No. 02-469

In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH C. NORD,

Respondent.

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

BRIEF AMICI CURIAE ON BEHALF OF PEABODY ENERGY CORPORATION, OLD REPUBLIC INSURANCE COMPANY AND SIGNAL MUTUAL INDEMNITY ASSOCIATION, LTD. IN SUPPORT OF PETITIONER

MARK E. SOLOMONS
Counsel of Record
LAURA METCOFF KLAUS
GREENBERG TRAURIG LLP
Suite 500
800 Connecticut Ave., N.W.
Washington, D.C. 20006
(202) 553-2361

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES:

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

INTEREST OF AMICI[1]

Peabody Energy Corporation ("Peabody") is the largest investor-owned coal producer in the world, providing coal for the generation of 9% of all electricity produced in the United States in 2001, and 2.5% of all electricity produced in the world for that year. Peabody owns and operates coal mines in nine states, including states within the jurisdiction of the Fourth, Sixth, Seventh and Ninth Circuits. Many of Peabody's 6,500 employees participate in employee benefit plans subject to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ("ERISA"). Like petitioner Black & Decker, Peabody now is subject to inconsistent rules for establishing the appropriate weight to be accorded treating doctors in disability claims submitted under company-sponsored employee benefit plans.

Many of Peabody's employees are employed in the production and transportation of coal. Peabody and its coal production employees are subject to the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("BLBA") and some employees are covered under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901-950 ("LHWCA"). Peabody has filed two petitions for a writ of certiorari to challenge the Sixth Circuit's treating doctor preference or presumption in black lung benefit claims. *Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3154 (Aug. 17, 2002) (U.S. No. 02-249), *petition for reh. filed*; *Gray v. Peabody*

[1] Counsel for amici are the sole authors of this brief. Amici are the sole contributors to the cost of this brief. The parties' written consent to file this brief have been submitted to the Court.

Coal Co., 35 Fed. Appx. 138 (6th Cir. 2002) (unpublished), *petition for cert. filed*, 71 U.S.L.W. 3319 (U.S. Oct. 17, 2002) (No. 02-585).

Peabody also pays tens of millions of dollars annually into the Black Lung Disability Trust Fund. *See* 26 U.S.C. § 4121. This Trust Fund pays benefits in black lung claims for which no mine operator or insurer is directly liable under the BLBA. 30 U.S.C. § 934. The substantial relaxation of benefit eligibility criteria attributable to a treating doctor rule increases Peabody's liability to the Trust Fund over time and eventually will extend the life of the excise tax that funds the Trust for an unknown but significant period of years. *See* 26 U.S.C. §§ 4121, 9501.

The Old Republic Insurance Company ("Old Republic"), a subsidiary of the Old Republic International Corporation, is a commercial insurance carrier licensed in most coal mining states to insure the workers' compensation liability of mine operators under the BLBA. For many years, Old Republic was the principal servicing carrier for the National Worker's Compensation Reinsurance Pool and various states' residual market pools in coal mining states allowing private workers' compensation insurance. Old Republic has received over 35,000 federal black lung claims since 1974, as a direct insurer, residual market servicing carrier and third party administrator. Thousands of previously filed claims remain active and thousands more are anticipated in coming years. Old Republic also is co-petitioner in *Jericol Mining, Inc. v. Napier*, 301 F.3d 703 (6th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3401 (U.S. Nov. 27, 2002) (No. 02-834), a case that challenges the Sixth Circuit's treating doctor rule for black lung claims. Hundreds of other pending cases surely will

involve a determination by the adjudicator whether to rely on a treating doctor preference.

Signal Mutual Indemnity Association Limited is a not-for-profit group self-insurance facility authorized by the U.S. Secretary of Labor to secure benefits payable to workers and their families under the LHWCA, and its extensions. Signal's members include over 200 employers subject to the LHWCA, including stevedores, terminal operators, shipbuilders, ship and container repairers, offshore drilling and marine construction companies.

The LHWCA establishes the general rules of evidence and procedure for the adjudication of both LHWCA and BLBA claims. 33 U.S.C. §§ 919-21, *incorporated by reference into* 30 U.S.C. § 932(a).

