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

PETITIONER'S BRIEF ON THE MERITS

WILLIAM G. BRUNER III
Senior Corporate Counsel
THE BLACK & DECKER CORPORATION
701 East Joppa Road
Towson, Maryland 21286-5559
Phone: (410) 716-2692
Fax: (410) 716-2660

LEE T. PATERSON
Counsel of Record
JOHN R. ATES
AMANDA C. SOMMERFELD
WINSTON & STRAWN
333 South Grand Avenue, 38th Floor
Los Angeles, California 90071-1543
Phone: (213) 615-1700
Fax: (213) 615-1750

Attorneys for Petitioner The Black & Decker Disability Plan

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

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.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit filed on July 15, 2002 is reported at 296 F.3d 823 (2002). The opinion of the United States District Court for the Central District of California was issued on March 22, 2000 and is unreported. [Petition App. 18-36][1]

JURISDICTION

The judgment of the Ninth Circuit was entered on July 15, 2002. [Petition App. 1-7] The Petition for Writ of Certiorari was filed on September 19, 2002, and was granted on January 10, 2003. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1104, 1109, 1132(a)(1)(B), 1133 (2002).

STATEMENT OF THE CASE

There is no dispute that Respondent, Kenneth L. Nord, a former material planner for Kwikset Corporation ("Kwikset"), has mild spinal degeneration. This case arises

[1] The Appendix to Petition for Writ of Certiorari, filed on September 19, 2002, is referred to hereafter as "Petition App." followed by the page number.

from a dispute over whether or not Respondent's spinal degeneration has caused him back pain that is so severe he can not perform his regular occupation even with accommodation and/or with the use of pain suppressing medication.

Respondent's treating physician, Dr. Hartman, an internist, found that he is physically impaired.[2] Four examining physicians for Respondent determined that Respondent has mild spinal degeneration. An examining neurologist, Dr. Mitri, found that Respondent has spinal degeneration and chronic pain and also found after reviewing his job description that Respondent can, nevertheless, perform the duties of his job if he is permitted to stand and walk periodically. The plan administrator, after reviewing all of the medical opinions, the medical records, the requirements of the job and Respondent's employment history found that Respondent's impairment did not meet

[2] The Ninth Circuit erroneously found that Respondent had three treating physicians' opinions. *Nord v. Black & Decker Disability Plan,* 296 F.3d 823, 832 (2002). In fact, the evidence on the record is that Respondent had two treating physicians, Dr. Hartman and Dr. Silva, only one of which, Dr. Hartman, made a diagnosis of Respondent's impairment. *See* Lodging for Petition for Writ of Certiorari filed September 19, 2002 referred to hereinafter as "L:" followed by the page number. [L:53, 81] Dr. Silva only provided his progress notes with indecipherable references to diagnoses. [L:83-94] In addition, Respondent saw Dr. Williams, from whom there were no notes, no test results and no diagnosis. Dr. Williams referred Respondent to Dr. Go. Dr. Williams also signed a Physical Capacities Evaluation for Respondent. [L:83] There is no evidence on the record that Dr. Williams treated Respondent. Dr. Silva also had an associate, Dr. Katz, who examined Respondent on one occasion, but made no report. [L:95] Respondent had three other examining physicians, Dr. Go who conducted a CT scan and a discogram, Dr. Zandpour who conducted x-rays and an MRI, and Dr. Ali who conducted an electromyography (EMG). [L:49-52, 73-75, 97-100]

the plan's disability definition of "the complete inability . . . of a participant to engage in his regular occupation with the Employer." [L:20,155-156] In the words of Learned Hand, "[a] man may have to endure discomfort or pain and not be totally disabled; much of the best work of life goes on under such disabilities." *Theberge v. United States*, 87 F.2d 697, 698 (2nd Cir. 1937).

A. Petitioner's Plan And Respondent's Job

The Black & Decker Corporation ("Black & Decker"), the parent of Kwikset, voluntarily maintains a disability plan ("the Plan") for its employees. The Plan provides a short-term disability benefit for 30 months to disabled employees.[3] [L:7] The plan narrowly defines "disability" for purposes of the 30 months of benefits as "the complete inability (whether physical and/or mental) of a participant to engage in his regular occupation with the Employer." [L:20, 23] The Plan designates the Plan Manager as the administrator. [L:15] The Plan does not require the Plan Manager to defer to the findings of an employee's treating physician; rather, it provides that the "determination of Disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's prior employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." [L:20]

The Plan Manager, Ray Brusca, is Black & Decker's Vice-President of Benefits. [L:17] He has delegated some of

[3] The Plan also provides a long-term disability benefit which is not involved in this case. [L:7]

his administrative functions to Metropolitan Life Insurance Company ("MetLife"). [L:26]

Respondent was a material planner working for Kwikset. Respondent's duties as a material planner included ordering goods, interacting with vendors and maintaining inventory levels. [Petition App. 90] His job was sedentary. [Petition App. 92-93] It involved up to six hours of sitting and up to two hours of standing or walking. [L:143] Respondent's job did not require him to climb, twist, bend over, crouch, stoop, balance, reach above shoulder level, push or pull, grasp, or make repetitive motions with hands or feet. *Id*. His job description provided that occasionally he was required to carry up to 20 pounds, but never more. *Id*.

B. Respondent's Disability Claim

Respondent's treating physician since early 1993 was Dr. Hartman, an internist. [L:65] Dr. Hartman treated Respondent for general medical problems such as stomach upsets, sore throats and ear infections. [L:62-65] In early 1997, Respondent complained to Dr. Hartman about back pain. [L:61] Dr. Hartman referred Respondent to Bellwood Imaging Center where he was given an MRI and diagnosed with 1) mild degenerative changes of the lower lumbar spine and 2) mild degenerative disc disease. [L:73-74]

Respondent stopped working on July 15, 1997. [Petition App. 91] To support his leave of absence from work, he submitted a letter from Dr. Hartman stating a diagnosis of "lumbar disc syndrome." [L:81, 84] Respondent later submitted a claim for weekly disability benefits under the Plan. [Petition App. 91] There is no record evidence that

Respondent was prescribed or tried pain relieving medication for his back pain prior to leaving work.

In August, 1997, Dr. Hartman referred Respondent to Dr. Silva, an orthopedic surgeon. [L:57] Dr. Silva, in turn referred Respondent to Dr. Ali for nerve conduction studies and an EMG. Dr. Ali's diagnosis is "mild bilateral (L:5) radiculopathy." [L:97-99] Dr. Silva's only diagnosis of Respondent's condition is made in indecipherable references in his Progress Notes. [L:89-94]

On January 17, 1998, Respondent filled out a Personnel Profile Evaluation stating that he went fishing regularly, mowed the lawn, did housework and was able to care for his own personal needs (washing, bathing, dressing, etc.). [L:139-140]

Dr. Hartman's medical records show that Respondent was on medication for his back pain beginning in August 1997. [L:94] Dr. Silva's records concur that "medication helps" his pain, he "feels worse without medication" but it is "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [L:68, 87, 89] The records show prescriptions for Relafen, Darvocet and Flexeril. [L:104-108, 111-112, 114-115, 137]

C. Denial Of Benefits And Review Of The Denial

After a review of Respondent's medical records, MetLife denied benefits to Respondent on the grounds he was not totally disabled from performing his own job. MetLife referred to the fact that Respondent did housework, cared for his lawn, and that he had informed Dr. Silva that he was able to tolerate the pain with medication. MetLife informed Respondent that he could "request

a review of [his] claim" by sending a request to MetLife's "Group Claims Review." [L:144-145] Respondent retained an attorney who sent a letter to MetLife requesting review of the denial. [L:148-149]

