No. _____

In The
Supreme Court of the United States

KENNETH L. NORD,

Petitioner,

v.

THE BLACK & DECKER DISABILITY PLAN,

Respondent.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the Ninth Circuit err in requiring both evidence of a conflict of interest and evidence of actual bias in failing to invoke de novo review despite the presence of actual conflict of interest, i.e. where the plan administrator and sponsor pays for benefits it awards from its general assets?

LIST OF PARTIES

The parties to the proceedings below are the Petitioner-Plaintiff, Kenneth L. Nord and the Respondent-Defendant, The Black & Decker Disability Plan. There are no other parties.

RULE 29.6 STATEMENT

Petitioner is a natural person and not a corporation.

RELATED CASES

Petitioner is unaware of any related cases before the Supreme Court.

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PETITION FOR WRIT OF CERTIORARI

Petitioner-Plaintiff Kenneth L. Nord respectfully petitions for a writ of certiorari to review the January 23, 2004 decision of the United States Court of Appeals for the Ninth Circuit in the above-entitled proceeding finding that the court will review the decision of a plan administrator of an ERISA disability plan for abuse of discretion despite the earlier finding of a conflict of interest, i.e. that benefits payable to plan participants and beneficiaries come from the coffers of the plan administrator.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit on remand from the United States Supreme Court reinstating the decision of the United States District Court for the Central District of California is reported at 356 F.3d 1008. The opinion of the United States Supreme Court vacating the earlier decision of the United States Court of Appeals for the Ninth Circuit is reported at 538 U.S. 822. The vacated opinion of the United States Court of Appeals for the Ninth Circuit is reported at 296 F.3d 823. The opinion of the United States District Court for the Central District of California is unreported. All opinions are reproduced in the Appendix.

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STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Ninth Circuit was entered on January 23, 2004. The United States Court of Appeals for the Ninth Circuit denied the petition for rehearing en banc on March 1,

2004. [Appendix ("App.") 59]. This Petition for Writ of Certiorari is filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1) (2003).

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1132(a)(1)(B) (2003)

Civil Enforcement.

(a) Persons empowered to bring a civil action – A civil action may be brought –

(1) by a participant or beneficiary –

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1103(c)(1) (2003)

Establishment of Trust

(c) Assets of plan not to inure to benefit of employer; allowable purposes of holding plan assets –

(1) Except as provided in paragraph (2), (3), or (4) or subsection (d) of this section, or under sections 1342 and 1344 of this title (relating to termination of insured plans), or under Pension Funding Equity Act of 2004, the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their

beneficiaries and defraying reasonable expenses of administering the plan.

29 U.S.C. § 1104(a) (2003)

Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(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;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

28 U.S.C. § 1254(1) (2003)

Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

STATEMENT OF THE CASE

Respondent Kenneth L. Nord was a material planner for Kwikset Corporation, a subsidiary of The Black & Decker Corporation. [App. 38-39]. As an employee of Kwikset Corporation, Respondent Kennth L. Nord participated in The Black & Decker Disability Plan.

Petitioner Kenneth Nord stopped working on July 15, 1997 due to a severe back injury. [App. 39]. The Respondent Plan denied the claim for benefits under the "own occupation" definition of disability. [App. 44]. Black & Decker funds the first 40% of basic compensation as long-term disability benefits without employee contribution. [Supplemental Excerpts of the Clerk's Record ("SECR") at 17]. Coverage for either 60% or 70% of basic compensation as long-term disability benefits requires employee contribution. [SECR at 17].

The district court found an apparent or technical conflict of interest but reviewed the decision of the Respondent Plan for abuse of discretion. [App. 52]. The Ninth Circuit acknowledged Petitioner's basic argument, that because Black & Decker operated under a conflict of interest, the court should review the decision of Black & Decker to deny benefits *de novo*. [App. 30-31]. This Court vacated the decision of the Ninth Circuit in its reliance on the "treating physician rule" as a basis for stripping the plan administrator of discretion otherwise conferred in the documents and instruments governing the Respondent Plan. [App. 20-21]. On remand from this Court, the Ninth Circuit determined that the actual conflict of interest did not sufficiently affect the decision-making process to warrant deviation from abuse of discretion review. [App. 2-4]. The Ninth Circuit thus determined that in addition to showing a conflict of interest that Petitioner Kenneth L. Nord must also prove the presence of actual bias in order to invoke a more searching standard of review.

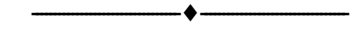
The Presence of a Conflict of Interest

Black & Decker funds the first 40% of basic compensation as long-term disability benefits without employee

contribution. [SECR at 17]. Employees of Black & Decker or any of its subsidiaries pay no contribution for basic long-term disability coverage. [SECR at 17]. Coverage for either 60% or 70% of basic compensation as long-term disability benefits requires employee contribution. [SECR at 17]. Employees pay for only a portion of the cost associated with the higher levels of coverage. [SECR at 17].

Black & Decker (U.S.) Inc. is the plan sponsor. [SECR at 24]. Black & Decker (U.S.) Inc. Pension Committee provides plan administration. [SECR at 24]. Raymond J. Brusca, an officer of Black & Decker, is the plan manager. [SECR at 24]. Black & Decker has an apparent conflict of interest in the payment of benefits to participants in Respondent The Black & Decker Disability Plan. The district court found an apparent or technical conflict of interest but reviewed the decision of the Respondent Plan for abuse of discretion. [App. 52]. The Ninth Circuit acknowledged Petitioner's basic argument, that Black & Decker operated under a conflict of interest. [App. 30-31].

In the exercise of *de novo* review, the Ninth Circuit would make a factual finding that Petitioner Kenneth Nord suffers from a disability as that term is defined in the Respondent Plan. [App. 36-37].



REASONS FOR GRANTING THE PETITION

The Supreme Court should grant this Petition because the circuits exist in a complete state of disarray on "just how deferential review can be when the judicial eye is peeled for conflict of interest?" *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n. 15, 122 S.Ct. 2151 (2002).

The Ninth Circuit acknowledged the lack of guidance. In further briefing before the Ninth Circuit, Respondent Plan argued:

> Both Nord and The Plan agree that the Ninth Circuit's *Atwood* [*v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995)] test is inconsistent with the Supreme Court's decisions in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002).

[Appellee's Further Brief on Remand from the United States Supreme Court at 6].

In *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), the Court explained, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Since that time, "courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto v. Reliance Standard Life Ins. Co.,* 214 F.3d 377, 383 (3d Cir. 2000).

The determination of what constitutes a conflict of interest, and how the conflict weighs as a "factor," has plagued courts for the last fourteen years, resulting in essentially five different standards among the circuits. The fractured state of conflict of interest analysis among the circuits, from presumptively void with a defense of no

actual bias,[1] evidence of bias required to heighten review upon showing conflict of interest,[2] a more "bite" analysis,[3] the proverbial "smoking gun,"[4] and amorphous sliding scale analysis,[5] cannot stand in light of *Rush Prudential*. The Court should provide clear guidance to the lower courts on this issue of just how much deference a conflicted plan administrator may claim, if any, so as to render clarity to the exclusive remedies provided participants and beneficiaries of ERISA plans.

NLRB v. Amax Coal Co., 453 U.S. 322, 329-330, 101 S.Ct. 2789, 69 L.Ed.2d 672 (1981) addressed the issue of conflict of interest under the Labor Relations Management Act and the National Labor Relations Act. The Court held:

> Under principles of equity, a trustee bears an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties. Restatement (Second) of Trusts § 170(1) (1957); 2 A. Scott, Law of Trusts

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[1] *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990).

[2] *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995).

[3] *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999).

[4] *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996).

[5] *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999); *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999); *Peruzzi v. Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998); *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 986 (7th Cir. 1999); *Barnhart v. UNUM Life Ins. Co.*, 179 F.3d 583, 589 n. 9 (8th Cir. 1999); *Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (10th Cir. 2000).

> § 170 (1967). To deter the trustee from all temptation and to prevent any possible injury to the beneficiary, the rule against a trustee dividing his loyalties must be enforced with "uncompromising rigidity." *Meinhard* v. *Salmon,* 249 N.Y. 458, 464, 164 N.E. 545, 546 (Cardozo, C. J.). A fiduciary cannot contend "that although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one." *Woods* v. *City National Bank & Trust Co.,* 312 U.S. 262, 269.

Id. The Court further observed that a plan administrator's decision may never inure to the benefit of the employer of that plan administrator. 453 U.S. at 333-334 *citing* ERISA § 403(c)(1) (29 U.S.C. § 1103); S. Rep. No. 93-383, pp. 31, 32 (1973); H.R. Conf. Rep. No. 93-1280, p. 309 (1974) (prevention of plan administrators operating under dual loyalties paramount under ERISA).

CONCLUSION

The Court should disabuse the lower courts of the notion that a plan beneficiary must come forward with both evidence of conflict of interest and evidence of actual bias in order to deprive a conflicted plan administrator of self-retained discretion. Rather, the Court should announce a clear and readily applied rule; evidence of either a conflict of interest will deprive the affected plan administrator of retained discretion to make a determination on entitlement to plan benefits. As a disjunctive codicil to the rule, it is equally clear that evidence of actual bias, in the absence of a conflict of interest, will deprive the affected

plan administrator of retained discretion to make a determination on entitlement to plan benefits.