INTRODUCTION AND SUMMARY OF ARGUMENT

There is no good and valid treating doctor rule which adds evidentiary weight for the doctor's status. Parties to disputes, however they are judged, universally expect that equal standards will apply to all proof and that conflicts in that proof will be resolved for good and fair reasons. Our system of justice, in part, earns the confidence and respect of the people who call upon it by meeting those expectations. A system that perpetuates demonstrably false rules, rules that divert attention from the truth-seeking function of the adjudication, and rules that we all know cheat the truth are unacceptable. Treating doctor rules, in whatever form they take, always cheat the truth.

A treating doctor rule may be dressed up in "criteria" like SSA's rules[2] and the Department of Labor's ("DOL") black lung regulations,[3] or it may reflect a simple *per se* preference like the Ninth Circuit's ERISA rule under review here. In either case, there is no doubt about the purpose of the rule. Its purpose is to enhance the weight of a treating doctor's opinion when that opinion or testimony does not merit more weight because it is more persuasive, better reasoned and best documented by medical data. Its principal purpose is to accord weight because of the doctor's status as the treating physician. The principal consequence of applying a treating doctor rule is to down-grade better evidence.

All treating doctor rules are predicated on a judicial belief that treating doctors, even in this age of modern technology, gain special insight and enhanced powers of understanding by having treated a patient. If that belief were true and a physician's report or testimony reflected superior understanding that withstood cross-examination, then the treating doctor's opinion would merit the most weight whether or not a treating doctor preference was in force. The rule applies, therefore, only when the treating doctor's opinion is undermined by other relevant evidence and it works its magic by elevating evidence of lesser persuasion. It is not surprising that litigants on the losing end of any dispute decided because of a treating doctor preference feel unfairly prejudice.

---

[2] 20 C.F.R. §§ 404.1527(d), 416.927(d).

[3] 20 C.F.R. § 718.104(d).

A rule with the power to control the outcome of large numbers of adjudications that is predicated on scientific or medical assumptions must have those assumptions tested before the rule is approved. If the rule fails the test, this Court's precedents preclude its use. The treating doctor rule is not supported by good or any science. It is a pernicious, outcome-determinative rule that exaggerates the significance of certain proof without any valid foundation. It undermines the adjudicator's gatekeeper function and casts doubt on the integrity of the adjudication in which the rule is invoked. It defies ordinary appellate review.

No treating physician rule should survive review by this Court.

ARGUMENT

1. A Treating Physician Rule Is Scientifically Unsupported

In *Teeter v. Flemming*, 270 F.2d 871, 874-5 (7th Cir. 1959), the Seventh Circuit reached the unremarkable conclusion that an SSA disability benefit applicant's treating physician's report is admissible evidence and where uncontroverted, should be credited. This seems to be the origin of the treating physician rule. A few years later, an Indiana federal district court added a new word to the *Teeter* rule. The Indiana court held that the treating physician's report was "binding" if not controverted. *Walker v. Gardner*, 266 F.Supp. 998, 1002 (S.D. Ind. 1967). Neither case engages in a discussion of the significance of being a treating doctor and in both cases, the focus is on the presence of uncontradicted medical evidence, not on

the treating doctor status of the witness offering the opinion.

Relying on *Teeter* and *Walker*, the Second Circuit almost unintentionally launched a true treating doctor preference in *Gold v. Sec'y of Health, Ed. & Welfare*, 463 F.2d 38, 42 (2d Cir. 1972). Minnie Gold was a Holocaust survivor who never made more than $1,403 annually. During her years in hiding from Nazi occupation, she contracted tuberculosis. After a life of hardship and struggle, her earlier affliction led to a disabling lung disease. SSA denied her claim and the district court upheld the denial. The Second Circuit reversed, citing *Teeter* and *Walker*, and held that supportive treating physicians' reports addressing a patient's disability are "binding if not controverted by substantial evidence to the contrary." *Id.* That the supportive evidence was supplied by treating doctors seem coincidental.