Dr. Hartman referred Respondent to Dr. Williams. [L:55] There is no evidence on the record that Dr. Williams ever treated Respondent, but he did refer him to USC University Hospital for a CT scan and a discogram[4]. [L:49-52] The impression from the CT scan was, "Annular Thinning of the Intervertebral Discs at L4-5 and L5-S1, Loss of Disc Space at L4-5 and L5-S1". [L:51] The impression from the discogram was, "Concordant pain was demonstrated at L4-5 and L5-S1 following injection of the discs." [L:50]

Respondent's attorney secured "Physical Capacity Evaluations" from Dr. Hartman and Dr. Williams. [Excerpts from Clerk's Record BD 142; L:53, 83] Both evaluations are "check the box" type evaluations that have 33 questions with up to eight choices per question. Both evaluations are virtually identical. They both estimate that Respondent could sit for only one hour during a work day. Neither of the reports addresses Respondent's ability to perform his job of material planner either with accommodation, such as intermittent standing or walking, or mediation, including medication. There is no evidence in

[4] A discogram is a diagnostic procedure to determine which disc is the cause of pain. When an electrical charge was sent through a needle inserted into various parts of Respondent's spinal column, he was asked to report whether he felt a pain or not. Since lidocaine, an anesthetic, was used, the discogram could not have determined the level of pain that Respondent experiences in his work life. [L:49-50]

the record that any of Respondent's doctors ever evaluated his work capacity or looked at his job description.

The American Medical Association has published guides that establish criteria for the degree of pain suffered by a patient. *Guides to the Evaluation of Permanent Impairment,* American Medical Association 18.3f (Fifth Ed. 2002). [Brief App. 1][5] Respondent never submitted any medical opinions as to the level of pain that he suffered during his normal workday.

At Petitioner's request, Respondent was examined and evaluated by Dr. Antoine Mitri, a neurologist. Dr. Mitri's independent medical examination report, dated July 17, 1998, states that the examination was normal except for some limitation of bending. [L:43-48] Dr. Mitri's report notes that Respondent had "no limitation" with respect to transportation, standing, sitting, changing positions between standing and sitting, reaching forward and overhead, grasping or handling, finger dexterity, operating electrical equipment and concentrated visual attention. *Id*. Dr. Mitri noted "some limitation in assuming cramped or unusual positions, twisting, pushing or pulling, repetitive movements, and operating a truck or dolly." *Id*. Dr. Mitri's diagnosis was lumbrosacral degenerative disc disease and chronic myofascial pain syndrome. [L:45, 46] The report concludes that

> "[after] *reviewing the patient's job description,* and on the basis of the general examination

[5] The Appendix to Petitioner's Brief on the Merits, filed on February 24, 2003, is referred to hereafter as "Brief App." followed by the page number.

> and neurological examination, and after reviewing the report of his test, [MRI and the EMG] I think that the patient should be able to do sedentary work with some interruption by walking in between. Accordingly, *I do not think the patient is disabled to perform that kind of work* even though he is complaining from low back pain [because] all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work with some walking interruption in between." [L:45] (emphasis added)

MetLife sent Dr. Mitri's report to Respondent. MetLife asked that Respondent submit Dr. Mitri's report to Respondent's treating physician and obtain his comment on it. [Petition App. 88] Respondent failed to provide his treating physician's response to Dr. Mitri's opinion. MetLife made a second request that he provide a response to Dr. Mitri's report from his treating physician. [Petition App. 87] Respondent never provided the requested comments from his treating physician. [L:156]

Respondent's attorney sent a set of hypothetical questions to Janmarie Forward, a human resources representative at Kwikset.[6] [L:33-37] An example of one of his hypothetical questions is:

> Dr. Mitri indicates that's [sic] Kenneth Nord can do sedentary capacity, as long as he can

[6] The Ninth Circuit opinion erroneously states that "Forward's opinion was solicited by the administrator." 296 F.3d at 830. This statement is not supported by the record. Respondent's counsel sent these questions directly to Ms. Forward. [Excerpts from Clerk's Record BD 132-37; L:33-37]

> interrupt his sitting by walking in between at will. In your employer statement provided to Metropolitan, you have described the job as requiring sitting between 5 and 6 hours in a day and standing and walking between 1 and 2 hours in a day. Assume that the need to stand and walk to relieve pain is unpredictable and that when the pain requires walking about, the individual must get up and move.
>
> **Could the individual with those limitations perform the work of a material planner?**
>
> **___yes___no**
>
> Ms. Forward checked the response "yes." [L:36-37]

Ms. Forward responded "yes" that Respondent could perform the job of a material planner to all but the following question:

> Dr. Mitri describes Kenneth Nord as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Nord would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day.
>
> **Could individual [sic] of those limitations perform the work of a material planner?**
>
> **___yes___no**

Ms. Forward checked the response "no." *Id*.

The question is a hypothetical that is not based upon any medical evidence in the record. There is no medical evidence that Respondent suffered "moderate" pain; the only medical evidence is that he suffered some pain which was controlled by medication. [L:43-47, 49-52, 68, 85-94, 97-100, 102-103, 155-156]

After reviewing the reports, MetLife made a recommendation to the Plan Manager to uphold the denial of Respondent's claim and provided the Plan Manager with all of the information upon which it relied in coming to that conclusion. [L:42]

Prior to making his decision, the Plan Manager telephoned Ms. Forward and asked her about her response to the hypothetical question posed by Respondent's counsel as to whether Respondent could perform his job if moderate pain "interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress." The Plan Manager questioned Ms. Forward about her response. He also asked Ms. Forward about the job of a material planner. Ms. Forward told him that it was a desk job and that Respondent was free to sit or stand at will and that help was available for lifting. [Petition App. 93]

Using his "sole and absolute discretion" to interpret the Plan and make a disability benefit determination based on "suitable medical evidence," the Plan Manager decided that Respondent's back pain was not so disabling that he was unable to perform his own job. The Plan Manager informed Respondent of his decision on October 27, 1998 and how he could appeal that decision under ERISA. [L:155-156]

D. The Litigation

Respondent filed suit in the Central District of California seeking benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). Petitioner and Respondent both filed motions for summary judgment. In considering both motions, the district court reviewed the denial of benefits for an abuse of discretion under the standard set forth in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989). [Petition App. 33] The district court found that Respondent had not sufficiently met his burden under prior Ninth Circuit precedent to invoke *de novo* review by providing material probative evidence tending to show that Petitioner's self-interest caused a breach of fiduciary duty. Respondent argued to the court that Janmarie Forward's answers to his hypothetical questions showed that he was disabled. The court stated it was within the Plan Manager's discretion to reject the opinion of an untrained person over the opinion of a medical examiner and that the question posed to Ms. Forward failed to deal with the effect of medication on Respondent's work behavior. [Petition App. 33-34] Respondent also argued the "treating physician rule." The court held it was within the Plan Manager's discretion whether to accept the opinion of a treating physician or the opinion of an examining expert. [Petition App. 35-36] The court pointed out that this was especially true where the Petitioner had provided two opportunities for Respondent's treating physicians to review and respond to the independent examining physician's report which they failed to do. [Petition App. 34-35] The district court upheld the denial of benefits as properly within the Petitioner's discretion, granted Petitioner's motion for summary judgment and denied Respondent's motion for summary judgment. [Petition App. 18]

Respondent appealed the judgment on Petitioner's Motion for Summary Judgment but did not appeal the denial of Respondent's Motion for Summary Judgment. [Excerpt from the Clerk's Record, No. 34] In considering the appeal, the Ninth Circuit relied on its ruling in *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130 (9th Cir. 2001), which requires application of a treating physician rule to ERISA governed disability plans. The Ninth Circuit agreed that Petitioner's Plan conferred discretion to determine eligibility for benefits on the Plan Manager. However, the court concluded that the Plan Manager had an actual conflict of interest which tainted his decision because (1) his rejection of the response of Janmarie Forward was "high handed" and evidence of a conflict of interest; and (2) the fact that the Plan Manager had not complied with the Ninth Circuit's treating physician rule was material probative evidence that the conflict of interest had tainted the Plan Manager's decision. Therefore, the Ninth Circuit held that the appropriate standard of review was *de novo*.

