefit claim denial, which in some cases may run before a claimant can even file a lawsuit, Respondents urge this Court to adopt an extra-contractual, implied "reasonableness" requirement as that articulated by the Second Circuit in *Burke v. PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), which would give ERISA beneficiaries the right to challenge a plan's accrual provision on a case-by-case basis. Given the reality of benefit claim and review procedures, the requirement and expectation that participants and administrators will work together in good faith during the claim determination and review process, and ERISA's goals of soundness and stability, a case-by-case determination of reasonableness is unworkable.

A. An Accrual at Final Denial Provides Certainty.

As noted by the Petitioner, one of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time by relying on the

face of written plan documents. Brief of Petitioner at 44. A claimant who has exhausted administrative remedies and is trying to ascertain her right to file a lawsuit should be able to review the plan document which sets forth a limitations period from a point in time that is easily ascertainable. An accrual period that can begin no earlier than before her claim becomes live avoids the needless speculation of what turn of events in her internal claim and review process may give her additional time to find an attorney and file a lawsuit. This need for clarity is particularly important where, as highlighted above, there are a number of different factual scenarios which may protract the internal claims review process.

There are at least two scenarios where starting the accrual period as Respondent suggests, 90 days from when a beneficiary becomes eligible for long-term disability benefits, would lead to the expiration of the statute of limitations even before there is any dispute or the plan has engaged in the claims review process. The first is where a plan accepts a late-filed claim because a state law regulating insurance requires the plan to do so unless it can show prejudice. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999). In California, this law is referred to as the "notice-prejudice" rule and it applies to ERISA-governed disability plans that are funded by insurance policies. *Id*. at 359. Although a plan may require that a disability claim be filed within 90 days of the date of disability, it cannot reject a claim filed, for example, three years after the

date of disability unless it can show prejudice. In this situation, if an accrual period started and finished before a claim was even filed, but where the claimant maintained a right to file a claim, the participant would be denied a reasonable opportunity to avail herself of ERISA's civil enforcement scheme. Instead of courts deciding on a case-by-case, state-by-state, insured plan vs. self-funded plan, basis whether equity tolls the statute of limitations, a bright-line rule that accrual starts from final denial would create uniformity in circumstances where one claimant may have the benefit of a notice-prejudice rule but where another claimant does not.

Another scenario where Respondents' proposal leads to an absurd result is where a claim was initially approved but then denied months or years later. Many denial-of-benefit claims involve claims that were approved for some period of time and then later terminated. For example, many long-term disability policies have two definitions of disability: disability from one's own job and disability from any job that the claimant may perform. Plans conducting reviews at the juncture of a change in the definition of disability will often terminate a claim for benefits. Before a claimant can exhaust the appeals process for the termination of her benefits, she will be outside of the contractually shortened statute of limitations. Although a court could toll the statute pending the claimant's exhaustion of internal remedies, it is unnecessarily laborious to engage in any analysis of tolling and equity in these situations which occur so

frequently and where a bright-line rule would apply the same result to a claimant whose claim was denied off the bat and to a claimant whose claim was paid for several years before a termination of benefits.

B. A "Reasonableness" Standard Will Create Unnecessary Litigation and Increase Costs of Suit.

As this Court has recognized: "Benefits decisions arise in too many contexts, concern too many circumstances . . . for special procedural rules [which] would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress." *Glenn*, 554 U.S. at 116-17. Allowing the internal claims procedure the time to take its course without the pressure of a ticking time of accrual will limit the burden on the federal courts to decide claims that may have otherwise been approved in the absence of a lawsuit. A number of claims are resolved in favor of a participant even after the period of time set forth by the regulations. *See* 29 C.F.R. § 2560.503-1(f)(1); *Dunnigan v. Metropolitan Life Ins Co.*, 214 F.R.D. 125 (S.D.N.Y. 2003) (involving putative class of participants whose claim for long-term disability benefits were approved beyond the 90 days after they were submitted without any notice of the need for an extension of time as required by ERISA).

Because "reasonableness" determined on a case-by-case basis creates uncertainty, it may be litigated

as a threshold issue in many denial of benefit claims, requiring reviewing courts to parse which circumstances in a claim process tolled the statute of limitations. This nit-picking of the claims process is hardly desirable with the alternative of a clear bright-line rule. A judicial inquiry into the claims process to determine "reasonableness" could also lead to costly discovery disputes as plaintiffs attempt to uncover procedural irregularities and conflicts of interest which contributed to unnecessary tolling or unreasonable requests for information by administrators. Although a reviewing court is generally limited to the administrative paper record in reviewing whether an administrator abused its discretion, *see Abatie*, 458 F.3d at 969-70, determining whether there are factors that contribute to the reasonableness of a limitations accrual may require an inquiry into matters beyond the administrative record. A bright-line rule would eliminate the need for costly litigation that does not contribute to a judicial assessment as to whether or not a participant is disabled.