Although the Seventh Circuit later repudiated its so-called treating doctor rule in *Cummins v. Schweiker*, 670 F.2d 81 (7th Cir. 1982), the Second Circuit embraced a powerful version of the rule. *See Schisler v. Bowen*, 851 F.2d 43, 47 (2d Cir. 1988). Later, a rationale for the rule was supplied. In upholding SSA's somewhat more modest regulations, the Second Circuit accorded deference to the agency rule in substitution for the circuit rule because it "continue[s] to give deference to the opinion of treating physicians based on the view that opinions based on a patient-physician relationship are more reliable than opinions based, say, solely on an examination for purposes of the disability proceedings themselves."

Schisler v. Sullivan, 3 F.3d 563, 568 (2d Cir. 1993). The source of the conclusion is not revealed.[4] Other reasons in support of the rule emerged over time. The Ninth Circuit observed "that deference to the opinion of the claimant's treating physician [is proper] because 'he is employed to cure and has greater opportunity to know and observe the patient as an individual.'" *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1140 (9th Cir. 2001), *petition for cert. filed*, 71 U.S.L.W. 3001 (U.S. No. 01-1840), *quoting Morgan v. Comm'r, SSA*, 169 F.3d 595, 600 (9th Cir. 1999).

In *Regula*, the Ninth Circuit applied the SSA rule to ERISA claims, reasoning that both were federally based disability programs and uniform standards made sense. *Regula*, 266 F.3d at 1140.[5] *Regula* does not test the validity of the treating doctor rule or clearly specify whether the Court is adopting the SSA regulation or the Second Circuit's "controlling weight" rule or something else. The court believed, simply, that in addition to the virtues of consistency, "common sense" supported the treating doctor preference. *Regula*, 266 F.3d at 1139.

---

[4] It is likely that the SSA regulation was motivated mostly by that agency's unwillingness to accept the Second Circuit's powerful treating doctor rule, and not to reflect any medically justified improvement in SSA's eligibility criteria.

[5] The circuits that have refused to import the SSA treating physician rule into ERISA cases are fairly dismissive in their reasoning and do not directly challenge the notions articulated in *Regula*. *See e.g.*, *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002); *Connors v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127, 136 n.4 (2d Cir. 2001); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-8 (4th Cir. 1999).

The Sixth Circuit then followed *Regula*, relying also on a recent black lung benefit decision and the premise that the treating doctor's knowledge and observation of the patient warrant deference. *Darland v. Fortis Benefits Insurance Co.*, 317 F.3d 516 (6th Cir. 2003) (*citing Peabody Coal Co. v. Groves*, 277 F.3d at 833-35).[6] The Sixth Circuit's first decision mandating a treating doctor rule for black lung claims relies on SSA's rule. *See Tussey v. Island Creek Coal Co.*, 982 F.2d 1036 (6th Cir. 1993) (citing SSA cases as authority for holding "it is clearly established that opinions of treating physicians are entitled to greater weight. . . . "). The Sixth Circuit looks also to DOL's new treating doctor regulation for guidance, whether or not the regulation applies to the particular case. *Groves*, 277 F.3d at 837. It is not clear whether the Sixth Circuit now intends to apply the SSA rule or the black lung rule or

[6] The Sixth Circuit black lung rule is a preference guided by DOL's new regulation roughly approximating the SSA regulation. Under DOL's regulation, the treating doctor's opinion is controlling not only with respect to the extent of disability, which might be enhanced by personal observation, but also with respect to diagnosis, determination of cause of death and occupational causation, none of which are even arguably enhanced by personal observation. *See e.g.*, *Wolf Creek Collieries v. Director, OWCP*, 298 F.3d 511 (6th Cir. 2002) (cause of death), *Groves*, 277 F.3d 829 (diagnosis of occupational disease). The DOL regulation directs the factfinder to consider the nature of the relationship, the duration of the relationship, the frequency of treatment, the extent of treatment and, lastly, the credibility of the physician's opinion. 20 C.F.R. § 718.104(d). The rule offers no guidance on how to apply the criteria or what weight each carries but it also provides that the treating doctor's status, *i.e.*, "the relationship between the miner and his physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight." *Id.* § 718.104(d)(5).

whether the court considers the two rules to be sufficiently similar that it is unnecessary to distinguish them.