In its *de novo* review of the evidence, the court found the only evidence offered by Petitioner was the opinion of Dr. Mitri, a qualified neurologist. Despite the fact that Dr. Mitri had examined Respondent, physically tested him, reviewed his previous medical records and examinations and reviewed his job description, the court discounted Dr. Mitri's opinion. The court stated that Dr. Mitri's opinion was "a scintilla of evidence" that "does not present a genuine issue of material fact." *Nord,* 296 F.3d at 832.[7] The

[7] This finding is in conflict with prior Ninth Circuit SSA precedents. "Where the opinion of the claimant's treating physician is

(Continued on following page)

court found that Dr. Mitri's opinion was overwhelmed by substantial evidence in the record, including "the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner."[8] *Id.* The court set aside the decision of the district court on Petitioner's Motion for Summary Judgment. Instead of remanding the case to the district court for further proceedings, the court *sua sponte* entered judgment for Respondent on the basis that "no reasonable person could conclude that Respondent was not disabled." *Id.*

SUMMARY OF ARGUMENT

The Ninth Circuit's treating physician rule is inconsistent with ERISA's goals of not discouraging employers from adopting disability benefit plans and increasing the benefits of ERISA disability benefit plans. The Ninth Circuit's treating physician rule imposes an unduly heavy burden on lay plan administrators to rebut a treating physician's opinion by providing specific, legitimate

contradicted, and the opinion of a nontreating source is based on independent clinical findings that differ from those of the treating physician, the opinion of the nontreating source may itself be substantial evidence; it is then solely the province of the ALJ to resolve the conflict." *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995).

[8] There is no evidence in the record at all that three treating physicians opined that Respondent was "unable to meet the physical requirements of his position as a Material Planner." Dr. Hartman provided his diagnosis and an estimate of his physical capacity. [L:57, 81, 84] Dr. Williams only provided an estimate of his physical capacity. [L:83] Dr. Silva provided no opinion at all.

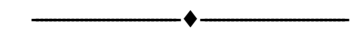
reasons for rejecting the opinion based on substantial evidence or in some cases clear and convincing evidence in the record. The rule ignores the fiduciary obligations already placed on plan administrators by ERISA. Placing this legal standard on plan administrators forces them to hire expensive medical experts and to engage legal counsel to review their benefit denials. In addition, the rule encourages litigation by claimants.

The Ninth Circuit's treating physician rule infringes on and conflicts with the authority given to the Department of Labor ("DOL") to ensure that disability benefit plans provide a reasonable opportunity for a full and fair review by the plan administrator of a denial of benefits. The DOL in its regulations has never imposed a treating physician rule on plan administrators. Instead, the DOL has attempted to "preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." The Ninth Circuit's treating physician rule interferes with that flexibility and infringes on the administrator's discretion.

The Ninth Circuit's treating physician rule is based upon a false assumption that the treating physician is the most responsible and credible physician in regard to a claimant's disability. The rule fails on its face because it does not take into account the quality of the treating physician's opinion, the length of time she has treated the patient, her experience with similar impairments and her training. In addition, the rule assumes that treating physicians will provide objective diagnoses of their patient's disability. Yet, due to of the shift in medical decision making from independent physicians to managed care institutions, treating physicians have become advocates for their patients in obtaining insurance benefits. A large

number of treating physicians admit that they make false diagnoses and reports to help patients obtain insurance payments. A treating physician may or may not be the most responsible or knowledgeable medical professional regarding a patient's disability. For example, many treating physicians have little or no experience or training in regard to back pain. However, a consulting neurologist may have treated thousands of similar cases. There is no legitimate reason to have a blanket rule giving the opinions of treating physicians preference over other physicians' opinions.

The Ninth Circuit treating physician rule shifts the burden from a claimant to prove that the plan administrator's decision was an abuse of discretion to the plan administrator to show specific legitimate reasons for rejecting the treating physician's opinion based upon substantial evidence or, in some cases, clear and convincing evidence in the record. The rule is contrary to this Court's holding in *Firestone* that the plan administrator's decision should be reviewed for abuse of discretion in all cases where, like here, the plan administrator has discretion to make benefit decisions. The Ninth Circuit treating physician rule conflicts with the abuse of discretion test when it is used to determine (1) whether an actual conflict of interest tainted the plan administrator's decision and (2) the reasonableness of the plan administrator's decision in a *de novo* review. The rule places an unreasonable and costly burden on plan administrators. It is contrary to this Court's prior opinions and should be rejected by this Court.



ARGUMENT

THE TREATING PHYSICIAN RULE IS INCONSISTENT WITH ERISA'S GOAL OF NOT UNDULY DISCOURAGING EMPLOYERS FROM OFFERING DISABILITY PLANS

This Court held in *Varity Corp. v. Howe,* 516 U.S. 489, 497 (1996), that one of the Congressional concerns in drafting ERISA was " . . . not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " In determining whether to impose restrictions on the decisions of ERISA plan administrators, this Court has balanced carefully the burden of the restriction against the public benefit in encouraging the formation of employment disability plans. *Pilot Life v. Dedeaux,* 481 U.S. 41, 54 (1987). The Ninth Circuit treating physician rule disrupts that balance by imposing a legalistic standard on plan administrators which will have the effect of increasing plan administration, medical expenses and legal costs. The Ninth Circuit treating physician rule discourages, rather than encourages, employers to adopt ERISA disability plans.

A. Plan Administrators Are Fiduciaries

Congress created ERISA knowing that employers would appoint employee plan administrators who are fiduciaries and beneficiaries of plans, as well as managers of the company.

> "Under ERISA, however, a fiduciary may have financial interests adverse to beneficiaries. Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of

> employee beneficiaries, when they act as employers (*e.g.,* firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (*e.g.,* modifying the terms of a plan as allowed by ERISA to provide less generous benefits)." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

Employers are not required to offer ERISA plans or particular plan benefits. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). One of ERISA's tradeoffs to encourage employers to offer ERISA benefit plans is to allow employers to appoint employee plan administrators who are both fiduciaries and beneficiaries, as well as managers. The Ninth Circuit treating physician rule assumes that plan administrators who do not rebut treating physician's opinions are not providing fellow employees their rightful plan benefits. The rule ignores the fact that plan administrators are also beneficiaries of the plan, as well as fiduciaries who have legal obligations to the plan members:

> "The most fundamental duty owed by the trustee to the beneficiaries of the trust is the duty of loyalty. . . . It is the duty of a trustee to administer the trust solely in the interest of the beneficiaries." 2A A. Scott & W. Fratcher, Trusts § 170, 311 (4th ed. 1987).
>
> . . . .
>
> "The statute provides that fiduciaries shall discharge their duties with respect to a plan 'solely in the interest of the participants and beneficiaries,' § 1104(a)(1), that is, 'for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan,' § 1104(a)(1)(A)."

Pegram, 530 U.S. at 223-24. Plan administrators must discharge their duties:

> "(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
>
> . . . .
>
> "(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."

29 U.S.C. § 1104(a)(1).

When Congress placed fiduciary obligations in the law, it assumed the plan administrators would heed those obligations. If Congress had not made that assumption, it would not have permitted companies to appoint employee administrators. For those few plan administrators who ignore their fiduciary obligations, it placed personal liability in the law. 29 U.S.C. § 1109(a). The Ninth Circuit's decision assumes that employee plan administrators will ignore the requirements of ERISA and will violate the law. There is no fact or reason on which to base such an assumption and this Court should strike down the Ninth Circuit treating physician rule.