Respectfully submitted,

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KENNETH L. NORD, *Plaintiff-Appellant,* v. THE BLACK & DECKER DISABILITY PLAN, *Defendant-Appellee.*	No. 00-55689 D.C. No. CV-99-00408-CM Central District of California, Los Angeles ORDER

Appeal from the United States District Court
for the Central District of California
Carlos R. Moreno, District Judge, Presiding

Argued and Submitted
October 16, 2001 – Pasadena, California

Original Opinion Filed July 15, 2002
Opinion Vacated by the Supreme Court May 27, 2003
Filed January 23, 2004

Before: Betty B. Fletcher, Dorothy W. Nelson, and
M. Margaret McKeown, Circuit Judges.

ORDER

The Supreme Court has vacated our opinion in *Nord v. Black & Decker Disability Plan,* 296 F.3d 823, 828 (9th Cir. 2002) and remanded for further proceedings. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003).

Kenneth Nord challenges the decision of Black & Decker Disability Benefits Plan ("Black & Decker" or the

"Plan") to deny Nord's application for thirty months of disability benefits. The district court upheld the denial of benefits. We reversed and held that when making benefits decisions under the Employee Retirement Income Security Act of 1974 ("ERISA"), plan administrators must credit the opinions of an employee's treating physician over the opinion of a physician retained by the plan. We also held that Black & Decker's denial of benefits to Nord, taking into consideration the weight that should be given the treating physician's opinion, showed a conflict of interest and therefore that the Plan's denial should be reviewed de novo and summary judgment granted to Nord. The Supreme Court reversed only as to the treating physician rule but vacated our opinion and remanded for further proceedings. We now reinstate the district court's judgment.

As we stated in our prior opinion, where, as here, a plan administrator has "discretionary authority to determine eligibility for benefits," we review the benefits decision for abuse of discretion. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 828 (9th Cir. 2002) ("*Nord I*"), *reversed on other grounds by Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *see also Hensley v. Northwest Permanente P.C. Retirement Plan & Trust*, 258 F.3d 986, 994 (9th Cir. 2001). However, where the "benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' " *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). As the Supreme Court has recently noted, if a conflict of interest is "plausibly raised," the "review for abuse of discretion [should] home in on [that] conflict . . . . " *Rush Prudential HMO, Inc. v.*

Moran, 536 U.S. 355, 384 n.15 (2002). The Court left an open question as to "just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Id.*

There is an apparent conflict of interest here, because Black & Decker is both the administrator and the funding source for the Plan. *See Nord*, 296 F.3d at 828. To create a rebuttable presumption that Black & Decker in fact violated its fiduciary obligations, we require "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). As the district court and we stated in *Nord I*, "material, probative evidence" may consist of "inconsistencies in the plan administrator's reasons, insufficiency of those reasons, or procedural irregularities in the processing of the beneficiaries claims." *Nord*, 296 F.3d at 829 (internal citations omitted). If there is probative evidence of a conflict of interest and Black & Decker cannot rebut it, the denial of benefits is reviewed de novo.

The district court recognized the apparent conflict of interest and reviewed the Plan administrator's decision with the special care required by *Firestone. See Firestone*, 489 U.S. at 115. We note that *Rush* left an open question about the level of deference that should be given to a plan administrator's decision where there is an apparent conflict of interest. *See Rush*, 536 U.S. at 384 n.15. However, here the district court gave appropriately careful scrutiny to all the evidence. The district court noted particularly that the primary evidence in Nord's favor was undermined because: (1) Nord's physicians did not respond to the Black & Decker physician's opinion when given the

opportunity; and (2) the opinion of Black & Decker's HR representative was undermined because the questionnaire was leading and she was not an expert with all the necessary information. Our review of the evidence confirms the district court's view that in the absence of a "treating physician's rule," there was not material evidence of an actual conflict of interest, and the Plan's decision was not an abuse of discretion.

We now reinstate the judgment of the district court.

REMANDED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 00-55689
CT/AG#: CV-99-00408-CM

KENNETH L. NORD

Plaintiff-Appellant

v.

THE BLACK & DECKER
DISABILITY PLAN

Defendant-Appellee

APPEAL FROM the United States District Court for the Central District of California, Los Angeles.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that this cause be, and hereby is REMANDED to the district court for further proceedings.

Filed and entered January 23, 2004

(Slip Opinion)

OCTOBER TERM, 2002

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

BLACK & DECKER DISABILITY PLAN *v.* NORD

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 02-469. Argued April 28, 2003 – Decided May 27, 2003

Petitioner Black & Decker Disability Plan (Plan), an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), provides benefits for eligible disabled employees of Black and Decker Corporation (Black & Decker) and certain of its subsidiaries. Black & Decker is the administrator of the Plan but has delegated authority to Metropolitan Life Insurance Company (MetLife) to render initial recommendations on benefit claims. Respondent Nord, an employee of a Black & Decker subsidiary, submitted a claim for disability benefits under the Plan, which MetLife denied. At MetLife's review stage, Nord submitted letters and supporting documentation from his physician, Dr. Hartman, and a treating orthopedist to whom Hartman had referred

Nord. These treating physicians stated that Nord suffered from a degenerative disc disease and chronic pain that rendered him unable to work. Black & Decker referred Nord to a neurologist for an independent examination. The neurologist concluded that, aided by pain medication, Nord could perform sedentary work. MetLife thereafter made a final recommendation to deny Nord's claim, which Black & Decker accepted. Seeking to overturn that determination, Nord filed this action under ERISA. The District Court granted summary judgment for the Plan, concluding that Black & Decker's denial of Nord's claim was not an abuse of the plan administrator's discretion. The Ninth Circuit reversed and itself granted summary judgment for Nord. The Court of Appeals explained that the case was controlled by a recent Ninth Circuit decision holding that, when making benefit determinations, ERISA plan administrators must follow a "treating physician rule." As described by the appeals court, that rule required a plan administrator who rejects the opinions of a claimant's treating physician to come forward with specific reasons for the decision, based on substantial evidence in the record. The Ninth Circuit found that, under this rule, the plan administrator had not provided adequate justification for rejecting the opinions of Nord's treating physicians.

Held: ERISA does not require plan administrators to accord special deference to the opinions of treating physicians. The "treating physician rule" imposed by the Ninth Circuit was originally developed by Courts of Appeals as a means to control disability determinations by administrative law judges under the Social Security Act. In 1991, the Commissioner of Social Security adopted regulations approving and formalizing use of the rule in the Social Security disability program. Nothing in ERISA or the Secretary of Labor's

ERISA regulations, however, suggests that plan administrators must accord special deference to the opinions of treating physicians, or imposes a heightened burden of explanation on administrators when they reject a treating physician's opinion. If the Secretary found it meet to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference. See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U.S. 837. But the Secretary has not chosen that course and an *amicus* brief reflecting the Department of Labor's position opposes adoption of such a rule for disability determinations under plans covered by ERISA. Whether a treating physician rule would increase the accuracy of ERISA disability determinations, as the Ninth Circuit believed it would, is a question that the Legislature or superintending administrative agency is best positioned to address. Finally, and of prime importance, critical differences between the Social Security disability program and ERISA benefit plans caution against importing a treating physician rule from the former area into the latter. By accepting and codifying such a rule, the Social Security Commissioner sought to serve the need for efficient administration of an obligatory nationwide benefits program. In contrast, nothing in ERISA requires employers to establish employee benefits plans or mandates what kind of benefits employers must provide if they choose to have such a plan. *Lockheed Corp.* v. *Spink,* 517 U.S. 882, 887. Rather, employers have large leeway to design disability and other welfare plans as they see fit. In determining entitlement to Social Security benefits, the adjudicator measures the claimant's condition against a uniform set of federal criteria. The validity of a claim to benefits under an ERISA plan, on the other hand, is likely to turn, in large part, on the interpretation of terms in the plan at issue. *Firestone Tire & Rubber Co.* v. *Bruch,* 489

U. S. 101, 115. Deference is due the Labor Secretary's stated view that ERISA is best served by preserving the greatest flexibility possible for operating claims processing systems consistent with a plan's prudent administration. Plan administrators may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician. But courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation. Pp. 5-11.

296 F. 3d 823, vacated and remanded.

GINSBURG, J., delivered the opinion for a unanimous Court.

Cite as: 538 U. S. ___ (2003)

Opinion of the Court

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 02-469

THE BLACK & DECKER DISABILITY PLAN,
PETITIONER *v.* KENNETH L. NORD

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

[May 27, 2003]

JUSTICE GINSBURG delivered the opinion of the Court.

Under a rule adopted by the Commissioner of Social Security, in determining whether a claimant is entitled to Social Security disability benefits, special weight is accorded opinions of the claimant's treating physician. See 20 CFR §§ 404.1527(d)(2), 416.927(d)(2) (2002). This case presents the question whether a similar "treating physician rule" applies to disability determinations under employee benefits plans covered by the Employee Retirement Income Security Act of 1974 (ERISA or Act), 88 Stat. 832, as amended, 29 U. S. C. §1001 *et seq*. We hold that plan administrators are not obliged to accord special deference to the opinions of treating physicians.

ERISA and the Secretary of Labor's regulations under the Act require "full and fair" assessment of claims and clear communication to the claimant of the "specific reasons" for benefit denials. See 29 U. S. C. §1133; 29 CFR §2560.503-1 (2002). But these measures do not command plan administrators to credit the opinions of treating physicians over other evidence relevant to the claimant's medical condition. Because the Court of Appeals for the

Ninth Circuit erroneously applied a "treating physician rule" to a disability plan governed by ERISA, we vacate that court's judgment and remand for further proceedings.