As is the case in ERISA matters, several courts of appeals reject the Department of Labor's treating doctor preference. *Consolidation Coal Co. v. Held*, 314 F.3d 184, 187-88 (4th Cir. 2002) (rejecting the premise that a treating doctor's status merits special weight); *Peabody Coal Co. v. McCandless*, 255 F.3d 465, 469-70 (7th Cir. 2001) (holding that an ALJ must have a valid medical reason for according extra weight to a treating doctor's opinion).

The legacy of Minnie Gold, who surely deserved benefits and whose best evidence was only coincidentally supplied by treating doctors as well as others, is a fog of rules that provide little or no guidance to anyone. The rules now are more a result orientation[7] than they are sound and valid guidelines for adjudication. The one question that neither the Ninth Circuit, nor the Sixth Circuit, nor the Second Circuit seems concerned with is whether there is a valid medical rationale for any treating doctor preference. These courts are satisfied simply to accept their own medical judgments as sufficient. No

[7] The Sixth Circuit's decision in *Napier* is instructive. There, the Court held that the ALJ had no valid reason to give more credit to the treating doctor, but then affirmed an award of benefits, finding that the ALJ's decision was supported by substantial evidence. In this sleight of hand, the court simply ignores the fact that the ALJ resolved the medical questions in the case principally on the basis of a strong treating doctor preference. *See Napier*, Petition for Cert. at App. 36, 65. Both DOL and the Sixth Circuit seem inclined to enforce a *per se* treating doctor rule while denying having done so. The court's decision in *Gray*, which demands greater weight because of the treating doctor's status, is incompatible with the Sixth Circuit's denial that its rule is very strong indeed. *See Gray*, Petition for Cert. at App. 5-7.

medical authority is cited in any case, nor do any of the treating doctors in the cases claim to have enhanced insight that goes beyond the reasoning and documentation in their reports.

Congress has not adopted or, as far as amici have found, held hearings on a proposed treating doctor rule. It seems also that SSA adopted its rule mostly to eliminate the Second Circuit's rule which SSA apparently considered unacceptable.

The only search for a validating scientific principle occurred in DOL's black lung rulemaking from 1997-2001, and that exercise proves fairly conclusively that treating doctors do not have sufficient enhanced insight to warrant presuming its existence as a matter of course.

In response to DOL's specific request for assistance in designing a treating doctor rule, 64 Fed. Reg. 54919 (Oct. 8, 1999), the public comments on the rulemaking from the medical community uniformly opposed any rule.

The American College of Chest Physicians commented:

> We agree that some opinions should be considered to carry more weight than others. Opinions that carry the most weight should be based on the competence of the physicians and the competence of the opinion that was written. Everything else (the duration of the relationship between the doctor and the miner or the extent of the treatments) is irrelevant. This is an important error in the proposed regulations which must be corrected in the amended version of the black lung regulations.

Exhibit 5-165 to Proposed Rulemaking ("Comments on Proposed Rule: Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended" by Daniel E. Banks, M.D., FCCP, *et al.*, representing the American College of Chest Physicians Section on Occupational and Environmental Health (Aug. 20, 1997)). The Occupational Lung Disorder Committee of the American College of Occupational and Environmental Medicine opposed the preference:

> The Committee recognizes that the treating physicians can provide important insight and medical information when rendering an opinion in regard to pulmonary disease related to coal mine dust exposure. The treating physician, however, has an inherent conflict of interest in determining whether the coal miner patient is totally disabled from pneumoconiosis due to coal mine dust exposure. By supporting their patient's claim for black lung benefits, the treating physician is helping to guarantee future reimbursement for medical services rendered by the treating physician for almost any type of pulmonary disorder in ensuing years based on the proposed amendments to the Black Lung Benefits Act. This represents a direct financial conflict of interests. The eligibility determination for Black Lung Benefits should be done as independent medical evaluations by physicians with extensive experience and training in occupational pulmonary disease. The treating physician's medical records and supportive documentation should be available for review by the independent medical examiners and taken under consideration when rendering their opinions. The treating physician's opinion can be counted as a pulmonary evaluation but should be given equal and not

> controlling weight in determining whether a coal miner is totally disabled or died due to pneumoconiosis.