B. The Ninth Circuit's Treating Physician Rule For ERISA Cases

The Ninth Circuit's treating physician rule as applied in *Regula* and *Nord* is:

> If the treating physician's opinions are uncontroverted, the plan administrator may reject the treating physician's opinions only by providing "specific, legitimate reasons" which must be "clear and convincing" and "based on substantial evidence in the record." *Regula*, 266 F.3d at 1140 (quoting *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) and *Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996)).
>
> If the treating physician's opinions are controverted, the plan administrator may reject the treating physician's opinions only by giving "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord*, 296 F.3d at 831 (quoting *Morgan*, 169 F.3d at 600).

C. The SSA Treating Physician Rule

The treating physician rule first appeared in a Second Circuit Court of Appeals case in 1972 involving disability determinations by administrative law judges ("ALJ's") under the Social Security Act. *Gold v. Secretary of Health, Education and Welfare,* 463 F.2d 38, 42-43 (2d Cir. 1972). Under intense pressure from the Second Circuit, the Social Security Administration ("SSA") adopted regulations in 1991 requiring ALJs to apply the treating physician rule. 20 C.F.R. § 404.1527(d); *see Schisler v. Sullivan,* 3 F.3d 563, 565-569 (2d Cir. 1993) *See* Pierce, *Administrative Law Treatise* § 11.3. However, even while the Second Circuit requires the SSA to apply its treating physician rule, the Second Circuit has held that the treating physician rule

does not apply in ERISA cases. *Conners v. Connecticut General Life Ins. Co.,* 272 F.3d 127, 135 n.4 (2d Cir 2001).

D. The Ninth Circuit Does Not Follow The Treating Physician Rule In The SSA Regulations

In this case and in *Regula*, the Ninth Circuit referenced the treating physician rule used by the SSA and codified at 20 C.F.R. §§ 404.1527(d), 416.927(d) (2001). However, the Ninth Circuit does not follow the SSA rule, even in SSA cases. The Ninth Circuit applies its own version of the treating physician rule in cases brought under the Social Security Act. *Magallanes v. Bowen*, 881 F.2d 747, 750 (9th Cir. 1989); *Lester v. Chater,* 81 F.3d 821, 831-32 (9th Cir. 1995); and *Morgan v. Commissioner of the SSA*, 169 F.3d 595, 600, 601 (9th Cir. 1999). The Ninth Circuit in *Regula* and *Nord* adopted this judicially created version of the treating physician rule into the ERISA context. *See* Pierce, *Administrative Law Treatise* § 11.3.

E. The SSA Disability Rule Has Been Rejected By The Courts In Other Disability Determinations

The treating physician rule has been rejected by the courts for disability determinations in other contexts. The SSA treating physician rule has been rejected for veterans' disability benefit determinations. *White v. Principi,* 243 F.3d 1378 (Fed. Cir 2001). In addition, the courts have rejected the treating physician rule in black lung disability determinations. *See, e.g., Peabody Coal Co. v. Helms*, 901 F.2d 571, 573 (7th Cir. 1990). "[I]t is irrational to prefer the opinion of the treating physician, who is often not a specialist, over the opinion of a nontreating specialist *solely* because one physician is the treating physician."

Peabody Coal Co. v. Director, Office of Workers' Compensation Programs, 972 F.2d 178, 182 (7th Cir. 1992) (emphasis added); *Consolidated Coal Co. v. Held*, 314 F.3d 184 (6th Cir. 2002); *but see 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'g pending*.

In addition, the Courts of Appeal for the First, Second, Fourth, Seventh and Eleventh Circuits have all rejected the SSA treating physician rule in ERISA cases.[9]

F. ERISA Disability Claims Are Different Than SSA Claims

In *Regula,* the Ninth Circuit held, "[t]herefore, 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, we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions." *Regula,* 266 F.3d at 1139. However a formal adjudicative decision by a trained administrative law judge applying specific regulatory criteria is entirely different than a decision by a lay ERISA plan administrator applying plan language. As stated in the dissent in *Regula*:

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[9] *Leahy v. Raytheon Company*, 315 F.3d 11 (1st Cir. 2002) (unanimous opinion declining to adopt Ninth Circuit's treating physician rule joined by Fletcher, J., the author of *Nord* and *Regula*); *Conners v. Connecticut General Life Ins. Co.,* 272 F.3d 127, 135 n.4 (2d Cir 2001); *Elliott v. Sara Lee Corp.,* 190 F.3d 601, 607-8 (4th Cir 1999); *Wilczynski v. Kemper Nat'l. Ins. Co.* 178 F.3d 933, 938 (7th Cir. 1999); *Turner v. Delta Family-Care Disability and Survivorship Plan,* 291 F.3d 1270, 1274 (11th Cir. 2002).

> " . . . [T]here are significant differences between Social Security and ERISA that counsel against adoption of the rule in the ERISA arena. [¶] Congress and the Social Security Administration ('SSA') have created an elaborate statutory and regulatory scheme governing Social Security disability determinations. *See* 42 U.S.C. §§ 401-433; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. For instance, the SSA has created a detailed five-step procedure to evaluate which claimants are disabled and therefore entitled to Disability Insurance benefits. *See* 20 C.F.R. § 404.1520, 416.920; *see also Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 804 (1999) (describing the SSA's five-step evaluation process). As part of this sequential procedure, the SSA has created grids to provide guidance about whether a claimant is disabled. *See* 20 C.F.R. § 404, Subpart P, Appendix 1-2; *Reddick v. Chater*, 157 F.3d 715, 729 (9th Cir. 1998). The SSA has also codified the treating physician rule in the regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d); 416.927(d). Thus, although this Court reviews Social Security benefits eligibility determinations made by an Administrative Law Judge ("ALJ") for substantial evidence an application of the correct legal standards (similar to the ERISA context), see *Flaten v. Sec'y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995), an ALJ must follow far stricter guidelines (such as detailed grids) than a plan administrator making the same determination under ERISA."

Id., at 1150 (Brunetti, J. dissenting).

In addition, as in this case, a decision by a plan administrator that an employee is disabled from *his own*

occupation is entirely different than an ALJ's decision in an SSA case that a person is disabled from "any substantial gainful activity." 20 C.F.R. § 416.927(a)(1). First, the burden is ultimately on the SSA, and not on the claimant, to prove that the claimant is not totally disabled from any substantial gainful activity. *Bowen v. Yuckert*, 482 U.S. 137, 146, n. 5 (1987). Therefore, the treating physician rule in SSA does not shift the burden from the claimant to the ALJ. However, as applied by the Ninth Circuit in ERISA cases, the treating physician rule shifts the burden to the plan administrator to provide specific, legitimate reasons for rejecting the treating physician's opinion. Secondly, a determination that a person is disabled from his own occupation requires knowledge and information about that occupation. In this case, the plan administrator had to know the requirements of the job of material planner. A decision that a person is disabled from any substantial gainful activity does not require any knowledge of any specific job.

Finally, the Ninth Circuit treating physician rule is applied differently in SSA cases than in ERISA cases. In an SSA case, the Ninth Circuit treating physician rule is applied to determine whether the ALJ's opinion is supported by substantial evidence. In ERISA cases, the Ninth Circuit uses the treating physician rule: (1) to determine whether the plan administrator's denial of benefits is tainted by an actual conflict of interest, requires courts in the Ninth Circuit to apply *de novo* review; and (2) to test the reasonableness of the plan administrator's decision.

G. Imposing The Ninth Circuit's Treating Physician Rule On Plan Administrators Reduces The Administrator's Discretion And Discourages Employers From Adopting ERISA Plans And Improving Benefits

This Court has held that courts should not interfere with the contractual terms agreed upon by an employee and employer in forming an ERISA plan. *See, e.g.*, *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Where the plan requires a deferential abuse of discretion standard of review, and when reasonable minds could differ over the medical evidence in the record, then the administrator decides. *Consolidated Edison Co. v. NLRB,* 305 U.S. 197, 217 (1938). The Ninth Circuit treating physician rule requires a lay plan administrator to satisfy a court that she has rebutted the opinion of a treating physician for specific reasons that are based on substantial evidence, or in some circumstances clear and convincing evidence, in the record. Forcing lay plan administrators to rebut the treating physician rather than to evaluate the entire medical record conflicts with plans, such as this one, which provide for deferential review. It also conflicts with ERISA's goals of simplicity and ease of administration. *See Gallo v. Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996) (holding it is error for court to require "that plan administrator articulate the grounds for the interpretation in the course of reviewing an adverse determination on a claim for benefits, as if the plan administrator were an administrative agency. There is no such requirement in the law.")