I

Petitioner Black & Decker Disability Plan (Plan), an ERISA-governed employee welfare benefit plan, covers employees of Black and Decker Corporation (Black & Decker) and certain of its subsidiaries. The Plan provides benefits for eligible employees with a "disability." As relevant here, the Plan defines "disability" to mean "the complete inability . . . of a Participant to engage in his regular occupation with the Employer."[1] 296 F. 3d 823, 826, n. 2 (CA9 2002). Black & Decker both funds the Plan and acts as plan administrator, but it has delegated authority to Metropolitan Life Insurance Company (MetLife) to render initial recommendations on benefit claims. Disability determinations, the Black & Decker Plan provides, "[are to] be made by the [plan administrator] based on suitable medical evidence and a review of the Participant's employment history that the [plan administrator] deems satisfactory in its sole and absolute discretion." *Id.,* at 826, n. 1.

Respondent Kenneth L. Nord was formerly employed by a Black & Decker subsidiary as a material planner. His

[1] The Plan sets out a different standard for determining whether an employee is entitled to benefits for a period longer than 30 months. Because respondent Nord sought benefits "for up to 30 months," 296 F.3d 823, 826 (CA9 2002), the standard for longer term disability is not in play in this case.

job, classed "sedentary," required up to six hours of sitting and two hours of standing or walking per day. *Id.,* at 826.

In 1997, Nord consulted Dr. Leo Hartman about hip and back pain. Dr. Hartman determined that Nord suffers from a mild degenerative disc disease, a diagnosis confirmed by a Magnetic Resonance Imaging scan. After a week's trial on pain medication prescribed by Dr. Hartman, Nord's condition remained unimproved. Dr. Hartman told Nord to cease work temporarily, and recommended that he consult an orthopedist while continuing to take the pain medication.

Nord submitted a claim for disability benefits under the Plan, which MetLife denied in February 1998. Nord next exercised his right to seek further consideration by MetLife's "Group Claims Review." 296 F. 3d, at 827. At that stage, Nord submitted letters and supporting documentation from Dr. Hartman and a treating orthopedist to whom Hartman had referred Nord. Nord also submitted a questionnaire form, drafted by Nord's counsel, headed "Work Capacity Evaluation." Black & Decker human resources representative Janmarie Forward answered the questions, as the form instructed, by the single word "yes" or "no." One of the six items composing the "Work Capacity Evaluation" directed Forward to "[a]ssume 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." Lodging for Pet. for Cert. L-37. The associated question asked whether an "individual of those limitations [could] perform the work of a material planner." *Ibid.* Forward marked a space labeled "no."

During the MetLife review process, Black & Decker referred Nord to neurologist Antoine Mitri for an independent examination. Dr. Mitri agreed with Nord's doctors that Nord suffered from a degenerative disc disease and chronic pain. But aided by pain medication, Dr. Mitri concluded, Nord could perform "sedentary work with some walking interruption in between." *Id.,* at L-45. MetLife thereafter made a final recommendation to deny Nord's claim.

Black & Decker accepted MetLife's recommendation and, on October 27, 1998, so informed Nord. The notification letter summarized the conclusions of Nord's doctors, the results of diagnostic tests, and the opinion of Dr. Mitri. See *id.,* at L-155 to L-156. It also recounted that Black & Decker had forwarded Dr. Mitri's report to Nord's counsel with a request for comment by Nord's attending physician. Although Nord had submitted additional information, the letter continued, he had "provided . . . no new or different information that would change [MetLife's] original decision." *Id.,* at L-156. The letter further stated that the Work Capacity Evaluation form completed by Black & Decker human resources representative Forward was "not sufficient to reverse [the Plan's] decision." *Ibid.*

Seeking to overturn Black & Decker's determination, Nord filed this action in Federal District Court "to recover benefits due to him under the terms of his plan." 29 U. S. C. §1132(a)(1)(B). On cross-motions for summary judgment, the District Court granted judgment for the Plan, concluding that Black & Decker's denial of Nord's claim was not an abuse of the plan administrator's discretion.

The Court of Appeals for the Ninth Circuit roundly reversed and itself "grant[ed] Nord's motion for summary

judgment." 296 F. 3d, at 832. Nord's appeal, the Ninth Circuit explained, was controlled by that court's recent decision in *Regula* v. *Delta Family-Care Disability Survivorship Plan,* 266 F. 3d 1130 (2001). 296 F. 3d, at 829. The Ninth Circuit had held in *Regula* that, when making benefit determinations, ERISA plan administrators must follow a "treating physician rule." See 266 F. 3d, at 1139-1144. As described by the appeals court, the rule required an administrator "who rejects [the] opinions [of a claimant's treating physician] to come forward with specific reasons for his decision, based on substantial evidence in the record." *Id.,* at 1139. Declaring that Nord was entitled to judgment as a matter of law, the Ninth Circuit emphasized that Black & Decker fell short under the treating physician rule: The plan administrator had not provided adequate justification, the Court of Appeals said, for rejecting opinions held by Dr. Hartman and others treating Nord on Hartman's recommendation. 296 F. 3d, at 830-832.

We granted certiorari, 537 U. S. 1098 (2002), in view of the division among the Circuits on the propriety of judicial installation of a treating physician rule for disability claims within ERISA's domain. Compare *Regula,* 266 F. 3d, at 1139; *Donaho* v. *FMC Corp.,* 74 F. 3d 894, 901 (CA8 1996), with *Elliott* v. *Sara Lee Corp.,* 190 F. 3d 601, 607-608 (CA4 1999); *Delta Family-Care Disability and Survivorship Plan* v. *Marshall,* 258 F. 3d 834, 842-843 (CA8 2001); *Turner* v. *Delta Family-Care Disability and Survivorship Plan,* 291 F. 3d 1270, 1274 (CA11 2002). See also *Salley* v. *E.I. DuPont de Nemours & Co.,* 966 F. 2d 1011, 1016 (CA5 1992) (expressing "considerable doubt" on the question whether a treating physician rule should govern ERISA cases). Concluding that courts have no warrant to

order application of a treating physician rule to employee benefit claims made under ERISA, we vacate the Ninth Circuit's judgment and remand the case for further proceedings.[2]

II

The treating physician rule at issue here was originally developed by Courts of Appeals as a means to control disability determinations by administrative law judges under the Social Security Act, 49 Stat. 620, 42 U. S. C. §231 *et seq*. See Maccaro, The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits, 41 Soc. Sec. Rep. Serv. 833, 833-834 (1993). In 1991, the Commissioner of Social Security adopted regulations approving and formalizing use of the rule in the Social Security disability program. See 56 Fed.Reg. 36961, 36968 (codified at 20 CFR §§404.1527(d)(2), 416.927(d)(2) (2002)). The Social Security Administration, the regulations inform, will generally "give more weight to opinions from . . . treating sources," and "will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." §§404.1527(d)(2), 416.927(d)(2).

Concluding that a treating physician rule should similarly govern private benefit plans under ERISA, the Ninth Circuit said in *Regula* that its "reasons ha[d] to do

[2] The Plan sought review only of the Court of Appeals' holding "that an ERISA disability plan administrator's determination of disability is subject to the 'treating physician rule.' " Pet. for Cert. i. We express no opinion on any other issues.

with common sense as well as consistency in [judicial] review of disability determinations where benefits are protected by federal law." 266 F. 3d, at 1139. "Just as in the Social Security context," the court observed, "the disputed issue in ERISA disability determinations concerns whether the facts of the beneficiary's case entitle him to benefits." *Ibid.* The Ninth Circuit perceived "no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the [plan] administrator's positions." *Ibid.* The United States urges that the Court of Appeals "erred in equating the two [statutory regimes]." Brief for United States as *Amicus Curiae* 23. We agree.[3]

[3] The treating physician rule has not attracted universal adherence outside the Social Security context. Some courts have approved a rule similar to the Social Security Commissioner's for disability determinations under the Longshore and Harbor Workers' Compensation Act, 33 U. S. C. § 901 *et seq.,* see, *e.g., Pietrunti v. Director, Office of Workers' Compensation Programs,* 119 F.3d 1035, 1042 (CA21997), and the Secretary of Labor has adopted a version of the rule for benefit determinations under the Black Lung Benefits Act, 30 U. S. C. § 901 *et seq.,* see 20 CFR § 718.104(d)(5) (2002). One Court of Appeals, however, has rejected a treating physician rule for the assessment of claims of entitlement to veterans' benefits for service-connected disabilities, see *White v. Principi,* 243 F.3d 1378, 1381 (CAFed 2001), and another has rejected such a rule for disability determinations under the Railroad Retirement Act of 1974, 45 U. S. C. § 231 *et seq.,* see *Dray v. Railroad Retirement Bd.,* 10 F.3d 1306, 1311 (CA7 1993). Furthermore, there appears to be no uniform practice regarding application of a treating physician rule under state workers' compensation statutes. See *Conradt v. Mt. Carmel School,* 197 Wis. 2d 60, 69, 589 N. W. 2d 713, 717 (Ct. App. 1995) ("Conradt misrepresents the state of the law when she claims that a majority of states have adopted the 'treating physician rule.' ").

"ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co.* v. *Bruch,* 489 U. S. 101, 113 (1989) (internal quotation marks and citations omitted). The Act furthers these aims in part by regulating the manner in which plans process benefits claims. Plans must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U. S. C. §1133(1). ERISA further requires that plan procedures "afford a reasonable opportunity . . . for a full and fair review" of dispositions adverse to the claimant. §1133(2). Nothing in the Act itself, however, suggests that plan administrators must accord special deference to the opinions of treating physicians. Nor does the Act impose a heightened burden of explanation on administrators when they reject a treating physician's opinion.