Exhibit 5-166 to Proposed Rulemaking (Comments of the American College of Occupational and Environmental Medicine, Occupational Lung Disorder Committee regarding the DOL Proposal to Amend Regulations Implementing the Black Lung Benefits Act (Aug. 21, 1997)).

Drs. Ben Branscomb and William Bailey, both distinguished professors of pulmonary medicine at the University of Alabama at Birmingham, opposed any treating doctor preference:

> We feel it is bad science to impose upon the adjudicator regulations that mandate giving controlling weight to the treating physician. In everyday practice, physicians evaluate numerous medical reports and weigh different physicians' opinions depending on *the question that is being asked and the scientific quality of the answer.* We see no reason why medical questions for coal miners should be adjudicated differently.

Exhibit 5-174: App. 8 at 13-14, Comments of the National Mining Assn., *et al.* (Aug. 21, 1997). Dr. Branscomb further testified:

> . . . I think that to assign particular weight to someone called the treating physician is artificial and is going to interfere with the objectives of the department in getting the right information out. . . . [T]he doctor's opinion ought to stand on itself, not on some designation that he's a treating physician.

* * *

> And I think it is contrived and contrary to good practice to artificially assign a special weight to the treating physician.

Exhibit 35 (Branscomb Tr. at 42, 43). Dr. Greg Fino, a board-certified pulmonologist with extensive experience in examining and treating miners, testified:

> The Department's proposal to give opinions from treating doctors "controlling" weight is a departure from sound medical practice. The medical evaluation of coal miners is no different than the evaluation of any other patient with respiratory or pulmonary symptoms or complaints. Doctors do not evaluate medical reports or opinions based on the status of the doctor, they weigh different opinions based on the question that is at issue and the underlying support both in the science and in the studies conducted. There simply is no scientific support for the Department's proposal that treating doctors are in a better position to diagnose pneumoconiosis or determine both the extent and cause of a patient's impairment.
>
> * * *
>
> Frequent contact alone provides no advantage. The mere fact of treatment of a miner's general health is medically irrelevant if the doctor does not have the basic skills or has not performed the relevant tests. The quality of an opinion by a treating doctor, an examining doctor, or a consultant on questions of impairment depends on the special training, skill, and expertise of the doctor and the availability of objective tests of lung function that can be validated according to published standards by a qualified pulmonary physician. . . . There is no medical rationale to automatically give more weight to a treating

> physician in the evaluation of a miner's pulmonary status.

Exhibit 89-37: App. C (Greg Fino, *et al.*, "Comments on the Medical and Scientific Issues Presented in the Department of Labor's Proposal dated October 8, 1999").

The National Institute for Occupational Safety and Health, DOL's statutory medical advisor for black lung benefit eligibility criteria, *see* 30 U.S.C. § 902(f)(1)(D), was solicited for its comments on the DOL regulation and simply did not mention the treating doctor rule. *See* Exh. Nos. 72 and 5-173 to Proposed Rulemaking. No medical authority supported the rule.

Notwithstanding DOL's failure to generate any supportive evidence for the rule, the agency adopted it anyway, noting: "The rule's purpose is to recognize that a physician's professional relationship with the miner may enhance his insight into the miner's pulmonary condition. A treating physician may develop a more in-depth knowledge and understanding of the miner's respiratory and pulmonary condition than a physician who examines the miner only once or who reviews others' examination reports." 65 Fed. Reg. 79923 (Dec. 20, 2000). DOL, like the Ninth Circuit, is committed to this rationale whether or not it is a generally accepted medical view or accepted by any reasonable medical authority.

There is not a scintilla of support for this rationale in the rulemaking record.[8] There is not much doubt that a

[8] The D.C. Circuit held that DOL needed no record to support the rule, treating it as a pure policy judgment entrusted to the agency. *National Mining Assn. v. DOL*, 292 F.3d 849, 870-71 (D.C. Cir. 2002).

(Continued on following page)

treating physician rule is simply a cheater's rule. Its only function is to change the outcome where the evidence fails to prove one side's case.[9] This is not reasoned decisionmaking and it is not compatible with any proper expectation of fair adjudication.