"Employers do not have to provide employee disability plans. Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what

kind of benefits employers must provide if they choose to have such a plan." *Lockheed,* 517 U.S. at 887. The *Regula* treating physician rule takes away employer discretion and forces employers to pay disability benefits even when their plan administrators have an honest and good faith belief that the claimant is malingering. Employers without disability plans have no incentive to adopt a disability plan with burdensome procedures that encourage court litigation and require plan administrators to hire expensive medical and work capacity experts.

Forcing the Ninth Circuit's treating physician rule onto ERISA plan administrators is counterproductive to one of the basic purposes of ERISA – to encourage employers to adopt disability plans and to increase benefits to current plans. This Court should decline to adopt such a rule as part of the federal common law.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE INFRINGES ON AND CONFLICTS WITH THE AUTHORITY DELEGATED BY CONGRESS IN ERISA TO THE DEPARTMENT OF LABOR

The treating physician rule infringes on the specific delegation of authority by Congress to the DOL to ensure that a benefit plan affords a "reasonable opportunity" for a "full and fair review" by a plan fiduciary of a decision denying a claim for benefits.[10] The DOL has exercised this

[10] "In accordance with regulations of the Secretary, every employee benefit plan shall . . . (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." 29 U.S.C. § 1133(2).

Congressionally-delegated authority and adopted regulations providing standards that are incumbent in a "full and fair" review process. The DOL has never required plan administrators or fiduciaries to adopt the treating physician rule. Indeed, in its most recent revisions to the "full and fair" review rules, the DOL regulatory scheme mandates that before the plan fiduciary reaches a decision, it should consider evidence from the claimant (presumably in the form of a treating physician opinion) *and* consult with an independent health care professional with appropriate training and experience in the relevant field of medicine. *See* 29 C.F.R. §§ 2560.503-1(h)(2)(ii); (h)(3)(iii), (v); (h)(4).[11] In its guidance regarding these rules, the DOL has stated that they were written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. The DOL has written its ERISA regulations " . . . to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." *U.S. Department of Labor, Pensions and Welfare Benefits Administration,* www.dol.gov/pwba [Petition App. 52-53]

Congress expressly gave the DOL authority to regulate the procedures a plan administrator must follow in order to afford a reasonable opportunity for a full and fair review of a denial of claim benefits. The DOL's revised regulations have never imposed a treating physician rule. When the DOL adopts a regulation affecting procedures

[11] These rules became effective January 1, 2002, and therefore do not directly affect this case.

for ERISA plan administrators, it first studies the problem, publishes its proposed regulation for comment and accepts public comments on the proposed regulation. In this case, the Ninth Circuit reached out to an unrelated area of law and selected a rule to impose on ERISA plan administrators which is based upon a false assumption and is counterproductive to the purposes of ERISA. This Court should overturn the imposition of the Ninth Circuit's treating physician rule on ERISA plan administrators.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE IS GROUNDED ON A FALLACIOUS ASSUMPTION THAT A DOCTOR CHOSEN BY AN EMPLOYEE FOR TREATMENT IS INHERENTLY MORE RESPONSIBLE AND MORE COMPETENT THAN AN EXAMINING OR REVIEWING SPECIALIST

In *Regula*, the Ninth Circuit concluded that:

> "The treating physician rule applied in the Social Security setting requires that the administrative law judge ('ALJ') determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.' [citations omitted] This grant of deference to a treating physician's opinions increases the accuracy of disability determinations, by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record."

266 F.3d at 1139.

There is no empirical evidence that supports this statement.[12] The statement is an erroneous stereotype that does not reflect the current practice of medicine.

The Ninth Circuit's treating physician rule fails on its face because it does not address the quality of the treating physician, the length of treatment, or the experience and training, if any, of the treating physician in the type of disability the patient is claiming. There is no definition in the Ninth Circuit's treating physician rule of the term "treating physician." Under the rule, the opinion of a physician who has "treated" a patient one time is afforded the same weight as that of a physician who has been treating the patient through the entire course of his impairment. In addition, the rule assumes that there is only one treating physician's opinion. However, in many

[12] In fact the treating physician rule has been criticized even in the SSA context:

> "The courts have also frustrated the achievement of accuracy in SSA disability evaluations by forcing SSA and its ALJs to give weight to unreliable evidence at the expense of reliable evidence. According to the 'treating physician rule' • a judicially created exception to the deferential substantial evidence test • SSA and its ALJs must give greater weight to the opinions of applicants' treating physicians than to the opinions of consulting physicians. *See*, *e.g., Stieberger v. Bowen,* 801 F.2d 29, 31 (2d Cir. 1986). *See* § 11.3. The exception is premised on the courts' belief that treating physicians' opinions are more reliable than consulting physicians' opinions • a belief that the courts are alone in holding. Congress, SSA, ALJs, and independent investigators agree that 'as a matter of both bias and degree of qualification the consulting physician is likely to be much the better information source.' J. Mashaw, et al., Social Security Hearings at 57."

Pierce, *Administrative Law Treatise* § 9.10.

cases there are disputes between two or more treating physicians as to the extent of disability. When there are two dueling treating physicians, the Ninth Circuit's treating physician rule places the burden on the plan administrator to reject one of the opinions based on specific, legitimate reasons based on substantial evidence in the record, regardless of the fact that he accepted another treating physician's opinion.

Surveys conducted by doctors for doctors show that in today's medical environment treating physician's opinions are not the most responsible in regard to a patient's disability because, among other reasons: 1) the treating physician may be accommodating her patients to obtain insurance payments for them, and 2) the treating physician may lack experience and training in regard to the impairment that she is evaluating.

A. Treating Physicians Often Accommodate Their Patients To Obtain Insurance Payments For Them

Within the past fifteen years the medical world has changed dramatically. The image of the general practitioner who has a long-term relationship with each of his patients and who diagnoses and treats all of their ills has given way to managed care facilities and HMOs where patient care is determined by medical administrators, where a patient may never see the same doctor twice and where specialists are brought in for one time testing and evaluation of patients. "With amazing speed, American medicine is evolving in uncharted directions. Managed care has transformed a 'cottage industry' run by highly individualistic physicians into a far more controlled enterprise in which many other players wield major

influence, both financial and professional." Alper, Philip R., M.D., *The Doctor-Patient Breakdown: Trouble At The Core Of The Medical Economy,* Heritage Foundation, Policy Review April 1, 2002. [Brief App. 157] The Seventh Circuit recognized this shift in the medical profession in *Peabody Coal Co. v. McCandless,* 255 F.3d 465, 469 (7th Cir. 2001) "[t]reating physicians often succumb to the temptation to accommodate their patients . . . at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views."