ERISA empowers the Secretary of Labor to "prescribe such regulations as he finds necessary or appropriate to carry out" the statutory provisions securing employee benefit rights. §1135; see §1133 (plans shall process claims "[i]n accordance with regulations of the Secretary"). The Secretary's regulations do not instruct plan administrators to accord extra respect to treating physicians' opinions. See 29 CFR §2560.503-1 (1997) (regulations in effect when Nord filed his claim); 29 CFR §2560.503-1 (2002) (current regulations). Notably, the most recent version of the Secretary's regulations, which installs no treating physician rule, issued more than nine years after the Social Security Administration codified a treating physician rule

in that agency's regulations. Compare 56 Fed. Reg. 36932, 36961 (1991), with 65 Fed. Reg. 70265 (2000).

If the Secretary of Labor found it meet [sic] to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference. See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U. S. 837 (1984). The Secretary has not chosen that course, however, and an *amicus* brief reflecting the position of the Department of Labor opposes adoption of such a rule for disability determinations under plans covered by ERISA. See Brief for United States as *Amicus Curiae* 7-27. Although Congress "expect[ed]" courts would develop "a federal common law of rights and obligations under ERISA-regulated plans," *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U.S. 41, 56 (1987), the scope of permissible judicial innovation is narrower in areas where other federal actors are engaged, cf. *Milwaukee* v. *Illinois,* 451 U. S. 304, 317-332 (1981) (because Congress had enacted a comprehensive regulatory program dealing with discharge of pollutants into the Nation's waters, the State could not maintain a federal common-law nuisance action against the city based on the latter's pollution of Lake Michigan).

The question whether a treating physician rule would "increas[e] the accuracy of disability determinations" under ERISA plans, as the Ninth Circuit believed it would, *Regula,* 266 F. 3d, at 1139, moreover, seems to us one [sic] the Legislature or superintending administrative agency is best positioned to address. As compared to consultants retained by a plan, it may be true that treating physicians, as a rule, "ha[ve] a greater opportunity to know and observe the patient as an individual." *Ibid.* (internal quotation marks and citation omitted). Nor do we question the Court of Appeals' concern that physicians repeatedly

retained by benefits plans may have an "incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." *Id.,* at 1143. But the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an "incentive" to make a finding of "not disabled," so a treating physician, in a close case, may favor a finding of "disabled." Intelligent resolution of the question whether routine deference to the opinion of a claimant's treating physician would yield more accurate disability determinations, it thus appears, might be aided by empirical investigation of the kind courts are ill equipped to conduct.

Finally, and of prime importance, critical differences between the Social Security disability program and ERISA benefit plans caution against importing a treating physician rule from the former area into the latter. The Social Security Act creates a nationwide benefits program funded by Federal Insurance Contributions Act payments, see 26 U. S. C. §§3101(a), 3111(a), and superintended by the Commissioner of Social Security. To cope with the "more than 2.5 million claims for disability benefits [filed] each year," *Cleveland* v. *Policy Management Systems Corp.,* 526 U. S. 795, 803 (1999), the Commissioner has published detailed regulations governing benefits adjudications. See, *e.g., id.,* at 803-804. Presumptions employed in the Commissioner's regulations "grow out of the need to administer

a large benefits system efficiently." *Id.,* at 804. By accepting and codifying a treating physician rule, the Commissioner sought to serve that need. Along with other regulations, the treating physician rule works to foster uniformity and regularity in Social Security benefits determinations made in the first instance by a corps of administrative law judges.

In contrast to the obligatory, nationwide Social Security program, "[n]othing 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 Corp.* v. *Spink,* 517 U. S. 882, 887 (1996). Rather, employers have large leeway to design disability and other welfare plans as they see fit. In determining entitlement to Social Security benefits, the adjudicator measures the claimant's condition against a uniform set of federal criteria. "[T]he validity of a claim to benefits under an ERISA plan," on the other hand, "is likely to turn," in large part, "on the interpretation of terms in the plan at issue." *Firestone Tire,* 489 U. S., at 115. It is the Secretary of Labor's view that ERISA is best served by "preserv[ing] the greatest flexibility possible for . . . operating claims processing systems consistent with the prudent administration of a plan." Department of Labor, Employee Benefits Security Administration, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html, Question B-4 (as visited May 6, 2003) (available in Clerk of Court's case file). Deference is due that view.

Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician. But, we hold, courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's

physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.[4] The Court of Appeals therefore erred when it employed a treating physician rule lacking Department of Labor endorsement in holding that Nord was entitled to summary judgment.

* * *

For the reasons stated, the judgment of the United States Court of Appeals for the Ninth Circuit is vacated, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

[4] Nord asserts that there are two treating physician rules: a "procedural" rule, which requires a hearing officer to explain why she rejected the opinions of a treating physician, and a "substantive" rule, which requires that "more weight" be given to the medical opinions of a treating physician. Brief for Respondent 12-13 (internal quotation marks omitted). In this case, Nord contends, the Court of Appeals applied only the "procedural" version of the rule. *Id.,* at 13. We are not certain that Nord's reading of the Court of Appeals decision is correct. See 296 F.3d, at 831 (faulting the Plan for, *inter alia,* having "[n]o evidence . . . that Nord's treating physicians considered inappropriate factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions"). At any rate, for the reasons explained in this opinion, we conclude that ERISA does not support judicial imposition of a treating physician rule, whether labeled "procedural" or "substantive."

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KENNETH L. NORD,

Plaintiff-Appellant,

v.

THE BLACK & DECKER DISABILITY PLAN,

Defendant-Appellee.

No. 00-55689

D.C. No.
CV-99-00408-CM

OPINION

Appeal from the United States District Court
for the Central District of California
Carlos R. Moreno, District Judge, Presiding

Argued and Submitted
October 16, 2001 – Pasadena, California

Filed July 15, 2002

Before: Betty Binns Fletcher, Dorothy W. Nelson, and M. Margaret McKeown, Circuit Judges.

Opinion by Judge B. Fletcher

COUNSEL

Lawrence D. Rohlfing, Esq., Santa Fe Springs, California, for the plaintiff-appellant.

Lee T. Paterson, Esq., Los Angeles, California, for the defendant-appellee.

OPINION

B. FLETCHER, Circuit Judge:

This case arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. Plaintiff Kenneth Nord seeks disability welfare benefits from defendant Black & Decker Disability Benefits Plan ("Black & Decker" or the "Plan"). The district court granted summary judgment in favor of Black & Decker, holding that it did not abuse its discretion by denying Nord disability benefits under the terms of the Plan. Nord appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. Based on our recent decision in *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130 (9th Cir. 2001), we conclude that the district court erred in reviewing the disability determination for an abuse of discretion. We review *de novo* and reverse.

FACTUAL AND PROCEDURAL BACKGROUND

Kenneth Nord was formerly employed as a Material Planner for Kwikset Corporation, a subsidiary of the Black & Decker Corporation. Nord's responsibilities as a Material Planner included ordering goods, interacting with vendors, and maintaining inventory levels. The position is a sedentary one, requiring up to six hours of sitting and up to two hours of standing or walking per day.

Through his employment at Kwikset, Nord was enrolled in the Black & Decker Disability Plan. The language of the Plan grants absolute discretion to the Plan

Manager to make disability determinations.[1] The Plan also invests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. The third-party Claims Administrator retained while Nord's claim was under review was Metropolitan Life Insurance Company ("MetLife"). The Plan provides long-term benefits coverage for participating employees who are prevented by disability from occupying their regular jobs for the first 30 months of the disability. At issue here is Nord's disability from performing his regular job for 30 months. Continuing benefits are available for those participants who are prohibited from engaging in any gainful employment for which they are qualified due to their disabilities.[2]

In March 1997, Nord consulted Dr. Hartman regarding his experience with intermittent hip and low back pain. Dr. Hartman concluded that Nord suffered from mild degenerative disc disease at the L4-L5 and L5-S1 vertebral

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[1] The Plan 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 employment history that the Plan Manager deems satisfactory in its sole and absolute discretion.

[2] The Plan defines "disability" to mean:

> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability), and became with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with any employer for which the Employee is, as of his Disability Date, reasonably qualified by education, training or experience.

levels.[3] In July 1997, Dr. Hartman diagnosed Nord as suffering from sciatica and disc disease at L4-L5 and placed him on medication. After a one-week trial with that treatment plan, Dr. Hartman concluded that Nord had experienced no improvement, and he took Nord out of work temporarily. He recommended orthopedic consultation while continuing medication. On July 16, 1997, Nord submitted a claim under the Plan for up to 30 months of long-term disability benefits.

On August 13, 1997, Dr. Hartman drafted a letter indicating that Nord was under his medical care and would be unable to return to work until he experienced sufficient recovery from his lumbar disc syndrome. Dr. Hartman wrote an additional letter in March 1998, after Nord had begun treatment by an orthopedist, Dr. Lytton Williams, confirming continuing medical treatment and restating his earlier conclusion that Nord remained unable to return to work. In April 1998, Dr. Hartman performed a physical capacity evaluation in which he estimated that Nord could sit for up to one hour a day and could occasionally lift up to five pounds.[4] Nearly identical findings were made by Nord's treating orthopedic physician, Dr. Williams, around the same time.

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[3] This diagnosis was later reconfirmed by an MRI scan, conducted on July 23, 1997, which showed degenerative disc disease at L4-L5 and L5-S1, with disc desiccation and a mild diffuse bulge.

[4] At the same time, Nord underwent overlapping treatment from two orthopedic doctors, Dr. Silva and Dr. Mumtaz Ali. Both doctors confirmed aspects of Dr. Hartman's diagnosis, including the presence of lumbosacral pain requiring continued treatment with medication and physical therapy.

On February 16, 1998, MetLife informed Nord that his claim had been denied because he did not meet the "own occupation" definition of disability for the first 30 months of coverage. In the same letter, MetLife also informed Nord that he could "request a review of [his] claim" by sending his request to MetLife's "Group Claims Review." Nord requested review of his claim through a letter sent by counsel. Between March 25, 1998 and October 14, 1998, Nord and MetLife exchanged letters and medical documentation in an effort to process the review of his claim.

