No. 02-469

In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

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

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND THE MICHIGAN MANUFACTURERS ASSOCIATION ON THE MERITS IN SUPPORT OF THE BLACK & DECKER DISABILITY BENEFITS PLAN

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INTEREST OF THE *AMICI CURIAE*[1]

The National Association of Manufacturers ("NAM") is the nation's largest industrial trade organization. NAM represents 14,000 members, including 10,000 small and mid-sized companies, and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

The Michigan Manufacturers Association ("MMA") is a business association composed of 3,000 private Michigan businesses. An important aspect of MMA's activities is representing the interests of its member-companies in matters of paramount importance before the courts, the United States Congress, the Michigan Legislature, and governmental agencies. MMA appears before this Court as a representative of private business concerns employing over 90% of the industrial work force in Michigan – over one million employees – many of whom are affected by the issues in the case presently before the Court.

Members of the NAM and MMA provide disability benefits to their employees under disability plans similar to the plan at issue before the Court. Like the employer in the case before the Court, these members are frequently both the sponsor and the administrator of their employee benefit plans. As plan administrators, they are keenly aware of

[1] Pursuant to Rule 37.6, (1) counsel for a party to this case has not authored this brief in whole or in part, and (2) no person or entity other than the *amici curiae* listed above has made a monetary contribution to the preparation of submission of this brief. Pursuant to Rule 37.3(a), *amici curiae* have received written consent of all parties to file this brief.

their fiduciary responsibilities under ERISA and its regulations. The NAM and MMA submit this brief *amici curiae* in support of The Black & Decker Disability Benefits Plan to focus the Court's attention on the irreconcilable conflict between ERISA's explicit statutory provisions for administrators/fiduciaries and the court of appeals' decision in this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Black & Decker Disability Benefits Plan ("Plan") provides benefits when the administrator determines, in its "sole and absolute discretion," that there is satisfactory medical evidence that the employee suffers from "the complete inability . . . to engage in his regular occupation with the Employer[.]"[2] Kenneth Nord applied for Plan benefits, contending that he was unable to perform his sedentary job. An independent neurologist examined Nord and concluded that he was able to perform sedentary work "with some walking interruptions."[3] After reviewing the independent neurologist's report and information submitted by Nord, including the conclusions of his treating physicians,[4] the Plan's third-party claims administrator

[2] *Nord v. The Black & Decker Disability Benefits Plan*, 296 F.3d 823, 826, n.1 and n.2 (9th Cir. 2002). This definition of disability applies to the first 30 months of Plan benefits, the benefits at issue in the case. *Id.*

[3] *Id.* at 830.

[4] In addition to medical evidence, Nord submitted answers to hypothetical questions that his attorney had posed to a human resources representative who worked at the same company that employed Nord. The Plan administrator discussed the responses with the human

(Continued on following page)

denied Nord's claim.[5] Nord appealed, and after a second review, the Plan administrator itself – the Black & Decker Corporation – concluded that Nord was ineligible for Plan benefits.[6] Nord then asked the United States District Court to award benefits. After reviewing the administrator's decision for abuse of discretion, the District Court upheld the denial, holding that it did not conflict with the Plan's terms and was not based on clearly erroneous factual findings.

Nord appealed to the United States Court of Appeals for the Ninth Circuit, which reviewed the administrator's decision *de novo*, reversed, and ordered payment of benefits. The court of appeals determined that *de novo* review was appropriate because the Plan administrator acted with an "inherent" conflict of interest and breached a fiduciary obligation to Nord. The court of appeals applied the so-called "treating physician rule" found in Social Security regulations and determined that Nord was entitled to Plan benefits, since the Plan administrator failed to demonstrate "substantial evidence" to overcome the treating physicians' conclusions that Nord was disabled. The Plan challenged the court of appeals' decision in a petition for certiorari, granted by this Court on January 10, 2003.

The National Association of Manufacturers and the Michigan Manufacturers Association, as *amici curiae*,

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resources representative during review of Nord's claim. *The Black & Decker Disability Benefits Plan's Petition for Writ of Certiorari*, pp. 5-7.