Treating physicians report that they frequently accommodate their patients by not accurately reporting their diagnoses to obtain insurance payments for their patients.[13] In a survey of doctors by doctors, 78% of treating physicians reported that they would deceive an insurance company to obtain insurance payments for a patient. Novack, et al., *Physician Attitudes Towards Using Deception To Resolve Different Ethical Problems* 261 J. Am. Med. Assn. 2980 (1989). [Brief App. 94] In another survey of doctors, 64.3% of the treating physicians reported that it is necessary to manipulate insurance plan rules to obtain insurance payments, including exaggerating the severity of the patient's condition. Wynia, *Physician Manipulation of Reimbursement Rules for Patients* 283 J. Am. Med. Ass'n 1858 (April 12, 2000). [Brief App. 23] In addition, 39% of

[13] This practice is so widespread that the health care industry has adopted a euphemism for the practice – "gaming the system." *See Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 Archives, Int. Med. 443-447 (1999) [Brief App. 135]; Wynia, *Physician Manipulation of Reimbursement Rules for Patients* 283 J. Am. Med. Ass'n 1858 (April 12, 2000). [Brief App. 23]

those treating physicians surveyed reported that within the past year they had 1) exaggerated the severity of a patient's condition, or 2) changed the patient's billing diagnosis, or 3) reported signs or symptoms that the patient did not have in order to help the patient secure payments from insurers. *Id.* Of the physicians surveyed, 28.5% agreed with the statement, "[t]oday it is *necessary* to game the system to provide high quality care" and 15.3% agreed that it is also *ethical* to do so. *Id*. In a poll by the Association of American Physicians and Surgeons, Inc., 87% of the treating physicians reported that they purposefully kept medical information out of their patients' records. *Guarding Medical Secrets, At A Cost,* U.S. News and World Report, August 13, 2001. [Brief App. 122] In another survey of doctors by doctors, 57.7% of the treating physicians reported that they would give a false diagnosis to obtain insurance payments for a patient. Freeman, *Lying for Patients – Physician Deception of Third-Party Payers*, 159 Archives of Internal Med. 2263 (October 25, 1999). [Brief App. 61]

The DOL has recognized that a treating physician is not an unbiased decision maker, but rather is a "representative of the claimant." 63 Fed. Reg. 48390, 48392 (Notice of Proposed Rulemaking Sept. 9, 1998) ("it is the Department's view that an individual's attending physician would generally be treated as a representative of the claimant.") This is, in part, based on the DOL's perception that within the managed care context the separation between medical decision making and coverage determinations has been substantially eroded. *Id*. at 48391. The American Medical Association also sees the treating physician as an advocate, "[p]hysicians should advocate for patients in dealing with third parties when

appropriate." *Fundamental Elements of the Patient-Physician Relationship,* American Medical Association, http://www.ama-assn.org/ama/pub/category/2510.html (February 15, 2003) [Brief App. 123]

A treating physician needs to build a rapport with her patients, first to cure them, and second to keep them as patients. "The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability." *Stephens v. Heckler,* 766 F.2d 284, 289 (7th Cir. 1985). If the treating physician reports symptoms which do not exist to obtain insurance payments, declares a malingering patient disabled from work or performs requested but unnecessary tests to obtain additional insurance benefits for her patient, she builds patient rapport and goodwill. If the patient reports subjective pain, inability to function or psychological problems, the treating physician will lose patient rapport if she challenges the statements and build patient goodwill and trust if she accepts the patient's statements as true.

> "When psychological testimony is used to establish the presence of psychological injury, the circumstances are very different. In virtually every case, the patient presents his or her history and symptoms to the therapist, who generally accepts the account at face value. *No attempt is made to test or disconfirm the implicit hypothesis that the patient's account of events is accurate.* The basis of successful psychotherapy is a trusting relationship between therapist and client. Since any attempt by a therapist to verify or disconfirm the patient's version of events would probably destroy this trust, *treating therapists rarely attempt to assess the possibility of false imputation or malingering*."

Eric G. Mart, *Psychotherapist Testimony to Personal Injury Cases: Coping with The Stealth Evaluation*. Massachusetts Bar Association Lawyers Journal (March 1997) (emphasis added). [Brief App. 53]

The treating physician rule assumes that doctors are providing objective, unbiased opinions regarding patient disability. However, that assumption is not supported by the medical profession's own surveys of treating physicians. The Ninth Circuit's treating physician rule is based upon an outdated stereotype of treating physicians. It has no place in today's medical managed care marketplace.

B. The Treating Physician May Have Misdiagnosed The Patient Through Inexperience Or Lack Of Training

The Ninth Circuit's treating physician rule assumes that the patient has selected a responsible, competent physician, who has provided a correct diagnosis. The patient, however, may have selected a physician who has never treated or observed a similar infirmity.[14] "The regular physician also may lack an appreciation of how one case compares with other related cases. A consulting physician may bring both impartiality and expertise." *Stephens,* 766 F.2d at 289. There is nothing inherently

[14] An example of this was pointed out in *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). "While Moran's primary care physician acknowledged petitioner's affiliated surgeons had not recommended the unconventional surgery and that he was not 'an expert in this or any other area of surgery' . . . [n]onetheless he opined, without explanation, that Moran would be 'best served' by having that surgery." 536 U.S. at 405 (Thomas, J., dissenting).

reliable about a patient's selection of a treating physician. She may have selected her physician because the office was convenient, the physician was recommended by a friend, or the physician treated her for other unrelated complaints. The inexperience of the patient in selecting the doctor may result in the selection of a doctor who is inexperienced or incompetent. As stated by the Nevada Supreme Court in *McClanahan v. Raley's, Inc.*, 34 P.3d 573, 577 (Supreme Court of Nevada 2001):

> "Nevertheless, we question the premises upon which the treating physician rule rests. We do not agree that because a physician has a duty to cure a patient that the physician will necessarily be more familiar with an issue such as the cause of an injury. An ability to reliably identify the cause of an injury may be less a product of familiarity with a patient and more the product of specialized skill, training and experience. We recognize that physicians commonly rely not solely upon their own observations but upon the expertise of other physicians with particular specialties when trying to resolve questions such as diagnosis of a condition and causation of an injury. Under these circumstances physicians may send the patient's records to another physician for review or the patient may be referred by the treating physician to be examined by a specialist. Additionally, a treating physician will not necessarily have spent more time with a patient than a physician who has been consulted for a second opinion. Even if a treating physician has spent more time with the patient, we do not view the quantity of time spent as a reason to give greater weight to that physician's opinion. The medical issue may be too complicated to resolve based

> solely upon the treating physician rule's supposition that the treating physician has spent more time with the patient than any other doctor. It is for these reasons that we reject the treating physician rule and determine that it has no applicability in this state."

Many treating physicians are inexperienced and untrained in providing work capacity evaluations. Even a qualified doctor may be unable to distinguish between medical impairment and disability from a particular occupation.

> "[M]edical impairments are not related to disability in a linear fashion. An individual with a medical impairment can have no disability for some occupations, yet be very disabled for others. For example, severe degenerative disk disease may impair the functioning of the spine of both a licensed practical nurse and a bank president in a similar fashion when performing their activities of daily living. However, in terms of occupation, the bank president is less likely to be disabled by this impairment than the licensed practical nurse."

Guides to the Evaluation of Permanent Impairment, American Medical Association 1.2b (Fifth Ed. 2002). [Brief App. 1]

In this case, Dr. Hartman's opinion reported Respondent's level of impairment. Dr Hartman reported that Respondent suffered from "lumbar disk syndrome." [L:66, 81, 84] He also reported Respondent's subjective complaints of pain. There is no evidence in the record which indicates in any way that Dr. Hartman knew the essential functions of the position of a material planner or considered work accommodations which could be provided to

Respondent. By focusing only on Respondent's impairment, he missed the critical elements of a work disability determination.

Dr. Hartman and Dr. Williams checked the boxes on a Physical Capacity Evaluation. However, while they reported on Respondent's ability to perform certain physical functions, they did not report on Respondent's work capacity for the job of material planner. Some persons with limited physical capacity outperform persons with no limitations; there is no direct relationship between a person's physical capacity and a person's work capacity.

