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NO. 02-469

In The
Supreme Court of the United States
October Term, 2002

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE ERISA INDUSTRY COMMITTEE AS AMICUS CURIAE IN SUPPORT OF PETITONER

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QUESTION PRESENTED

Whether the Ninth Circuit erred in holding that an ERISA disability plan administrator's determination of disability is subject to the "treating physician rule" and, therefore, the plan administrator is required to accept a treating physician's opinion of disability as controlling unless he rebuts that opinion based upon substantial evidence on the record.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

FEDERAL CASES

STATE CASES

FEDERAL STATUTES & REGULATIONS

MISCELLANEOUS

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BRIEF OF THE ERISA INDUSTRY COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

The ERISA Industry Committee ("ERIC") respectfully submits this brief *amicus curiae* in support of petitioner Black & Decker Disability Plan. Letters from

petitioner and respondent indicating consent to file have been filed with the Clerk. [1]

INTEREST OF AMICUS CURIAE

ERIC is a nonprofit organization representing America's largest private employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans, providing benefits to millions of active workers, retired persons, and their families nationwide. All of ERIC's members do business in more than one State, and many have employees in all fifty States. ERIC frequently participates as amicus in cases with the potential for far-reaching effect on employee benefit plan design or administration.[2]

ERIC and its members have a vital interest in this case, which imports into the disability plans administered by private employers the "treating physician rule" used in determining disability claims under Titles II and XVI of the Social Security Act. That holding deprives employers of the discretion afforded them under ERISA with respect to plan design and plan administration and, if upheld, will cause additional expense in the administration of plans, to the

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[1] Pursuant to Rule 37.6, amicus states that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than ERIC and its members, made a monetary contribution to the preparation or submission of this brief.

[2] *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

detriment of both the employers and employees whose contributions fund them.[3]

Because of the importance of these issues to ERIC and its members, ERIC respectfully submits this brief urging the Court to reverse the decision below and reject application of the treating physician rule to ERISA disability determinations.

SUMMARY OF ARGUMENT

While both the Employee Retirement Income Security Act ("ERISA") and the Social Security Act involve disability programs subject to federal court review, their statutory and regulatory schemes are by no means interchangeable, and the procedures that apply to one are inappropriate for the other.

ERISA governs the design and administration of pension and welfare plans established by employers for their employees. ERISA does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink,* 517 U.S. 882, 885 (1996). ERISA does, however, promise "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." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to that statutory provision, the Department of Labor recently completed a major review and overhaul of

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[3] These costs are not borne solely by employers. Because of the favorable tax consequences to benefit recipients, many disability plans are funded through after-tax employee contributions. *See* Ken McDonnell, *Disability Income: Voluntary Employment-Based Plans* 9 (EBRI Notes June 2002).

its regulations governing claims procedures for group health and disability plans, including the process for review of adverse benefit determinations and the need for medical consultations. Those regulations strive to reconcile "the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000). The newly promulgated rules do call for consultation with medical professionals in certain circumstances but nowhere require plans to defer to a claimant's treating physician.

The "treating physician" rule that the Ninth Circuit imposed on the ERISA plan below appears to be based on that used in making disability determinations under the Social Security Act. That rule was adopted by the Social Security Administration upon injunction from the U.S. Court of Appeals for the Second Circuit and is premised on the Act being "a remedial statute, to be broadly construed and liberally applied." *Gold v. Secretary of Health, Educ. and Welfare*, 463 F.2d 38, 41 (2d Cir. 1972) (quoting *Haberman v. Finch*, 418 F.2d 664, 667 (2d Cir. 1969)); *Schisler v. Sullivan,* 3 F.3d 563, 567-68 (2d Cir. 1993) (reciting history). The Social Security regulations gives the opinion of the claimant's treating physician controlling weight unless rebutted by substantial evidence in the case record. In a variant of that rule, the court below held that a plan administrator could depart from the opinion of the treating physician only by giving "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord v. Black & Decker*, 296 F.3d 823, 831 (9th Cir. 2002).

The treating physician rule adopted by the court below has the effect of transferring the burden of persuasion from the claimant to the plan administrator, and it has generally not been considered to be appropriate outside of the massive disability insurance programs administered by the Social Security Administration. Courts have rejected its

application to reviews of claims for Medicaid or veterans benefits, for example, and it likewise should be rejected here. The ERISA regulatory regime already imposes on plan administrators a fiduciary obligation to participants and beneficiaries and puts in place procedures to ensure plan participants a full and fair review of any disability determination that makes the remedial presumptions of the treating physician rule both unnecessary and out of place.