[5] *Id.* at 827.

[6] *Id.*

support the Plan's position that the court of appeals erred. The court of appeals' decision rests on three errors:

First, the court of appeals wrongly assumed that there is an "inherent conflict of interest" between an employer serving as administrator of a benefit plan and an individual seeking plan benefits. This assumption, which directly conflicts with ERISA's provision that the funding sponsor is a proper plan administrator, led the court to second-guess the administrator's decision.

Second, the court of appeals wrongly assumed that the administrator breached a fiduciary duty to Nord by not applying the so-called "treating physician rule," thereby triggering *de novo* review of the administrator's decision. The alleged "breach" is not a violation of ERISA or its regulations. Instead, the administrator acted as a proper ERISA fiduciary should – for the benefit of the Plan as a whole, following Plan terms.

Third, the court of appeals erroneously applied the "treating physician rule" to ERISA-governed benefits. This rule interferes with the freedom of contract preserved under ERISA, is inconsistent with regulations promulgated by the Department of Labor, and will most likely escalate the cost of providing disability benefits.

If these errors are not corrected, plan sponsors will no longer be free to design objective procedures for determining disability. They will be unfairly penalized for serving as administrators, and their administrative decisions will be continually challenged in court. Under these conditions, employers will be reluctant to provide disability benefits at all.

Amici curiae urge this Court to reverse the court of appeals on all three points, as set forth in detail below.

ARGUMENT

I. UNDER ERISA, THERE IS NO "INHERENT CONFLICT OF INTEREST" BETWEEN AN EMPLOYER SERVING AS PLAN ADMINISTRATOR AND AN INDIVIDUAL SEEKING BENEFITS.

The Ninth Circuit has only applied the so-called "treating physician rule" in cases where it was concerned that the administrator was acting under an "inherent conflict of interest" as the plan's sponsoring employer. *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130, 1142-1144 (9th Cir. 2001);[7] *Nord v. The Black & Decker Disability Benefits Plan*, 296 F.3d 823, 828 (9th Cir. 2002). It is evident that the court has imposed the "treating physician rule" in an attempt to counteract this perceived "inherent conflict." Although the court can legitimately consider whether the administrator acted with a "conflict of interest,"[8] ERISA makes clear that

[7] In *Regula*, the court of appeals raised the "conflict of interest" issue *sua sponte*, finding "the apparent existence of a conflict" and remanding "for a proper determination as to the administrator's impairment due to a conflict of interest." *Regula*, 266 F.3d at 1144.

[8] This Court has commented 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.' " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting Restatement (Second) of Trusts § 187, Comment *d* (1959)).

the "conflict" that triggered the court of appeals' concern in *Regula* and *Nord* simply does not exist.

The court of appeals correctly noted that the Plan administrator is a "fiduciary" under ERISA's definition of that term.[9] The court of appeals then assumed, without any statutory analysis, that the common law of trusts defines the scope of the ERISA fiduciary's "conflict of interest." Relying on the common law of trusts,[10] the court of appeals held that, as the employer who funded the plan, the administrator had "an inherent conflict of interest" that could amount to a breach of fiduciary duty to Nord.[11]

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[9] The concept of a fiduciary dates back to Roman times, and there is a considerable amount of common-law jurisprudence related to fiduciaries. *Cf.* definition of "fiduciary" in *Black's Law Dictionary* 625 (6th Ed. 1990). ERISA, however, supplies its own definition of the term "fiduciary" that is somewhat different than common law. 29 U.S.C. § 1002(21)(A). The statute also contains lengthy provisions establishing the proper role and responsibilities of an ERISA fiduciary. *See* 29 U.S.C. § 1104 (imposing a prudent person standard and requiring the fiduciary to act with respect to a plan solely in the interests of participants and beneficiaries); § 1106 (prohibiting types of self-dealing between the plan and defined "parties in interest"); § 1108(c)(2) (prohibiting additional compensation for fiduciaries who are full-time employees of unions or employers).