> "[T]he impairment evaluation, however, is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adaptations can be made to the environment, the individual may not be disabled from performing that activity." *Guides to the Evaluation of Permanent Impairment* 1.2b (Fifth Ed. 2002). [Brief App. 1]

This Court has recognized that

> "[a]n individualized assessment of the effect of an impairment is particularly necessary when the impairment is one whose symptoms vary widely from person to person. Carpal tunnel syndrome, one of respondent's impairments, is just such a condition. While cases of severe carpal tunnel syndrome are characterized by muscle atrophy

> and extreme sensory deficits, mild cases generally do not have either of these effects and create only intermittent symptoms of numbness and tingling."

Toyota Motor Mfg., KY, Inc. v. Williams, 534 U.S. 184, 199 (2002). It would be ironic, indeed, if this Court were to hold that an employer must provide disability payments to an employee who the employer believes can work with the use of corrective measures and workplace accommodations, when at the same time, the employer is required by federal disability law to provide accommodations and consider corrective measures for individuals with a disability so they can work.

Over 75% of the American population will have low back pain at some time during their life. *Accommodating Individuals with Back Impairments* U.S. Department of Labor http://www.jan.wvu.edu (February 17, 2003). [Brief App. 125] For many people, it clears up within weeks. For others, they suffer pain but continue to perform their occupations using medication, therapy and avoidance of strain on their backs. There is no direct correlation between back injury and workplace disability. Each case must be evaluated individually. *Id.* The Respondent's physicians in this case only considered Respondent's impairment. There is no evidence on the record in this case that any of them went the next step and investigated whether Respondent could perform his job with accommodations and corrective measures, including pain relieving medication.

Dr. Mitri, the examining neurologist, diagnosed Respondent's impairment as lumbrosacral degenerative disc disease and chronic myofascial pain syndrome. [L:44-45] However, after diagnosing Respondent's condition, Dr.

Mitri looked at Respondent's job description and considered whether he could perform the work of a material planner. He determined that Respondent could perform his normal occupation if he was permitted to stand up and walk periodically. [L:43-45]

The Plan Manager who made the final decision denying benefits had available to him the requirements of the job of material planner, the reports of all of the medical doctors involved, the response of Janmarie Forward, his interview with Janmarie Forward and the Plan definition of disability. The Plan Manager had the information necessary to make the decision as to whether or not Respondent's impairment constituted a disability under the Plan. His decision was within the bounds of his discretion and should have been upheld. There is no legitimate reason in this case why the Plan Manager should have the burden of proving that the treating physician's opinion as to Respondent's impairment was wrong. This Court should reject the Ninth Circuit's treating physician rule in ERISA cases.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE CONFLICTS WITH THIS COURT'S DECISION IN *FIRESTONE* BY SHIFTING THE BURDEN FROM THE CLAIMANT TO SHOW THAT THE PLAN ADMINISTRATOR'S DECISION CONSTITUTED AN ABUSE OF DISCRETION TO THE PLAN ADMINISTRATOR TO DEMONSTRATE THAT THE TREATING PHYSICIAN'S OPINION WAS WRONG

ERISA itself does not designate burdens regarding the determination of eligibility for disability benefits. ERISA merely requires plans to afford a beneficiary a "reasonable opportunity" for a "full and fair" internal review of a

benefit denial and "provides a right for a subsequent judicial forum for a claim to recover benefits." *Rush Prudential HMO v. Moran,* 536 U.S. 355, 401 (2002); 29 U.S.C. §§ 1132(a)(1)(B), 1133(2).

Federal common law requires that the beneficiary of an ERISA disability plan bear the burden of proving that he is entitled to a benefit under 29 U.S.C. § 1132(a)(1)(B). *Horton v. Reliance Standard Life Ins. Co.,* 141 F.3d 1038, 1040 (11th Cir. 1998); *Fuja v. Benefit Trust Life Ins. Co.* 18 F.3d 1405, 1408 (7th Cir. 1994).

A. The Treating Physician Rule Is Inconsistent With An Abuse Of Discretion Standard Of Review

In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115, this Court held that a court must look to the language of the plan to determine the standard of review in any action brought under 29 U.S.C. § 1132(a)(1)(B) challenging a denial of benefits. In cases such as this one where the language of the plan grants the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the standard of review is abuse of discretion, regardless of whether or not the plan administrator is operating under an actual or potential conflict of interest. *Id.*

In reaching that conclusion, this Court reasoned that it "need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries."

Id.[15] Rather, the abuse of discretion standard of review applies regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. *Id*. However, the potential or actual conflict of interest is not entirely irrelevant: "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 'factor in determining whether there is an abuse of discretion.'" *Id*., quoting Restatement (Second) of Trusts § 187, Comment d (1959).

In this case, the Ninth Circuit used its treating physician rule from *Regula* first to determine that the plan administrator had an actual conflict of interest that tainted his decision and therefore mandated a *de novo* review by the court. *Nord*, 296 F.3d at 830-1; *Regula*, 266

[15] In *Firestone*, this Court rejected the Third Circuit's rationale that where an employer is itself the fiduciary and administrator of the plan, the plan's decision to deny benefits should be subject to *de novo* review because deference is unwarranted, given the lack of assurance of impartiality on the part of the employer. *Firestone,* 489 U.S. at 107-08, 115. The Ninth Circuit in this case used this same rejected logic to reach *de novo* review. That is, applying the treating physician rule, the Ninth Circuit concluded that Petitioner had an actual conflict of interest due to the fact that it rejected Respondent's treating physicians' reports and accepted the opinion of Dr. Mitri, without, in the Ninth Circuit's view, providing specific, legitimate reasons for doing so based on substantial evidence in the record. This conflict of interest voided the administrator's decision, subjecting it to *de novo* review. Yet, after this Court's opinion in *Firestone*, the Ninth Circuit's conflict of interest reasoning has no place in determining the standard of review. *Cf*. *Gallo*, 102 F.3d at 921-2 (holding that the question of the extent to which employers can be trusted to administer their own ERISA plans fairly is not an open question; where plan administrators have been given discretion, after *Firestone,* review is under abuse of discretion standard).

F.3d at 1147. ("[W]e add deviation from the treating physician rule to the short list of factors by which a court may determine that an apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in *de novo* review.") Second, the Ninth Circuit used the treating physician rule in its *de novo* review as a presumption that the treating physician's opinion was correct. *Nord*, 296 F.3d at 831-2 ("Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians"); *Regula*, 266 F.3d at 1139 (" . . . we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions.") Under *Firestone*, the Ninth Circuit should not have used the plan's failure to use the treating physician rule as evidence of a conflict of interest; it should not have used the conflict to mandate a *de novo* standard of review; and it should not have viewed the treating physician's opinion as presumptively valid.

> "The treating physician rule was totally inconsistent with the substantial evidence test. It was based on the Second Circuit's unsupported belief that treating physicians' opinions invariably are more reliable than consulting physicians' opinions. Congress, the SSA, ALJs, and independent researchers hold the contrary view: '[A]s a matter of both bias and degree of qualification the consulting physician was likely to be much the better information source.' J. Mashaw, et al, Social Security Hearings and Appeals 57 (1978). . . . "

Pierce, *Administrative Law Treatise* § 11.3.

In this case, Respondent should have borne the burden to prove that the plan administrator's decision denying him benefits constituted an abuse of discretion. In applying its own version of the treating physician rule, the Ninth Circuit fundamentally altered the *Firestone* standard. This artificially constructed burden shift conflicts with *Firestone* and should not be applied to ERISA disability benefit decisions.

B. The Ninth Circuit Used The Treating Physician Rule To Find An Actual Conflict Of Interest Which Tainted Petitioner's Decision To Deny Benefits

In this case, the Ninth Circuit correctly noted that Petitioner's Plan granted the administrator broad discretion over eligibility determinations. However, the Ninth Circuit concluded that Petitioner's denial of benefits was tainted by an actual conflict of interest because the Plan Manager: (1) did not credit the hypothetical opinion of its Human Resources representative, Janmarie Forward; and (2) did not meet the Ninth Circuit's treating physician rule requirements.[16] *Nord,* 296 F.3d at 830. Therefore, the court held that the Plan Manager's decision was presumptively void and should be reviewed *de novo*.[17] *Id.* at 831.