ARGUMENT

I. The Treating Physician Rule Has No Place In ERISA.

ERISA was enacted in 1974 to "safeguar[d] . . . the establishment, operation, and administration" of employee benefit plans by setting "minimum standards . . . assuring the equitable character of such plans and their financial soundness." 29 U.S.C. 1001(a). The statute does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink,* 517 U.S. 882, 885 (1996); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court addressed the standard of review for actions, such as this one, in which a plan participant brings suit under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), claiming that he has been denied benefits to which he is entitled under the terms of a plan governed by ERISA. Following trust law principles, the Court held that a deferential standard of review is appropriate when the plan administrator or other fiduciary is authorized to exercise discretionary power to construe the terms of the plan. *Id.* at 115. The Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as

a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

Although the plan in question gives discretion to the plan administrator in making disability determinations, the Ninth Circuit declined to review the decision under the abuse of discretion standard called for in *Firestone,* and instead concluded that it should review the administrator's decision *de novo* because the rejection of the opinion of respondent's treating physician was material evidence that the administrator's decision was colored by the "inherent conflict of interest" in Black & Decker's dual role "as the administrator and funding source for the plan." *Nord*, 296 F.3d at 829. Applying *de novo* review, the court also found that the departure from the treating physician's opinion was an abuse of discretion. The Ninth Circuit decision changes a denial of benefits review from a case in which the claimant must show an entitlement to benefits to one where the plan administrator bears the burden of establishing that the opinion of the treating physician is wrong. Nothing in the statute or the administrative regime it creates can support that result.

The overriding principle of ERISA is that benefits are governed by the language of the plan itself. *See Firestone*, 489 U.S. at 115. Requiring all employers to abide by the treating physician rule despite the uniqueness of each plan is precisely what ERISA is not intended to do. *See Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 732 (1985) (ERISA does not "regulate the substantive content of welfare-benefit plans."). ERISA neither contemplates nor requires a mandatory application of the treating physician rule. Rather, ERISA requires basic procedural safeguards in the determination of benefit plans and appeals. *See* 29 U.S.C. § 1133. In furtherance of that goal, Section 503 of ERISA delegates to the Department of Labor the authority to promulgate rules that will "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." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to Section 503, the Department of Labor recently overhauled the regulations governing the processing of benefit claims under ERISA-covered disability plans, effective for all claims filed after January 1, 2002. *See* 65 Fed. Reg. 70246 (Nov. 21, 2000). The new standards for handling disability claims are "intended and expected to improve the timeliness and accuracy of disability benefit claims determinations," "increase enrollee confidence in disability plans," and "promote efficiency in disability insurance and labor markets." *Id.* at 70261. As a general rule, an ERISA-covered disability plan must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." *Id.* at 70266.[4]

The new rules provide, among other things, that a claimant must have (i) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, upon request and free of charge; and (iii) a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without

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[4] The Department of Labor's interpretation of the proper balance between plan flexibility and required procedures is instructive, even though the particular claim at issue was processed prior to the new regulations being in effect.

regard to whether such information was submitted or considered in the initial benefit determination. 29 C.F.R. § 2560.503-1(h)(4).

In addition, claimants have the right to appeal an adverse benefit determination to an appropriate named fiduciary of the plan. If the determination is based "in whole or in part on a medical judgment," the fiduciary must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." A consulting health care professional cannot have been consulted in connection with the adverse benefit determination that is the subject of the appeal, nor be the subordinate of any such individual. 29 C.F.R. § 2560.503-1(h)(3)(iv-v).

Subsequent guidelines issued by the Department explain that the requirement of consultation "is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues." The guidelines go on to state that "[i]n all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, *weighing the advice and information so obtained*, and making an *independent* decision on the appeal." Benefit Claims Procedure Regulations Frequently Asked Questions, U.S. Dept. of Labor Q-D8 (visited February 20, 2003), <http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html> ("hereinafter "BCPR FAQ") (emphasis added).

The Department has concluded that its regulation strikes the appropriate balance between the need for "accuracy," "enrollee confidence in disability plans," and "efficiency in disability insurance prescribe and labor markets." 65 Fed. Reg. at 70261. As its subsequent guidance explains:

> The Department did not intend to *any particular process or safeguard* to ensure and verify consistent decision making by plans. To the contrary, the Department intended to *preserve the greatest flexibility possible* for designing and operating claims processing systems consistent with the prudent administration of a plan.

BCPR FAQ, *supra*, Q-B4 (emphasis added).

Contrary to this intent to preserve the "greatest flexibility possible," the Ninth Circuit has prescribed a specific and "particular process" that ERISA plans must follow in making disability determinations. According to the court, a plan administrator must accept the opinion of the treating physician unless it gives "specific, legitimate reasons for doing so that are based on substantial evidence in the record." 296 F.3d at 831. The articulation of that rule is a more stringent variation of the treating physician rule followed by the Social Security Administration in making disability determinations under its Disability Insurance ("SSDI") and Supplemental Security Income ("SSI") programs, which gives "a treating source's opinion on the issue(s) of the nature and severity of [the] impairment(s)" if that opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2).