[10] *Nord* referred vaguely to the common law of trusts without identifying the particular source of this "common law." *Nord* relied on the Ninth Circuit case, *Lang v. Long-Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997). *Lang*, in turn, relied upon *Brown v. Blue Cross & Blue Shield of Alabama, Inc.* 898 F.2d 1556, 1561-67 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (concluding that certain ERISA plans are not "true trusts" under common law and are, therefore, entitled to "less" deference).

[11] *Nord*, 296 F.3d at 828-829. In fact, the employer's administrative duties had been delegated to a third-party administrator, Metropolitan Life Insurance Company. The court of appeals held, without any legal or factual support, that the third-party administrator acted as the

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Finding this "inherent conflict of interest" was the first of two errors that led the court of appeals to review the administrator's decision *de novo*.[12]

But the common law of trusts is not controlling. Although ERISA requires plan administrators to follow fiduciary standards that are similar to the common law of trusts, Congress expected courts to interpret ERISA's standards "bearing in mind the special nature and purpose of employee benefit plans." *Varity v. Howe,* 516 U.S. 489,

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agent of the employer and so also "was operating under an inherent conflict of interest." *Id.*

[12] When a benefit plan gives its administrator discretion to determine eligibility, as the Plan did in this case, *Nord*, 296 F.3d at 826, the administrator's decision is entitled to deference, and the court reviews the decision for an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The deferential standard ensures that the administrator's decision will be upheld if it was rational and consistent with the terms of the benefit plan. *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989), *cert. denied*, 495 U.S. 905 (1990). But where there is evidence that the administrator acted under an actual conflict of interest, the courts have weighed the conflict as one factor to be considered upon review, usually still according some deference to the administrator. The different circuits have different approaches to determining the standard of review when the plan administrator has a conflict of interest. Compare *Sullivan v. LTV Aerospace and Defense Co.,* 82 F.3d 1251, 1255-56 (2nd Cir. 1996) (applying a test following Section 187 of the Restatement (Second) of Trusts) with *Brown v. Blue Cross and Blue Shield of Alabama, Inc.* 898 F.2d 1157, 1566-67 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (utilizing a burden-shifting approach that favors the plan participant). In this case, it is unnecessary to determine the precise test to apply, since the court of appeals found a "conflict" where none was actually present.

497 (1996) (quoting H.R. Conf. Rep. No. 93-1280, pp. 295, 302 (1974), 3 Leg. Hist. 4562, 4569). Thus, "the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA's fiduciary duties." *Varity*, 516 U.S. at 498. While trust law offers a "starting point, . . . courts must go on to ask whether, or to what extent, the language of [ERISA], its structure, or its purposes require departing from common-law trust requirements." *Id.* If it is incongruent with ERISA, then the common law of trusts simply does not apply.[13]

Examining the statute itself shows that Congress saw no inherent conflict of interest in allowing the plan sponsor – usually the employer – to administer plan benefits. Congress specifically provided that the plan sponsor would be the plan administrator, unless the plan expressly appoints a different entity. *See* 29 U.S.C. § 1002(16)(A).[14] In so doing, Congress knew full well that the plan sponsor

[13] *See Mertins v. Hewitt Associates*, 508 U.S. 248, 261-263 (1993) (pointing out that ERISA's definition of fiduciary differs from that of common law and strictly applying the statute despite the argument that strict construction eliminated remedies available under common law).

[14] Indeed, the term "sponsor," by definition, refers to the entity establishing and maintaining (i.e., funding) the plan. 29 U.S.C. § 1002(16)(A) provides:

> The term "administrator" means –
>
> (i) the person specifically so designated by the terms of the instrument under which the plan is operated;
>
> (ii) if an administrator is not so designated, the plan sponsor; or
>
> (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

funds the benefits (*see* 29 U.S.C. § 1002(16)(B)),[15] but did not view funding as an inherent conflict of interest. Indeed, ERISA expressly permits the employer to serve as plan administrator, although this arrangement might be prohibited under the common law of trusts. *Varity*, 516 U.S. at 498.

The National Association of Manufacturers and the Michigan Manufacturers Association urge this Court to correct the court of appeals' erroneous determination that there is an "inherent" conflict of interest present whenever the funding employer serves as plan administrator.