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[16] Of course, the Plan Manager did not know that the Ninth Circuit's treating physician rule applied on October 27, 1998, because *Regula* was not reported until September 24, 2001.

[17] Various circuits apply inconsistent levels of review when a conflict of interest exists. *Note: Inconsistency Among The Circuits Concerning The Conflict Of Interest Analysis Applied In An ERISA Action With An Emphasis On The Eighth Circuit's Adoption Of The*

(Continued on following page)

The first reason is not supported by the record. The Ninth Circuit stated that, "Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner." *Id.* at 830. There is no evidence in the record to support this finding. Forward's opinion in effect was that if Respondent could not get along with his peers, he could not do his job. In addition, her answer was given in response to an incomplete hypothetical posed by Respondent's attorney which ignored whether or not Respondent could have engaged in intense interpersonal relations with legally required accommodation, 42 U.S.C. § 12101 *et seq.* (the Americans with Disabilities Act), or mitigating measures such as medication. *Cf. Sutton v. United Air Lines Inc.,* 527 U.S. 471, 488-489 (1999) (holding that a disability for purposes of the ADA must be construed in light of corrective measures.) It is uncontroverted that Respondent was mediating his back pain by taking medication to control the pain and that his pain was "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [L:68, 87, 89]

The Ninth Circuit held that the plan administrator failed to give legitimate specific reasons for rejecting the treating physicians' opinions. *Nord,* 296 F.3d at 831. Therefore, the court held that Petitioner had not overcome the presumption of an actual conflict of interest created by

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Sliding Scale Analysis In Woo v. Deluxe Corporation, 75 N. Dak. L. Rev. 815 (1999). The Ninth Circuit applies the "presumptively void" test. *Atwood v. Newmont Gold Co., Inc.,* 45 F.3d 1317, at 1322-1323 (9th Cir. 1995).

its treating physician rule. The court gave no consideration to the fact that Petitioner: (1) had relied on the opinion of Dr. Mitri, a neurologist, that Respondent was able to perform his duties with accommodation as a material planner; (2) had given a copy of Dr. Mitri's report to Respondent and twice requested that he obtain the opinion of his treating physician on Dr. Mitri's conclusions, which Respondent failed to do; (3) the treating physician's diagnosis only went to impairment and not to work capacity; and (4) the treating physician's opinion did not address possible workplace accommodation measures such as intermittent standing and sitting and medication. The court shifted the burden from the claimant to show the plan administrator abused his discretion to the plan administrator to prove that there was not an actual conflict of interest that tainted his decision.

Using the treating physician rule as a determiner of actual conflict of interest by the plan administrator conflicts with the abuse of discretion test set out by this Court in *Firestone*. The Court should strike down the test and affirm the abuse of discretion standard in ERISA disability determinations where the plan administrator is given discretion to make benefit decisions or interpret the plan.

C. The Ninth Circuit Used The Treating Physician Rule In Its *De Novo* Review To Test The Reasonableness Of Petitioner's Decision To Deny Benefits

Relying upon its holding in *Regula* that " . . . we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions," the Ninth Circuit reviewed the opinions of Respondent's alleged three treating physicians

and the opinion of Dr. Mitri, the independent neurologist. *Nord,* 296 F.3d at 830-1. The court found that Dr. Mitri's opinion was overwhelmed by the opinion of the treating physicians that "Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner," despite the fact that none of the Respondent's physicians ever expressed an opinion as to Respondent's ability to perform the job of a material planner. *Id.* at 832. Not only did the court shift the burden to Petitioner to provide specific legitimate reasons for rejecting the treating physicians' opinions, the court also erroneously translated the treating physicians' opinions on Respondent's impairment into opinions on his work capacity to perform the job of material planner.

Using the treating physician rule in this manner conflicts with the abuse of discretion standard set out by this Court in *Firestone.* The Court should reverse the Ninth Circuit's plain error and reaffirm that the abuse of discretion standard applies.

D. The Ninth Circuit's Treating Physician Rule Places An Unreasonable Burden On The Plan Administrator

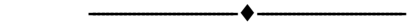
The Ninth Circuit's treating physician rule places an almost insurmountable burden on the plan administrator who believes that the treating physician's opinion is erroneous. As an example, if a podiatrist opined that his patient was disabled from throat cancer, under *Firestone*, the plan administrator could reject that opinion as incompetent and incredible, and all other factors being equal, that opinion would be subject to an abuse of discretion review. In that review, the claimant would have the burden of proving that the administrator's decision was

not based upon substantial evidence. However, under the Ninth Circuit's treating physician rule, the claimant has no burden other than producing the podiatrist's opinion. The administrator, however, has the burden to reject the podiatrist's opinion by specific, legitimate reasons which must be based on substantial evidence in the record; if he fails to do so, then his opinion is subject to a *de novo* review in which the treating physician's rule is used to test whether the plan administrator's decision is reasonable.[18]

The record in this case illustrates the unreasonable burden that the Ninth Circuit treating physician rule places on plan administrators. Instead of focusing on the administrator's decision in this case, the Ninth Circuit focused on the opinions of three doctors who were evaluating a subjective complaint by Respondent. The Ninth Circuit focused on the only objective evidence that was available – that Respondent had a mild degeneration of his spine. However, the Court missed the key issue of: What was Respondent's capacity to perform the job of material planner? If the Court has followed this Court's teachings in *Firestone*, it would have focused on Petitioner's decision and found the substantial evidence in Dr. Mitri's work capacity opinion, saving the plan and the courts from needlessly using their limited resources.

[18] In meeting its burden to reject the treating physician's opinion, the plan administrator will be forced to retain a highly qualified and expensive medical expert to oppose even an incompetent or incredible opinion. Plan administrators have been warned by the Ninth Circuit's opinion in *Nord* that a medical opinion as to impairment and work capacity by an examining neurologist in a back pain case is only "[a] scintilla of evidence that is not significantly probative [and] does not present a genuine issue of material fact." *Nord*, 296 F.3d at 832.

The Ninth Circuit's treating physician rule effectively puts a "thumb on the scale" in favor of the claimant by requiring the administrator to *produce* reasons based upon *substantial evidence* refuting the opinion submitted by the claimant's treating physician, rather than leaving the burden on the claimant to show a *lack of substantial evidence* to support the administrator's decision. A draconian rule which makes the opinion of the treating physician paramount, trumping conflicting medical evidence belies common sense. Where there is conflicting evidence in regard to a claimant's disability, resolution of that conflict should be left to the entity charged with making the decision – the plan administrator. As stated in *Dray v. Railroad Retirement Board* 10 F.3d 1306, 1311 (7th Cir. 1993): "In the case of dueling doctors, it remains the province of the hearing officer to decide whom to believe – a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a consulting specialist who may bring expertise and knowledge about similar cases." This Court should overrule the Ninth Circuit's treating physician rule.



CONCLUSION

This Court should reverse the holding of the Ninth Circuit Court of Appeals that its treating physician rule can be used (1) to show an actual conflict of interest that tainted Petitioner's decision to deny benefits and therefore requires *de novo* review of Petitioner's decision and (2) as a test to determine the reasonableness of the plan administrator's decision. This Court should overturn the reversal of the Order on Summary Judgment and overturn the *sua*

sponte order granting judgment to Respondent and remand the case to the Ninth Circuit with direction to review the Plan Manager's denial of benefits for abuse of discretion consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*.

Respectfully submitted,

WINSTON & STRAWN
LEE T. PATERSON
Counsel of Record

JOHN R. ATES
AMANDA C. SOMMERFELD
333 South Grand Avenue,
38th Floor
Los Angeles, California 90071-1543
Phone: (213) 615-1700
Fax: (213) 615-1750

Attorneys for Petitioner
The Black & Decker Disability Plan