The court below justified its importation of the treating physician rule into ERISA on the theory that plan administrators faced a conflict of interest in reviewing disability claims. But plan administrators and fiduciaries that make disability determinations are bound to discharge their duties solely in the interest of participants and beneficiaries. 29 U.S.C. § 1004(a). In exercising those responsibilities, among other things, employers and

employees called upon to make or review benefit determinations must follow the claims procedures established by the Department of Labor. They must ensure that plan provisions are "applied consistently with respect to similarly situated claimants," provide for several levels of review, and at each level consult with appropriate health care professionals. 29 C.F.R. § 2560.503-1(h)(3). The fiduciary must "weigh[] the advice and information so obtained" and make an "independent decision" on the determination. *See* BCPR FAQ, *supra*, Q-D8.

Even if the Ninth Circuit is correct that there is an inherent conflict of interest in an employer's dual role as the funding source and administrator of a disability plan--and putting aside the question of plans funded through assets that by definition cannot revert to the employer, as is frequently the case with employer-sponsored disability plans[5]--the Department of Labor has already taken account of that dual role by establishing detailed and specific claims procedures "to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents." 65 Fed. Reg. at 70266. In light of those required procedures, there is no vacuum that would make it appropriate for a court to fill in the gaps through federal common-law making, as the court did below. *Cf. Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56 (1987).

Available data also shows no evidence that there is any conflict of interest that impedes employers or plan administrators in the exercise of their fiduciary duties in making and reviewing determinations for disability benefits.

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[5] *See, e.g., Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270 (11th Cir. 2002); *Abnathya v. Hoffman-La Roche, Inc.,* 2 F.3d 40, 45 n. 5 (3d Cir. 1993); *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998).

According to the Department of Labor, 36 million U.S. private-sector employees (or 32 percent of all such employees) are insured against short-term disability through employer-sponsored plans, and 26 million (or 23 percent) are insured against long-term disability. 65 Fed. Reg. at 70261. The Department of Labor also estimates that there are some 1,716,000 disability plans operating in the United States, and that together they process 1,389,700 claims a year, of which the overwhelming majority (1,304,900) are approved. *Id.* at 70263.

By contrast, in calendar year 2001, approximately 1.5 million claims for SSDI disability benefits were filed, with benefits being awarded in only 46.1 percent of cases. *See* Selected Data from Social Security's Disability Program (visited February 20, 2003) <http:// www.ssa.gov/ OACT/STATS/table6c7.html>. In the same year, there were approximately 1.5 million new applications and only 665,000 new entrants for SSI benefits based on blindness or disability. 2002 SSI Annual Report (visited Feb. 20, 2003) <http://www.ssa.gov/OACT/SSIR/SSI02/Participants_1.html .21334>.

The court below was simply incorrect in its assumption that that the treating physician rule is equally at home in all manner of disability determinations. In a similar context, the New York Court of Appeals held that application of the treating physician rule would be inappropriate in the Medicaid program because that program "confers broad discretion on participating States to determine the extent of services provided." *See Kuppersmith v. Dowling*, 710 N.E.2d 660, 662 (N.Y. 1999). Accordingly, the court rejected a class challenge to State Medicaid regulations on the ground that they did not accord sufficient weight to treating physicians' assessment of the scope of home health care services that must be provided in specific cases.

Likewise, in *White v. Principi*, 243 F.3d 1378, 1379 (Fed. Cir. 2001), the Federal Circuit rejected the argument that the Court of Appeals for Veterans Claims had "erred as a matter of law when it failed to adopt the 'treating physician' rule, which would require that additional evidentiary weight be given to the opinion of a physician who had treated her husband." The Federal Circuit found that the treating physician rule was "specifically designed" to address conflicts of opinion inherent in the Social Security disability determination process. *See id.* at 1380. Moreover, the court found that while the treating physician rule was consistent with the statutory scheme of Social Security, according additional weight to any one factor may conflict with a statute providing that Veterans Benefits determinations should be made on the basis of entire record. *See id.* at 1381 (citing 38 U.S.C. § 7104(a)). *See also Knudsen v. Department of Health and Human Servs.*, No. 90-2067V, 1992 WL 395631, at *6-*7 (Fed. Cl. Dec. 17, 1992) (holding that treating physician rule conflicts with National Vaccine Injury Compensation Program regulations requiring fact finder to consider entire record).

There is no room in ERISA for the treating physician rule. While its application may be appropriate for the massive Social Security disability insurance programs, which are "to be broadly construed and liberally applied," *Gold v. Secretary of HEW*, 463 F.2d 38, 41 (2d Cir. 1972), it is completely out of place under ERISA. As acknowledged in the rules for claims procedures, ERISA accords employers a great deal of flexibility to design their own plans, *see, e.g., Lockheed*, 517 U.S. at 885, but also imposes fiduciary obligations on the administrators of those plans to administer the plans fairly and consistently.

In sum, contrary to the decision below, it is neither "material evidence" of a conflict of interest or an abuse of discretion for a plan administrator to question or reject the opinion of a treating physician on the basis of other evidence

in the case record as a whole, and the opinion below should be reversed accordingly.

CONCLUSION

For all of these reasons, as well as those set forth in the brief for petitioner, amicus respectfully urges the Court to reverse the decision below.

Respectfully submitted,

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