While these amici curiae are concerned principally with the use of a treating doctor rule in black lung and longshore claims, neither is the rule appropriate for application in ERISA claims. In all cases, this rule, in whatever form, fails the test of elementary justice and it should be struck down for this important reason.

2. A Treating Physician Rule Violates Important Legal Principles

Bad science makes bad law and when courts embrace bad science or any demonstrably bad rule, the interests of justice are diminished. This Court repeatedly has rejected questionable, overbroad and unsubstantiated rules that impair the truth-seeking process. Although the Federal Rules of Evidence do not apply in most administrative adjudications, including ERISA, longshore and black lung disability claims, the principles articulated in *Daubert v.*

Employers continue to challenge the rule on the grounds that the adoption of a rule of science is not a policy judgment left to an agency, but must be supported.

[9] In the black lung rulemaking, DOL noted in Preamble commentary that one purpose of the treating doctor rule was to override this Court's decision in *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), striking down the "true doubt" rule on the grounds that it violated section 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d). 65 Fed. Reg. 79926 (Dec. 20, 1999).

Merrill Dow Pharmaceutical, 509 U.S. 579 (1993), and its progeny are no less valid for administrative litigants. Administrative judges and benefit plan administrators may not preside over factfinding by a jury, but should nonetheless impose upon themselves the same gatekeeping responsibilities that are expected of federal trial judges. *See McCandless*, 255 F.3d at 468-69 ("*Daubert* does not apply directly in black lung cases. . . . Agencies relax the rules of evidence because they believe that they have the skill necessary to handle evidence that might mislead a jury. . . . They have a corresponding obligation to use that skill when evaluating technical evidence."); *United States Steel Mining Co., Inc. v. Director, OWCP*, 187 F.3d 384, 388-89 (4th Cir. 1999) (holding that in an APA proceeding, "the agency process . . . requires that the ALJ perform a gatekeeping function while assessing evidence. . . . "); *see also* Miller, *et al.*, "'Gatekeeping' Agency Reliance On Scientific and Technical Materials After Daubert: Ensuring Relevance and Reliability in the Administrative Process," 17 *Touro L. Rev.* 297 (2000).

All the treating doctor rules distort the focus in the factfinding process and suggest that treating doctor's opinions are immune from the scrutiny that all adjudicators are expected to impose on all other kinds of evidence. *See Canavan's Case*, 432 Mass. 304, 313-14, 733 N.E.2d 1042 (Mass. 2000). "There is no logical reason" to support a special exception to the normal rules ensuring the reliability of medical evidence simply because a doctor treated or personally observed a patient. *Id.*

In the absence of any medical support for a treating physician preference or general acceptance by physicians that the treating relationship enhances insight, and in the presence of fairly uniform denials[10] of the medical validity of the rule, the reliance by the Ninth Circuit and DOL in its black lung rules on notions of "common sense" and a presumption of enhanced "insight" is not credible at all or even arguably valid.

The rule distorts the weight of evidence for no good reason, exaggerating the significance of one kind of evidence that does not deserve to be so elevated. This is not permitted under the APA and it should not be condoned in ERISA claims determinations. *See Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 377-78 (1998). It is a categorical rule that not only fails to hold true in a majority of cases, it probably rarely, if ever, is true to the extent that status alone is worthy of extra weight. This Court disapproves categorical or *per se* rules without an "empirical" or "logical" basis and the treating doctor rule fits well

---

[10] Amici have found nothing in medical literature to support the rule. Many commentators criticize it. *See e.g.*, Davis and Pierce, *Administrative Law Treatise* § 11.3 (3d ed. 1994); Prentice, "The SEC and MDP: Implications of the Self-Serving Bias for Independent Auditing", 61 *Ohio St. Law J.* 1597, 1621-22 (2000); Noah, "Pigeonholing Illness: Medical Diagnosis as a Legal Construct," 50 *Hastings Law J.* 241, 242-43, 296 (1999); Foley, "Physician Advocacy and Doctor Deception," 48 *The Fed. Lawyer* 25 (2001); Freeman, *et al.*, "Lying for Patients: Physician Deception of Third Party Payers," 159 *Arch. of Internal Med.* 2203 (1999); Sage, "Physicians as Advocates", 35 *Hous. L. Rev.* 1529 (1999); Schneider, "A Role for the Courts: Treating Physician Evidence in Social Security Determinations," 3 *U. Chi. L. Sch. Roundtable* 391, 412-13 (1996).

inside the prohibited territory. *See Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 122 S.Ct. at 1162 (2002).