This review process included the Plan's referral of Nord to Dr. Antoine Mitri for independent evaluation of his medical claims. Dr. Mitri observed Nord to be normal except for some limitations in bending and assuming cramped or unusual positions. Dr. Mitri opined that Nord should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication. However, the review process also included Nord's providing the Plan with a work capacity evaluation performed by Ms. Janmarie Forward, a human resources representative at Black & Decker, who determined that Nord lacked the capacity to perform the requirements of his job because of his physical limitations. Forward based this determination on the assumption that Nord faced chronic myofascial pain and that this experience of pain would make it impossible for him to carry on the necessary interpersonal relationships to perform his job.

MetLife made a final recommendation to the Plan Manager to deny Nord's claim, and the Plan Manager accepted that recommendation. In a letter dated October

27, 1998, the Plan Manager informed Nord by letter of the outcome of this initial step in his appeal and explained how Nord could perfect his appeal under ERISA. Black & Decker indicated that it had rejected the opinion of Forward that Nord's pain syndrome prevented him from resuming work in his former position.

Nord filed this action in the district court on January 14, 1999, asserting that Black & Decker's denial of his disability benefits violated ERISA. On February 28, 2000, the parties filed cross-motions for summary judgment. The district court granted the defendant's motion and denied Nord's motion. The court found that Black & Decker did not abuse its discretion by denying Nord's disability claim. Nord appeals the district court's order.

STANDARD OF REVIEW

We review the district court's order granting summary judgment *de novo. See Robi v. Reed,* 173 F.3d 736, 739 (9th Cir. 1999). In addition, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context." *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130, 1138 (9th Cir. 2001); *see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.,* 125 F.3d 794, 797 (9th Cir. 1997).

In reviewing a grant of summary judgment, we "must determine whether the evidence, viewed in a light most favorable to the nonmoving party, presents any genuine issues of material fact and whether the district court correctly applied the law." *Warren v. City of Carlsbad,* 58 F.3d 439, 441 (9th Cir. 1995); Fed. R. Civ. P. 56(c). *See also*

Pomerantz v. County of Los Angeles, 674 F.2d 1288, 1290 (9th Cir. 1982) (holding that the same standard applies for review of denial of summary judgment). An issue is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248 (1986).

DISCUSSION

District Court's standard of review for Black & Decker's disability determination

The district court reviewed Black & Decker's termination of Nord's disability benefits under an abuse of discretion standard, despite Nord's allegations that Black & Decker was operating under a conflict of interest. Nord relies on the opinion of Black & Decker's own human resources representative and the opinions of three treating physicians that Nord was no longer capable of occupying his former position. He argues that Black & Decker's arbitrary rejection of these opinions constitutes material, probative evidence that it was operating under an actual conflict. Nord further argues that, because Black & Decker was operating under a conflict of interest, the district court should have reviewed the administrator's decision *de novo.*

The standard of judicial review for a disability determination by an insurer covered under ERISA varies depending on the plan language. We review *de novo* the decision of a plan administrator to deny benefits "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989); *see also*

Tremain v. Bell Indus., Inc., 196 F.3d 970, 976 (9th Cir. 1999). The plan language must be explicit. *See Kearney v. Standard Ins. Co.,* 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc) (holding that plan language stating that the insurer will pay benefits "upon receipt of satisfactory written proof" of disability was ambiguous, and thus did not confer discretion). When the plan language confers discretion, we review the decision of the plan administrator under an abuse of discretion standard. *Tremain,* 196 F.3d at 976.

In this case, the plan language clearly confers discretion upon the Plan Manager both to determine benefits eligibility and to interpret the terms of the Plan.[5] However, the fact that the terms of the Plan confer broad discretionary authority upon the plan administrator does not end our inquiry into the proper standard of review. An insurer with a "dual role as the administrator and funding source for the [p]lan" has an inherent conflict of interest. *Lang,* 125 F.3d at 797. In *Firestone Tire & Rubber Co.,* the Supreme Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion." 489 U.S. at 115 (internal quotation marks omitted). We have held that our review in such cases is "still for abuse of discretion, [but it] is less deferential." *Tremain,* 196 F.3d at 976 (internal quotation marks omitted).

[5] *See supra* note 1.

Black & Decker admits that it acts as both the funding source and the plan administrator with regard to the Plan. It notes that administration of the Plan in Nord's case had been delegated to MetLife, a third-party administrator. However, MetLife acted as the agent of Black & Decker and not as the independent executor of a true trust.[6] *See Lang,* 125 F.3d at 798 (stating that "plans such as this one, funded by insurers and also administered by them, are not true trusts"). Therefore, Black & Decker, through MetLife, was operating under an inherent conflict of interest.

The "less deferential" standard of review for cases involving conflicts consists of two steps:

> First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary *has* made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

[6] MetLife processes the insured's claim and makes a recommendation whether to grant or deny benefits; Black & Decker's Plan Manager makes the final disability determination after receiving MetLife's recommendation.

Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, Nord would create a rebuttable presumption that the Plan's decision violated its fiduciary responsibilities. The Plan would then "bear[ ] the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Lang,* 125 F.3d at 798. If the plan fails to carry its burden, then we review *de novo* its decision to deny benefits. *Tremain,* 196 F.3d at 976.

This appeal is controlled by our recent ruling in *Regula v. Delta Family-Care Disability Survivorship Plan.* In *Regula,* we rejected the district court's application of the abuse of discretion standard to a claim for wrongful termination of disability benefits because the district court had failed to evaluate whether the insurer's apparent conflict of interest had affected its determination. If so, we would require that the court review the plan administrator's decision *de novo. Regula,* 266 F.3d at 1145-46; *see also Lang,* 125 F.3d at 799-800 ("The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled."). Our prior decisions have established that material, probative evidence of a conflict may consist of inconsistencies in the plan administrator's reasons, *Lang,* 125 F.3d at 799, insufficiency of those reasons, *Tremain,* 196 F.3d at 977, or procedural irregularities in the processing of the beneficiaries claims, *Friedrich v. Intel Corp.,* 181 F.3d 1105, 1110 (9th Cir. 1999). In *Regula,* we held that rejection of the opinions of the beneficiary's treating physicians could likewise establish conflict where the rejection is not "sufficiently supported by the record." 266 F.3d at 1147. On remand, we directed the district court to

consider Delta's departure from the prevailing opinions of Regula's treating physicians as material, probative evidence of an actual conflict of interest but to allow Delta to rebut that evidence in a manner consistent with our prior precedent. *See Lang,* 125 F.3d at 798; *see also Tremain,* 196 F.3d at 978.

In *Regula,* the conflict of interest issue was not litigated in the district court but was entertained by us on appeal because of its relevance to determining the standard of review. 266 F.3d at 1145-46. Therefore, we did not rule on the existence of a conflict of interest in that case. *Id.* at 1147. Rather, we remanded to the district court so that the defendant insurer would have an opportunity to rebut the material, probative evidence of conflict that we ascertained in our review of the district court record. *Id.*

In the case before us, the district court rejected Nord's argument that inconsistencies and procedural irregularities in Black & Decker's administration of his claim demonstrated the insurer's conflict of interest. In particular, the district court held that Black & Decker's rejection of the conclusion of its own human resources representative, Forward, was not material, probative evidence of a conflict. Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner. Forward's opinion was solicited by the administrator; she relied on Dr. Mitri's assessment as provided by the administrator. To contradict her opinion out of hand is not only high-handed but also certainly some evidence of a conflict.[7]

[7] In addition, Nord claims that the Plan violated its administrative procedural requirements by failing to provide, in its letter of October

(Continued on following page)

The district court erred also in its refusal to view Black & Decker's rejection of the prevailing opinions of Nord's treating physicians as germane to a determination of whether the Plan's administration was impaired by a conflict of interest. As discussed above, Nord was diagnosed with degenerative disc disease, sciatica, and myofascial pain syndrome. This diagnosis was confirmed by an MRI and CT scan and was not contradicted by Dr. Mitri, the independent clinician retained by Black & Decker to evaluate Nord's claim. Nord's primary treating physician, Dr. Hartman, concluded after a physical capacity evaluation that Nord could sit for up to one hour a day and could carry up to five pounds.[8] Black & Decker's own description of the physical requirements for a Material Planner indicate that the person occupying the position would have to sit for up to six hours a day and carry up to 20 pounds.[9] In addition, Dr. Hartman wrote two letters to Black &

27, 1998, specific reasons for rejecting the opinion of Forward. However, Black & Decker's letter was sufficiently responsive in that it provided the insurer's reasons for its ultimate decision to deny benefits. Black & Decker was under no duty to rebut with specificity all evidence adduced by Nord to support his claim. *Vizcaino v. Microsoft Corp.,* 120 F.3d 1006, 1016 (9th Cir. 1997) (en banc) (Fletcher, B., J., concurring in part and dissenting in part) (stating that under ERISA the reasons for a denial of benefits "must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial") (quoting *Booton v. Lockheed Med. Benefit Plan,* 110 F.3d 1461, 1463 (9th Cir. 1997)).

[8] This diagnosis of Nord's physical abilities was confirmed by an additional examination by Dr. Williams, who opined that Nord could sit for one hour at a time and for one hour during a day, and that he could occasionally lift up to five pounds.

[9] Nord represents that while working in his former position he was sometimes required to lift up to 60 pounds.

Decker in which he stated that Nord's medical condition prevented him from returning to work even though Nord had made improvements with physical therapy and medication. Dr. Hartman's diagnosis, as well as his prescribed course of treatment, were confirmed by Nord's other treating physicians, Drs. Williams and Silva.