C. Uncertainty Regarding the Accrual of the Statute of Limitations Will Hamper Participants' Access to ERISA's Remedial Regime.

One of ERISA's goals is to provide participants with ready access to the courts. 29 U.S.C. § 1001(b). Participants already have a difficult time finding

knowledgeable attorneys to handle ERISA benefit claims,[3] such that a rule that creates uncertainty about whether or not a lawsuit may be timely filed would create even more barriers for participants trying to exercise their rights under ERISA.

First, a participant who has just been denied income replacement benefits because she is not gainfully employable due to a medical condition is often in a multi-factor crisis situation. Instead of relying on benefits that she believed would protect her and her family against the hardship of disability, she is now in the midst of making alternative arrangements to fund basic life necessities and medical treatment. While battling a medical condition that has deprived her of the ability to care for herself, she now has to fight a denial of a benefit claim against a large company. It may take her several weeks, months, or years to get her life in order before having the wherewithal to seek out the small community of ERISA attorneys who may be willing to take her case. *See, e.g.*, *Steffy v. Liberty Life Assur. Co. of Boston*,

[3] The ERISA bar representing individuals is extremely small. For example, in 2010, there were 852 attorney members of the Employee Benefit Committee of the Section of Labor and Employment Law of the American Bar Association; of those, only 101 classified themselves as representing Employee-Plaintiffs, or approximately less than twelve percent (12%) of the total membership. Brief of AARP and National Employment Lawyers Association, as *Amici Curiae*, in Support of Petitioner, *Hardt v. Reliance Standard Life Ins. Co.*, 2010 WL 768489 (U.S.) (Appellate Brief).

No. 09-538, 2009 WL 3255219 (W.D. Penn. Oct. 7, 2009) (due, in part, to cognitive difficulties stemming from dementia, participant missed deadline to file a claim). Although written denial letters inform claimants of their right to file suit, they typically do not inform, nor do courts require that they inform, claimants of the deadline by when they must do so. *See Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899, 907-08 (9th Cir. 2009) (rejecting plaintiff's claim that administrator was obligated under ERISA to inform her of the deadline to file suit).

Absent a clear bright-line rule governing the accrual of a statute of limitations, *i.e.*, x number of years from the date of a final denial letter informing a claimant that she has exhausted administrative remedies and may now bring an action under § 502(a) (29 C.F.R. § 2560.503-1(j)(4)), determining whether or not a statute of limitations has run or might be tolled may be a time-consuming process. An attorney evaluating whether she is willing to represent a claimant who has exhausted administrative remedies on her own will have the additional challenge of determining whether or not a lawsuit may be timely filed, and while making that determination, be compelled to file a lawsuit to protect against any further accrual of the statute of limitations or risk a malpractice claim if the statute of limitations is later found to have run while the attorney was in the process of evaluating a claim for litigation.

As part of competently evaluating a claim for litigation, an attorney will need to do some investigation,

which includes requesting a copy of the participant's claim file and a copy of all plan documents. ERISA's regulations require that an administrator rendering an adverse benefit determination on review provide written notice informing a claimant that she is entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to her claim for benefits. 29 C.F.R. § 2560.503-1(j)(3); (m)(8). Plan administrators must also provide claimants with plan documents within 30 days of a written request. 29 U.S.C. § 1024(b); 29 U.S.C. § 1132(c). Operating under the bright-line rule proposed by Petitioner, an attorney would simply need to review a final denial letter and the Plan document, which may or may not set forth a contractually shortened limitations period, in order to ascertain quickly the deadline for filing suit.

Under the "reasonableness" standard, the determination of the statute of limitations is muddy. Take the above example of an internal claims review process and the contractual statute of limitations in the present case: three years after the time written proof of loss is required to be furnished according to the terms of the policy. Br. in Opp'n (BIO) App. 5a, 7a. Written proof of loss is due 90 days from when a beneficiary becomes eligible for long-term disability benefits. *Id*. at 5a. In the example, where tolling and two levels of appeal took three years, at the time of final denial, the three-year period has run. Even if a participant found an ERISA attorney the next day, who immediately requested the claim file and plan

documents, received the documents within 30 days, and reviewed everything with heroic speed, the attorney must decide in haste whether to take the case and file a complaint. If the attorney decides that she is unable to take the case and makes a referral, the participant must now find and consult with other attorneys who now have almost no time to file suit unless they determine that the statute of limitations will be tolled for the exhausted claimant. As most participants exhaust administrative remedies without attorney representation, the reality of a "reasonableness" approach will create unacceptable consequences for claimants who must be protected by a procedure that gives them ready access to the courts in the event of a wrongful benefit denial. After all, the E in ERISA stands for Employee.

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CONCLUSION

For the foregoing reasons, United Policyholders urges the Court to reverse the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

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