The Ninth Circuit's ERISA rule, like all the other treating doctor rules, hides behind a false rationale and serves only to give more weight to proof that is not good enough standing on its own. Rules like this deny parties their expectation of reasoned and fair decisionmaking and they should be soundly repudiated by this Court.

3. A Treating Physician Rule Spreads Adverse Consequences In Many Directions

The California experience with a treating doctor rule is instructive. A treating doctor presumption was adopted in 1993, by California for its workers' compensation system. The rule shifted the burden of persuasion on levels of disability by presuming the correctness of the treating doctor's opinion. *See Minniear v. Mt. San Antonio Comm. College Dist.*, 61 Cal. Comp. Cases 1055 (Cal. W.C.A.B. September 1996) (recon. denied). *Minniear* expanded the rule to include treatment decisions as well as disability determinations and through judicial decision, the treating doctor's opinion "on all medical issues was nearly irrebuttable, making it almost impossible for claims administrators to terminate unreasonable, unnecessary, excessive or incompetent care." Gardner and Swedlow, "California Workers' Compensation Medical Payments, Litigation and Claim Duration – A Post-Reform Report Card," *California Compensation Institute Research Notes* (May 2002) ("the California Study").

The huge financial impact on California employers of the California rule caused a legislative review of it. The California Study proved that the rule caused significant

increases in claims litigation rates, the duration of claims, treatment costs, total claims costs, medical-legal costs and claim frequency. California Study at 7. Legislation to significantly limit California's rule was adopted in February 2002. *See* Cal. Assembly Bill 749, Legislative Counsel's Digest § 18 (2002).

Commentators from a variety of disciplines have bad things to say about a treating doctor rule – that it adversely affects therapeutic decisionmaking, leads to improper or overtreatment of patients, that it creates unnecessary conflicts between doctors and patients and encourages physician dishonesty. It increases health care costs and the volume of litigation in the programs that adopt such a rule. *See supra* at 17, n.10. For the black lung program, actuaries reported that the rule would have an impact on most elements of a decision whether or not to award benefits and robs the system of predictability and insurability, at great and inappropriate cost to industry.[11] For these amici, the workers' compensation impact of a

[11] In the black lung rulemaking, Robert Briscoe, an actuary who specializes in black lung insurance and has served as a consultant to the Commonwealth of Kentucky and the National Council on Compensation Insurance ("NCCI"), a not-for-profit state licensed, worker's compensation insurance rating organization that assesses the cost of legislative or regulatory changes among other things, submitted several estimates of the consequences of DOL's new rules. Briscoe and NCCI pointed out that DOL's treating doctor rule was among the most costly of DOL's regulations and that the consequences of these rules as a whole would be a loss of up to 25,000 coal mining jobs and the insolvency of almost 1,000 small mine operators. DOL Rulemaking Record at Exh. 5-174 at Ex. 5; Exh. 89-37 at App. A; Exh. 35 (Tr. at 46), Exh. 5-137. These estimates were denied by DOL, but not refuted by comparable experts. In 2002, commercial insurance rates increased by more than 200% in most coal mining states in direct response to DOL's rules.

widely accepted treating doctor rule would be horrific and intolerable. It damages employer incentives to maximize health and safety at the workplace and operates irrationally to undermine the central premises of workers' compensation programs. The rule is not a common sense rule, it is nonsense.

CONCLUSION

The decision below should be reversed for the reason that a treating doctor rule is neither authorized nor appropriate.

Respectfully submitted,

MARK E. SOLOMONS
Counsel of Record
LAURA METCOFF KLAUS
GREENBERG TRAURIG LLP
Suite 500
800 Connecticut Ave., N.W.
Washington, D.C. 20006
(202) 533-2361