Dr. Mitri disagreed with Nord's treating physicians in two principal respects: First, Dr. Mitri found that Nord suffered from only minor limitations to his range of motion and in his ability to sit for long periods of time if he took his pain medication. The medications to which Dr. Mitri referred in drawing this conclusion (Relafen, Davrocet [sic], and Flexeril) are all medications that were prescribed by Drs. Hartman and Silva for Nord at various stages throughout their treatment of his condition. Second, Dr. Mitri concluded that Nord could lift and carry up to 15 pounds less than 20% of the business day. Thus, Dr. Mitri concluded that, under medication, Nord could perform "sedentary work with some walking interruption in between."

Thus, the long-term treating physicians and Black & Decker's independent (but one-time) clinical examiner disagreed. The same clinical materials were available to both. In such a circumstance, under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator "gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" *Morgan v. Comm'r of Soc. Sec. Admin.,* 169 F.3d 595, 600 (9th Cir. 1999) (quoting *Andrews v. Shalala,* 53 F.3d 1035, 1041 (9th Cir. 1995)).

Nowhere in the record is any reason advanced as to why the treating physicians' opinions were unreliable and

Dr. Mitri's more reliable. No evidence has been advanced that Nord's treating physicians considered inappropriate factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions. Instead, the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner. Given its dual role as funding source and administrator for the Plan, we conclude Black & Decker breached its fiduciary duty to Nord as a beneficiary of the Plan due to a conflict of interest.

Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative. We faced an analogous situation in *Tremain,* where we ruled that the district court had erred by failing to consider evidence even though it was outside of the administrative record in determining whether a conflict of interest had impaired the insurer's benefits determination. 196 F.3d at 976-77. Based on the evidence before us, presented to the district court before it granted the insurer's motion for summary judgment, we concluded that the insurer's inconsistent reasons for denying the beneficiary's claim constituted material, probative evidence of a conflict (a conclusion not reached by the district court) and that the insurer had failed to present any evidence to rebut the presumption that a conflict of interest had impaired its determination. *Id.* at 977.

Therefore, following our precedent in *Tremain* and *Regula,* we conclude that the disability determination must be reviewed *de novo.* Under *de novo* review, the question becomes whether there is a genuine issue of material fact as to whether Nord is disabled. *See Newcomb v. Standard Ins. Co.,* 187 F.3d 1004, 1006 (9th Cir. 1999). After cross-motions for summary judgment, we find that, although further record development for *de novo* review is sometimes appropriate, *see Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943-44 (9th Cir. 1995), it is unnecessary in this case. Indeed, Black & Decker asserted in the district court that no additional evidence was necessary for an adequate *de novo* review. *See* Defendant's Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for Summary Judgment at 17 & n.6. The administrative record reveals no genuine dispute as to whether Nord is disabled within the meaning of the plan for the first 30 months of coverage.

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. *Addisu v. Fred Meyer, Inc.,* 198 F.3d 1130, 1134 (9th Cir. 2000). We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is 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. Viewing the administrative record as a whole, we conclude that no reasonable trier of fact could conclude that Nord is not disabled. Therefore, we grant Nord's motion for summary judgment.

CONCLUSION

For the foregoing reasons, we reverse the ruling of the district court holding that Black & Decker was not operating under a conflict of interest. Upon a *de novo* review of the administrative record, we find that there is no triable issue of fact regarding Nord's disability and hold that Nord is entitled to disability benefits for the first 30 months of his disability.

REVERSED.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KENNETH L. NORD, Plaintiff, v. THE BLACK & DECKER DISABILITY PLAN, Defendant.	Case No. CV 99-0408 CM ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT (Filed Mar. 22, 2000)

THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d).

On February 28, 2000, Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment came before the Court on regular hearing. Having read and considered the moving papers, oppositions, and replies; the entire record in this action; and all other admissible evidence and argument offered in relation to the Motions, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment for the following reasons.

I.

Summary of Relevant Facts

This ERISA action arises from Plaintiff's claim for long-term disability benefits from Defendant. Plaintiff is a former employee of Kwikset Corporation ("Kwikset"), a subsidiary of Black & Decker Corporation. As a Kwikset employee, Plaintiff was entitled to participate in the Black

& Decker Disability Plan (the "Plan"). Under the terms of the Plan, "disability" was defined as follows:

> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability and beginning with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with an employer for which the Employee is, as of his Disability Date, reasonably qualified by education, experience or training. Declaration of Raymond J. Brusca In Support of Defendant's Motion, Exh. B at 24.

On or about July 15, 1997, Plaintiff ceased working in his position as a Material Planner for Kwikset and submitted his claim for long-term disability benefits. A review of Plaintiff's administrative claim file reveals the following facts relevant to the disposition of the instant Motions:

– On or about March 10, 1997, Plaintiff consulted with Leo Hartman, M.D. because of the presence of intermittent pain in the lower back and hips for the preceding three or four weeks;

– Between March 1997 and August 1997, Plaintiff was regularly treated by Dr. Hartman for lower back pain, sciatica, leg pain, and degenerative disc disease. As part of his treatment by Dr. Hartman, pain killers were prescribed for Plaintiff;

– On or about August 13, 1997, Dr. Hartman recommended that Plaintiff seek an orthopedic consultation from Ismael Silva, M.D.;

– Also on or about August 13, 1997, Dr. Hartman wrote a letter in which he indicated that Plaintiff was under his medical care and could not return to work until Plaintiff's lumbar disc syndrome had sufficiently recovered;

– As result of Plaintiff's consultation with Dr. Silva, Dr. Silva diagnosed Plaintiff with lumbosacral pain and prescribed physical therapy;

– On or about the same time as Dr. Silva's prescription of physical therapy for Plaintiff, Dr. Hartman also prescribed physical therapy for Plaintiff;

– Dr. Silva's treatment of Plaintiff included prescription painkillers as well as ordering an EMG and nerve conduction studies of Plaintiff's lower extremities in order to rule out disc disease;

– The results of the EMG and nerve conduction studies ordered by Dr. Silva suggested mild bilateral L5 radiculopathy;

– On or about January 12, 1998, Kwikset provided a statement regarding Plaintiff's claim for long-term disability benefits to Metropolitan Life Insurance Company ("MetLife"), the Plan's Third Party Claims Administrator. In that statement, Kwikset described Plaintiff's position as a Material Planner as requiring between five and six hours of sitting per day, one and two hours of standing, one and two hours of walking, the need to use the head and neck in the same position between one and two hours per day, looking up between one and two hours per day, and looking down between one and two hours a day. Kwikset further represented that the Material Planner position required occasional lifting and carrying of objects

weighing up to 20 pounds, continuous interpersonal relationships, frequent exposure to stressful situations, exposure to moving equipment and machinery, and overtime on a routine basis;

– On or about January 17, 1998, Plaintiff provided a response to a Personal Profile Evaluation as part of Metlife's assessment of his claim for long-term disability benefits. In the Personal Profile Evaluation, Plaintiff reported that he could not sit for more than 10 to 15 minutes at a time without pain, that he could not stand or walk for more than 10 to 15 minutes without pain, that pain radiated down his left leg and at times also down his right leg, that he walked until he experienced pain and then sat in a recliner and stood at invervals during a typical day, that he had no difficulty caring for his personal needs, that he did housework and that he got assistance from his mother with housework, that his father provided him assistance with shopping, that it takes him longer to mow his lawn because of his pain, and that his recreational activities included fishing and hunting although he had not been hunting since November of 1996. Plaintiff further stated that he expected to return to his job as a Material Planner if and when he could sit without pain; that, in the meantime, he did not expect to return to any other type of work on a full-time or part-time basis; and that he had no other sources of income;

– On or about January 23, 1998, Plaintiff returned to Dr. Silva for evaluation. Dr. Silva noted continued complaints of back pain, bilateral lumbosacral radiculopathy, and the continued use of prescription medication to control pain. Dr. Silva also found decreased lumboscaral range of motion and the presence of paralumbar muscle spasm;

– On or about February 16, 1998, MetLife wrote a letter to Plaintiff regarding his claim. In the letter, MetLife disallowed Plaintiff's claim for benefits. In so doing, MetLife cited Plaintiff's responses in his Personal Profile Evaluation as well as Plaintiff's medical history since the onset of his lower back pain. MetLife's letter also notified Plaintiff of his right to seek review of its denial of Plaintiff's claim by the Plan's Group Claims Review;

– On or about March 4, 1998, Plaintiff returned to Dr. Hartman with continuing complaints of lower back pain. Dr. Hartman noted the presence of recurring low back pain consistent with a herniated disc. Dr. Hartman recommended continuing the present treatment regiment [sic] and seeking an orthopedic follow-up from Lytton Williams, M.D.;

– On or about March 23, 1998, Dr. Hartman wrote a letter concerning Plaintiff. In the letter, Dr. Hartman confirmed Plaintiff's continuing treatment for lumbar disc syndrome. Dr. Hartman also stated that Plaintiff would not be able to work until his condition was sufficiently controlled and that Plaintiff would likely be of [sic] work until December 31, 1998;

– On or about March 25, 1998, Plaintiff, through his counsel, formally requested review of the denial of his claim;

– On or about March 26, 1998, Plaintiff underwent a lumbar discogram and a CT scan of the lumbar spine both based upon a clinical history of degenerative disc disease. The discogram revealed a concordant pain pattern at L4-5 and L5-S1. The CT scan revealed annular thinning of the

intervertebral discs and loss of disc space at L4-5 and L5-S1;