II. THE COURT OF APPEALS ERRED BY FINDING A "BREACH" OF A "FIDUCIARY DUTY" THAT DOES NOT EXIST UNDER ERISA.

Generally, the courts agree that if the administrator/fiduciary acts under a conflict of interest, the conflict is one factor considered upon review of the administrator/fiduciary's decision.[16] In contrast, the Ninth Circuit

[15] 29 U.S.C. § 1002(16)(B) provides, in relevant part:

> The term "plan sponsor" means:
>
> (i) the employer in the case of an employee benefit plan established or maintained by a single employer,
>
> (ii) the employee organization in the case of a plan established or maintained by an employee organization, or
>
> (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

[16] *See* n.12.

completely rescinds the administrator's discretion and conducts *de novo* review of the administrator's decision if it finds that the administrator breached a fiduciary duty "to the participant." *See Lang*, 125 F.3d 794, 798 (applying *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323-24 (9th Cir. 1995)). Here, the court of appeals determined that there was actual evidence "that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary."[17] The "evidence" of the "breach" was not a violation of ERISA, its regulations, or the terms of the plan. Instead, it consisted of the administrator's "failure" to apply the so-called "treating physician rule" – a "rule" that is not found in ERISA, its regulations, or the plan's terms, and did not apply to ERISA plans when the administrator decided Nord's claim.[18] For a second time, the court of appeals improperly analyzed the issue by failing to consider the statute and its regulations.

The court of appeals began with the incorrect assumption that the administrator's "fiduciary obligation to the beneficiary" is called into question when the administrator denies benefits.[19] This focus on the *individual* beneficiary's interest is improper. Under ERISA, the administrator has fiduciary responsibility for the *plan as a whole* and for

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[17] *Nord*, 296 F.3d at 829.

[18] The "treating physician rule" was first applied to ERISA plans in *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), long after the Plan administrator denied Nord's appeal on October 27, 1998. *See Nord*, 296 F.3d at 827.

[19] The court of appeals stated that it must determine whether "the affected beneficiary" provided evidence showing "that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations *to the beneficiary*." *Nord*, 296 F.3d 823, 829 (emphasis added).

participants and beneficiaries *as a group*. 29 U.S.C. § 1104(a)(1)(A).[20] This Court analyzed the detailed statutory provisions for ERISA fiduciaries, and the legislative history, and concluded that under ERISA, the fiduciary relationship exists between the fiduciary and the plan, not the individual participant. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) (rejecting proposition that individual participant may recover damages based upon administrator's breach of fiduciary duty in processing claim for benefits). This distinction is important, because the individual's interests may be at odds with the interests of the plan as a whole. For example, awarding benefits to an ineligible individual serves the individual's interests, but harms the plan's interests, since the plan is designed to limit benefits to eligible individuals and must conserve resources for those who truly qualify under the plan. *See* E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 Tenn. L. Rev. 511, 523-526 (1998) (pointing out that courts often confuse conflicts of interest that affect the benefit plan with conflicts of interest that affect an individual participant).

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[20] 29 U.S.C. § 1104(a) provides, in relevant part:

> (1) . . . a fiduciary shall discharge his duties with respect to the plan solely in the interests of the participants and beneficiaries and –
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan [.]

Since the fiduciary's responsibility is to the plan, and since ERISA requires fiduciaries to follow "the documents and instruments governing the plan,"[21] the administrator's actions must be evaluated in light of the plan's terms. Plan terms are critical because eligibility for disability benefits depends entirely upon the provisions of the particular plan; ERISA does not govern a disability plan's substantive content. *Massachusetts Mut. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). Yet the court of appeals virtually ignored the Plan in *Nord*, relegating its controlling provisions to footnotes in the "Factual and Procedural Background" portion of the opinion, without further discussion.[22] This disregard of Plan terms is consistent with the Ninth Circuit's astonishing and unprecedented assertion in *Regula* that "we reject the view that disability determinations under ERISA are determined almost exclusively by plan language[.]" *Regula*, 266 F.3d 1130 at 1140.