– On or about April 2, 1998, Dr. Williams completed a Physical Capacity Evaluation [sic] Plaintiff. Dr. Williams opined that Plaintiff could sit for one hour at a time and for one hour total during a day; that Plaintiff could occasionally lift or carry up to five pounds; that Plaintiff could not use his feet for repetitive movements; that Plaintiff could only occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about April 9, 1998, Dr. Hartman completed a Physical Capacity Evaluation of Plaintiff. Dr. Hartman opined that Plaintiff could sit for one hour at a time and for a total of one hour per day; that Plaintiff could occasionally lift up to five pounds; that Plaintiff could not use his feet for pushing or pulling of light controls; that Plaintiff could occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about June 22, 1998, MetLife advised Plaintiff that it had scheduled an independent medical examination of Plaintiff as part of its administration of Plaintiff's claim;

– On or about July 17, 1998, Antoine Mitri, M.D. conducted an independent neurological examination of Plaintiff pursuant to MetLife's request. Dr. Mitri concluded that Plaintiff suffered from degenerative disc disease and chronic myofascial pain syndrome. Dr. Mitri further concluded that there was no evidence of lumbosacral nerve root compression. Consequently, Dr. Mitri opined that Plaintiff should be able to do sedentary work with intermittent walking as necessary;

– On or about July 17, 1998, Dr. Mitri completed a Certified Consultant's Evaluation Summary Form as part of MetLife's administration of Plaintiff's claim. In that form Dr. Mitri noted the presence of lumbosacral degenerative disc disease and chronic myofascial pain syndrome and that Plaintiff had suffered from low back pain for 15 years. Dr. Mitri opined that Plaintiff would have some limitations with respect to stairs and ladders and that Plaintiff would need to completely avoid scaffolding and heights. Dr. Mitri further found limitations with respect to cramped or unusual positions, pushing, pulling, or twisting of arm and leg controls, repetitive movements of hands or feet, and operating vehicles. Dr. Mitri completely forbade climbing, balancing, bending, stooping, squatting, and the operation of heavy equipment. Dr. Mitri opined that Plaintiff could perform sedentary work with occasional walking;

– At some point prior to October 20, 1998, Janmarie Forward, a Black & Decker human resources employee, completed a Work Capacity Evaluation sent to her by Plaintiff's counsel;

– On or about October 27, 1998, Black & Decker upheld MetLife's denial of Plaintiff's claim. Black & Decker based its decision on its conclusion that Plaintiff could return to work in his own occupation which was, in turn, based on the evidence in Plaintiff's administrative claim file;

– Subsequent to its decision to uphold the denial of Plaintiff's claim, Black & Decker requested a review of the medical records and correspondence relating to Plaintiff's claim by James Ebeling, M.D. Dr. Ebeling concluded that

Plaintiff should be able to do sedentary work and he agreed with MetLife's decision to deny Plaintiff's claim.

II.

Applicable Standard

Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). In a trilogy of 1986 cases, the Supreme Court clarified the applicable standards for summary judgment. *See Celotex Corporation v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Anderson*, 477 U.S. at 256. Whether a fact is material is determined by looking to the governing substantive law; if the fact may affect the outcome, it is material. *Id.* at 248. If the moving party seeks summary adjudication with respect to a claim or defense upon which it bears the burden of proof at trial, its burden must be satisfied by affirmative, admissible evidence. By contrast, when the non-moving party bears the burden of proving the claim or defense, the moving party can meet its burden by pointing out the absence of evidence submitted by the non-moving party. The moving party need not disprove the other party's case. *See Celotex*, 477 U.S. at 325.

If the moving party meets its initial burden, the "adverse party may not rest upon the mere allegations or denials of the adverse party's pleadings, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e).

In assessing whether the non-moving party has raised a genuine issue, its evidence is to be believed, and all justifiable inferences are to be drawn in its favor. *Anderson*, 477 U.S. at 255 (citing *Adickes v. S. H. Kress and Company*, 398 U.S. 144 (1970)). Nonetheless, "the mere existence of a scintilla of evidence" is insufficient to create a genuine issue of material fact. *Id.* at 252. As the Supreme Court explained in *Matshushita*,

> When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts. . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial."

Id., 475 U.S. at 586-87.

To be admissible for purposes of summary judgment, declarations or affidavits must be based on personal knowledge, must set forth "such facts as would be admissible in evidence," and must show that the declarant or affiant is competent to testify concerning the facts at issue. Fed. R. Civ. P. 56(e). Declarations on information and belief are insufficient to establish a factual dispute for purposes of summary judgment. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989).

Summary judgment is not treated as "a disfavored procedural shortcut" but as "an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Celotex*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).

III.

Analysis and Discussion

Exhaustion of Administrative Remedies

As a general rule, "[an ERISA] claimant must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court." *Diaz v. United Agricultural Employee Welfare Benefit Plan and Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard,* 618 F.2d 559, 566-68 (9th Cir. 1980)), *see also Pengilly v. Guardian Life Insurance Co. of America*, 81 F.Supp.2d 1010, 1022 (N.D.Cal. 2000) (setting forth the specific terms of a disability policy's appeal's procedures in order to analyze the issue of exhaustion of administrative remedies). "Although not explicitly set out in the statute, the exhaustion doctrine is consistent with ERISA's background, structure and legislative history and serves several important policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the provisions of a nonadversarial method of claims settlement and a proper reliance on administrative expertise." *Diaz*, 50 F.3d at 1483. "Furthermore, prior fully considered actions by . . . trustees interpreting their plans and perhaps also further refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the

controversies." *Pengilly*, 81 F.Supp.2d at 1022 (citing *Amato v. Bernard*, 618 F.2d at 568).

The Summary Plan Description ("SPD"), *see* Brusca Decl. Exh. A, clearly provides that a claimant may appeal to the Plan Administrator within 60 days of the initial denial of a claim and that the Plan Administrator will render its decision on the appeal within another 60 days. Furthermore, the Plan Document itself, *see* Brusca Decl., Exh. B, provides that initial determinations of claims applications will be made by the Plan Manager or by a third party Claims Administrator who is providing administrative services to the Plan. *See* Brusca Decl., Exh. A, §9.07(A). Under the terms of the Plan Document, a claimant may appeal an initial denial of benefits to the Plan Manager within 60 days of the initial denial. *See id.* at §9.07(B). Finally, the Plan Document provides that the appeal will be decided by an Appeals Committee within 60 days of the date the claimant makes the appeal. *See id.* at §9.07(C).

Plaintiff argues that he exhausted his administrative remedies under the Plan Document and the SPD when he received a letter dated October 27, 1998 from Black and Decker, *see* Brusca Decl., Exh. D, notwithstanding the fact that this letter purported to inform Plaintiff of his right under ERISA to have claim reviewed on appeal yet again. Specifically, Plaintiff claims that the October 27, 1998 letter was notification of a final, binding decision on his appeal of MetLife's initial denial of his claim in its position as Third Party Administrator.

Defendant, however, characterizes MetLife's initial denial as a kind of recommendation to the Plan Manager

which the Plan Manager upheld after further investigation. *See* Brusca Decl. ¶¶11-19. Therefore, according to Defendant, under the terms of the Plan and the SPD, Plaintiff was still entitled to an appeal to the Plan's Appeals Committee. *See id.* ¶¶20-22. Because, according to Defendant's position, Plaintiff did not pursue an appeal to the Plan's Appeals Committee, this action is barred for failure to exhaust administrative remedies. *See* Defendant's Motion at 3-6, Defendant's Opposition at 4-5.

The Court holds that Plaintiff has exhausted his administrative remedies by making his initial claim and seeking review by the Plan Manager which resulted in the denial in the October 27, 1998 letter. There is no ambiguity in the SPD about the internal appeals process and to the extent there is any ambiguity in the Plan Document itself, *see* Brusca Decl. Exh. B at §§9.07(A)-(B), Plaintiff should not be prejudiced thereby. The SPD clearly provides that Plaintiff is entitled to one level of internal appeal after the initial denial; the Plan Document has similar terms. Nothing in these documents puts a claimant on notice of the fact that an initial denial by the Third Party Claims Administrator might be a mere recommendation that must be ratified by the Plan Manager before an actual internal appeal can take place. Furthermore, the initial denial letter sent to Plaintiff by MetLife, *see* Brusca Decl. Exh. C at 147, also states that Plaintiff had 60 days to request a review of MetLife's initial denial. This language may have reasonably led Plaintiff and his counsel to conclude that the October 27, 1998 denial was the product of the only level of internal appeal to which Plaintiff was entitled under the SPD and the Plan Document. Consequently, the Court concludes that Plaintiff exhausted his

administrative remedies and that, therefore, this action is not barred.[1]

Appropriate Standard of Review / Conflict of Interest

An ERISA plan administrator's decision to deny benefits is subject to de novo review unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). When such discretion is conferred, the exercise of that discretion is subject to review for abuse of discretion. *Tremain*, 196 F.3d at 976 (citing other Ninth Circuit caselaw).

"If, however, the plan administrator is also the insurer, that conflict of interest must be weighed as a factor in determining whether there is an abuse of discretion." *Id.* (citing *Snow v. Standard Insurance Co.*, 87 F.3d 327, 330 (9th Cir 1996)). In such a circumstance, a "less deferential" abuse of discretion standard is employed. *Tremain*, 196 F.3d at 976 (citing *Lang v. Long-Term Disability Plan*

[1] Tellingly, the draft version of Black & Decker's October 28, 1998 denial letter which was written by MetLife stated that the decision to uphold MetLife's denial "is the final decision on review and constitutes completion of the full and fair review required by Mr. Nord's Plan and federal law." The draft denial letter further states "Please be advised that under the provisions of his Plan, no further administrative appeals are available to him concerning his disability benefit." Rohlfing Decl., Exh. 2 at Bates No. BD 0039. Although the final version tracks MetLife's draft in many respects, the final version does not contain the above-quoted language. See Brusca Decl., Exh. D at 159 (Bates No. BD 0042).

of Sponsor Applied Remote Technology, Inc. 125 F.3d 794, 798 (9th Cir. 1997)).