Ignoring the Plan's terms and the administrator's statutory duty to follow the terms, the court of appeals accuses the administrator of violating its fiduciary

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[21] 29 U.S.C. § 1104 provides, in relevant part:

> (a) Prudent man standard of care.
>
> (1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –
>
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

[22] *See Nord,* 296 F.3d at 826, n.1 and n.2.

responsibility (to Nord) by "reject[ing] . . . the conclusion of its own human resources representative . . . [who] opined that Nord was unable, due to his medical condition, to perform the functions" of his job."[23] The court of appeals attacked the administrator as "high-handed" for "contradict[ing]" the human resource representative's opinion. This criticism is entirely unwarranted: under the Plan's terms, the administrator must determine disability by reviewing "suitable *medical* evidence" and "the Participant's prior employment history."[24] The human resources representative's responses to hypothetical questions posed by Nord's attorney are not "medical evidence" or "prior employment history" and, therefore, were properly excluded under the Plan's own terms.

The court of appeals also accused the administrator of violating fiduciary responsibility (to Nord) by rejecting "the prevailing opinions of Nord's treating physicians," holding that "under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator 'gives specific, legitimate reasons for doing so that are based upon substantial evidence in the record.' "[25] The "treating physician rule" is not a Plan term and is not a part of the Plan's procedure for determining benefit eligibility. The Plan never suggests that the treating physician's opinion is entitled to deference; instead, the Plan instructs the administrator to consider "suitable medical evidence and a review of the

[23] *Nord,* 296 F.3d at 830.

[24] *Nord*, 296 F.3d at 826, n.1.

[25] *Nord,* 296 F.3d at 830-831 (quoting Social Security case, *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)).

Participant's employment history" and gives the administrator "sole and absolute discretion" to determine which medical evidence is satisfactory.[26] Accordingly, the administrator simply cannot apply the "treating physician rule" without shirking its ERISA fiduciary responsibilities to follow Plan documents and protect the integrity of the Plan.

III. UNDER ERISA, THE ADMINISTRATOR'S DECISION MUST CONFORM TO THE PLAN'S TERMS, THE STATUTE, AND THE APPLICABLE REGULATIONS – NOT THE OPINION OF THE TREATING PHYSICIAN.

The court of appeals held that *Nord* was controlled by its decision in *Regula*. In *Regula*, the court found that the "treating physician rule" used in Social Security Disability cases should apply to ERISA disability claims "for reasons having to do with common sense as well as consistency in our review of disability determinations where benefits are protected by federal law[.]" *Regula*, 266 F.3d 1130 at 1139. Without relying on ERISA, its regulations, or even the common law of trusts, *Regula* concludes that "[a] guiding principle such as the treating physician rule that is effective in helping plan administrators make fair and accurate disability determinations is consistent with [ERISA's] goal" of "protect[ing] the rights of participants and beneficiaries." *Regula*, 266 F.3d at 1143.

The court of appeals grossly over-simplified ERISA's purpose. ERISA is "an enormously complex and detailed statute that resolved innumerable disputes between

[26] *Nord,* 296 F.3d at 826, n.1.

powerful competing interests – not all in favor of potential plaintiffs." *Mertins v. Hewitt Associates*, 508 U.S. 248, 262 (1993). More importantly, "vague notions of a statute's 'basic purpose'" cannot overcome ERISA's explicit provisions, which resulted from a decade of congressional study of employer-sponsored benefits. *Id.* at 261 (quoting *Pension Benefit Guaranty Corp. v. LTV Corp.,* 496 U.S. 633, 646-647 (1990)) and 251. "The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute." *Id.* at 257 (internal citation omitted).

As this Court has often noted, ERISA preserves the autonomy of employers and employees to negotiate whether health or disability benefits will be provided at all and allows them to set the terms and conditions of those benefits. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) ("ERISA does not mandate that employers provide any particular benefits"); *Massachusetts Mut. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 at 732 (ERISA "does not regulate the substantive content of welfare-benefit plans"); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (Congress deliberately did not create any substantive entitlement to employer-sponsored health or disability benefits, leaving "employers . . . generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans").

Employers chose plan terms carefully to restrict benefits to those who are truly unable to perform work, avoiding provisions that allow malingerers to refuse to return to work. By grafting Social Security's "treating physician rule" onto ERISA, the court of appeals disrupts the freedom to contract for benefits that Congress so carefully preserved in the statute. Regardless of the terms

chosen by the plan's sponsor, the rule of *Regula* and *Nord* now imposes a presumption that disability benefits must be paid if the treating physician concludes that disability exists; allocate the burden of overcoming the treating physician's conclusion to the administrator; and set the level of proof that an administrator must satisfy in order to deny benefits. Since the treating physician will generally advocate on the patient's behalf and find disability,[27] and since the rule fails to provide clear instruction for obtaining "substantial evidence" to overcome the treater's conclusion, the administrator is faced with the unpleasant task of awarding benefits in cases where the plan never intended benefits be paid.

Although the Department of Labor is empowered by ERISA to promulgate *procedural* – not substantive – regulations for administrative claim review,[28] the

[27] The American Medical Association's ethical guidelines for the treating physician require the physician to advocate on behalf of the patient when dealing with third parties. *American Medical Association Code of Ethics, E-10.01, Patient-Physician Relationship In General,* (6) (July 15, 2002). In contrast, physicians performing an independent medical examination have an ethical duty to evaluate the patient's health or disability "objectively." *Id.*, *E-10.03, Patient-Physician Relationship in the Context of Work and Independent Medical Examinations*, (1) (July 17, 2002).

[28] 29 U.S.C. § 1133 provides:

> Claims procedure
>
> In accordance with regulations of the Secretary, every employee benefit plan shall –
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

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regulations it has issued do not affect the sponsor's freedom of contract or the substantive provisions of a plan. *See* 29 C.F.R. §§ 2560.503-1(h). The regulations do not disturb the plan's ability to allocate the burden of proof to the individual seeking benefits and do not establish a presumption that the individual's treating physician's conclusion is entitled to deference.

In stark contrast to ERISA-governed disability benefits, Social Security disability benefits are a *public entitlement* established by Congress for workers and their eligible dependants. *See Mathews v. Eldridge,* 424 U.S. 319, 323, n.1, and 336 (1976). These benefits are funded by taxes and administered by state and federal agencies following detailed standards and procedures developed by the Secretary of Health and Human Services. *Id.* at 335-336. A determination of disability by the Social Security Administration ("SSA") does not take into account detailed, workplace-specific matters such as whether the individual could perform his or her job with a reasonable accommodation. *Cleveland v. Policy Management Sys. Corp.*, 526 U.S. 795, 803 (1999). Because the SSA must process more than 2.5 million disability claims each year on limited administrative resources, it relies on a set of regulatory presumptions that "inevitably simplify, eliminating consideration of many differences potentially relevant to an individual's ability to perform a particular job." *Id.* at 804. Thus, Social Security disability benefits

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(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.

may be granted to an individual who still "remain[s] capable of 'performing the essential functions' of her job." *Id.*

The presumptions followed by the SSA, including the treating physician rule, have no place in The Black & Decker Disability Benefits Plan. The Plan was designed to provide benefits only to an employee with "the complete inability . . . to engage in his regular occupation with the Employer." If an employee can perform the job with reasonable accommodation, such as the "walking interruption" that the neurologist found would allow Nord to perform his job, then by its terms, the Plan does not provide benefits.[29]

If the treating physician rule is upheld in this case, the court of appeals' misguided attempt to help disability claimants will ultimately cause a significant reduction in the number of employers who choose to offer employees this benefit. The administrative uncertainty created by the rule will discourage employers from offering disability benefits. *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (recognizing that in creating ERISA, Congress attempted to balance desire to offer employees enhanced benefit protection against the burden of a system whose administrative costs or litigation expenses would unduly discourage employers from offering the benefit in the first place).

[29] *Nord*, 296 F.3d at 826, n.1 and 830.

CONCLUSION

This Court should overturn the decision of the Court of Appeals for the Ninth Circuit and remand this case for entry of a decision consistent with this Court's opinion.

Respectfully submitted,

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