"If, however, the program participant presents material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breech of the administrator's fiduciary obligations to the beneficiary, a rebuttable presumption arises in favor of the participant." *Tremain*, 196 F.3d at 976 (citing *Lang*, 125 F.3d at 798). "The plan then bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits. *Tremain*, 196 F.3d at 976 (citing *Lang*). If the plan fails to carry this burden of rebutting the presumption, the fiduciary or administrator's decision to deny benefits is reviewed de novo. *Tremain*, 196 F.3d at 976 (citing *Lang*). Sufficient evidence of an actual conflict of interest includes, *inter alia*: (1) inconsistent position on the part of the administrator/fiduciary or (2) an administrator/fiduciary's failure to follow its own internal procedures or ERISA's mandatory claims procedures. *See Ellis v. Egghead Software Short-Term and Long-Term Disability Plans*, 64 F.Supp.2d 980, 985 (E.D.Wash. 1999) (citing *Lang*, 125 F.3d at 799, and *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-12 (9th Cir. 1999)).

Plaintiff concedes that the Plan Document grants discretion to the Plan Administrator. *See* Plaintiff's Motion at 4. Defendant likewise concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator. *See* Defendant's Motion at 11. However, Plaintiff has not sufficiently met his burden to invoke de novo review. *See* Defendant's Opposition at 10-15. More specifically, under

Ellis, Plaintiff has not demonstrated that Defendant assumed inconsistent positions during the pendency of the internal claims assessment and internal appeal. Furthermore, to the extent that Defendant may have deviated from the SPD's and Plan Document's stated procedures for an internal appeal, this issue has been resolved in Plaintiff's favor above as it relates to exhaustion of administrative remedies and Plaintiff also has not shown that this deviation caused a breach of fiduciary duty owed to him. *See Tremain*, 196 F.3d at 976 (plaintiff must produce sufficient evidence to show that the conflict of interest caused a breach of a fiduciary duty owed to him), *cf. Dames*, 49 F.Supp.2d at 1201 (a plaintiff is not entitled to a substantive remedy for violation of ERISA's reporting and disclosure requirements unless she can show reliance or prejudice).

Consequently, the Court holds that notwithstanding Defendant's apparent or technical conflict of interest, Defendant's decision to deny Plaintiff's claim for disability benefits is subject to review for abuse of discretion.

Propriety of Defendant's Denial of Plaintiff's Claim for Benefits

"It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood v. Newmont Gold*, 45 F.3d 1317, 1323-24 (9th Cir. 1995). "The mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." *Snow v. Standard Insurance Co.*, 87 F.3d 327, 331 (9th Cir. 1996). "Rather, 'review under the clearly erroneous standard is

significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.'" *Id.* (citing *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). "That standard certainly does not permit the overturning of a decision where there is substantial evidence to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.'" *Snow*, 87 F.3d at 331-32 (citing *Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994)). Finally, several courts have held that crediting the opinions of an independent medical examiner over the opinions of a claimant's treating physicians is not clearly erroneous or an abuse of discretion. *See, e.g., Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Gruman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D. Cal. 1999) (Collins, J.) (citing other cases) (finding that the administrator's decision to deny benefits was justified by sufficient evidence despite the fact that it contradicted the opinions of plaintiff's treating physicians).

In his briefing, Plaintiff's two main arguments in support of overturning Defendant's decision to deny him disability benefits are that: (1) Defendant's decision is contrary to the opinions provided by Janmarie Forward, a Black & Decker employee, in a Work Capacity Evaluation and (2) Defendant's decision credits the medical opinions of an independent medical examiner over the opinions of his Plaintiff's treating physicians. *See* Plaintiff's Motion at 11-19.

In making these arguments, Plaintiff essentially argues that Defendant's decision was based on factual findings which were clearly erroneous. It is clear under *Snow*, however, that the fact that Defendant's decision contradicts some evidence in the administrative record is not sufficient to overturn Defendant's decision. Consequently, the fact that an individual like Ms. Forward who apparently lacks any expertise or credentials in medicine, disability evaluation, and vocational evaluation has expressed an opinion contrary to Defendant's ultimate decision is not sufficient reason to overturn Defendant's decision given the other evidence in the administrative record.[2] Furthermore, it is also clear that Defendant need not credit the opinion of Plaintiff's treating physician over

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[2] Item 6 of the Work Capacity Evaluation reads as follows:

> 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 [an] individual of those limitations perform the work of a material planner?" Brusca Decl, Exh. C at 40.

Ms. Forward responded "no" to Item 6. *Id.* furthermore, in its October 27, 1998 denial letter, Black & Decker specifically referenced Ms. Forward's response in the Work Capacity Evaluation and stated "The results of that evaluation are not sufficient to reverse our decision." Brusca Decl., Exh. D. at 159. Furthermore, as Defendant persuasively argued at the hearing on the instant Motions, Ms. Forward's response to Item 6 of the Work Capacity Evaluation did not take account of the prescription painkillers Plaintiff had been taking virtually since the onset of his lower back pain in early 1997.

the opinions of an independent medical examiner. *See Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D.Cal. 1999) (Collins, J.) (citing other cases). This is especially the case when MetLife gave Plaintiff and Plaintiff's treating physicians an opportunity to comment on the independent medical examiner's opinions, *see* Brusca Decl. Exh. D. at 159, and Plaintiff apparently never took advantage of this opportunity. *Cf. Dames*, 49 F.Supp.2d at 1202 (fact that administrator did not consider untimely submitted medical opinions is not evidence of taint sufficient to invoke de novo review because of conflict of interest; decision not to consider untimely evidence was exactly the kind of exercise of discretionary authority which administrator was entitled to make).

Finally, at the hearing on the instant Motions, Plaintiff's counsel emphasized a conversation between the Plan Manager, Raymond Brusca, and Ms. Forward, the Black & Decker human resources employee who provided responses on a Work Capacity Evaluation sent to Black & Decker by Plaintiff. Although Defendant admits that a conversation took place, Defendant has not disclosed the exact details of the conversation. In his declaration, Mr. Brusca does state that he discussed the specific duties of the Material Planner position, the freedom of movement Plaintiff had in that position, and the availability of aid to Plaintiff in lifting in that position if aid were necessary. Brusca Decl. ¶17.

At the hearing, Plaintiff's counsel pointed to this conversation both as evidence sufficient to meet Plaintiff's

burden of demonstrating an actual conflict of interest and as evidence of an abuse of discretion on Defendant's part. The Court disagrees. Given Ms. Forward [sic] lack of expertise or credentials, her responses in the Work Capacity Evaluation cannot be said to constitute material evidence as Plaintiff claims. Consequently, any conversation between Mr. Brusca and Ms. Forward whether disclosed or undisclosed also cannot constitute evidence sufficient to demonstrate an actual conflict of interest or an abuse of discretion.

In sum, because an administrator's decision is not based on clearly erroneous factual findings when it conflicts with some evidence in the administrative record and because Defendant need not credit the opinions of Plaintiff's treating physicians over those of an independent medical examiner, the Court holds that Defendant did not abuse its discretion in denying Plaintiff's claim for benefits. *See Snow*, 87 F.3d at 331-32, *Voight*, 28 F.Supp.2d at 578-81, *Jordan*, 63 F.Supp.2d at 1161-64, *see also* Defendant's Opposition at 16-23, Defendant's Reply at 6-11, Defendant's Motion at 7-17.

IV.

Conclusion

For the foregoing reasons, the Court finds that Defendant has met its burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that it is entitled to judgment as a matter of law. Also for the foregoing reasons, the Court finds that Plaintiff has not met his burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that he is entitled to judgment as a matter of law. Therefore, the Court hereby *grants* Defendant's Motion for

Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment.

IT IS SO ORDERED.

DATED: March 22, 2000.

/s/ Carlos R. Moreno
Carlos R. Moreno
United States District Judge

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KENNETH L. NORD,

Plaintiff,

v.

THE BLACK & DECKER DISABILITY PLAN,

Defendant.

Case No. CV 99-0408 CM

JUDGMENT

(Filed Mar. 22, 2000)

THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d).

As set forth in the Order Granting Defendant Black & Decker Disability Plan's Motion for Summary Judgment and Denying Plaintiff Kenneth Nord's Motion for Summary Judgment filed concurrently herewith, the Court issued its Order on the parties motions on March 22, 2000. Having granted Defendant's Motion for Summary Judgment,

IT IS HEREBY ORDERED AND ADJUDGED that Plaintiff shall take nothing by his Complaint and that all of Plaintiff's causes of action against Defendant alleged therein are *dismissed with prejudice*.

IT IS SO ORDERED.

DATED: March 22, 2000.

/s/ Carlos R. Moreno
Carlos R. Moreno
United States District Judge

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

KENNETH L. NORD, Plaintiff-Appellant, v. THE BLACK & DECKER DISABILITY PLAN, Defendant-Appellee.	No. 00-55689 D.C. No. CV-99-00408-CM Central District of California, Los Angeles ORDER (Filed Mar. 1, 2004)

Before: B. FLETCHER, D.W. NELSON, and McKEOWN, Circuit Judges.

Judge McKeown votes to deny the petition for rehearing en banc and Judges B. Fletcher and D.W. Nelson so recommend.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc is denied.