No. _____

In The
Supreme Court of the United States

GENE ATKINS,

Petitioner,

v.

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN; THE NFL SUPPLEMENTAL DISABILITY PLAN; MANAGEMENT TRUSTEES OF THE NFL PLAYER RETIREMENT PLAN,

Respondents.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. When an ERISA plan fiduciary with discretionary authority to interpret the plan renders a final decision on a disability benefit claim review that is two years and 299 days past the plan and regulatory deadline, is the decision still entitled to judicial deference?

2. Can a deadlocked board retain any discretionary powers to interpret the plan or determine eligibility for benefits after it refers the ERISA-mandated fiduciary review to an arbitrator for a final decision that is binding on the board trustees in accordance with the plan and §302(c)(5) of the Labor Management Relations Act (LMRA)?

3. When an arbitrator is appointed to break a board deadlock and issue a binding decision on an ERISA benefit claim review, is he required to be a named fiduciary of the plan as that term is defined in §402(a)(2) of ERISA?

PARTIES TO THE PROCEEDINGS

All of the parties are included in the caption of the case on the cover page.

CORPORATE DISCLOSURE STATEMENT

Petitioner Gene Atkins is an individual who does not fall within the scope of the Supreme Court Rule 29.6's corporate disclosure statement.

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The opinion of the United States Court of Appeals for the Fifth Circuit is in the Appendix to this petition, pages 1-29, and is reported at *Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, 694 F.3d 557 (5th Cir. 2012). The Fifth Circuit's opinion affirmed the unpublished opinion of the United States District Court, Western District of Texas, Austin Division, which is also within the Appendix to this petition, pages 30-58.

STATEMENT OF JURISDICTION

The Fifth Circuit's decision was rendered on September 11, 2012. No petition for rehearing was filed. The jurisdiction of this court is invoked under 28 U.S.C. §1254(l).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Statutory Provisions

The Labor Management Relations Act (LMRA)

Title 29 United States Code, Section 186

(a) Payment or Lending, et. of money by employer or agent to employees, representatives, or labor organizations. . . .

> It shall be unlawful for an employer or association of employers . . . to pay . . . any money
>
> * * *
>
> 3) to any employee or group or committee of employees . . . in excess of their normal compensation for the purpose of causing such employee . . . to influence any other employees in the exercise of the right to organize and bargain collectively . . .

(c) Exceptions

The provisions of this section shall not be applicable

> * * *
>
> (5) with respect to money or other thing of value paid to a trust fund established by such representative, for the sole and exclusive benefit of the employees of such employer, and their families and dependents. . . .
>
> Provided that . . .
>
> (B) the detailed basis on which such payments are made is specified in a written agreement with the employer, and such employees and employers are equally represented in the administration of such fund . . . and in the event the employer

> and employee group deadlock on the administration of such fund and there are no neutral persons empowered to break such deadlock, such agreement provides that the two groups shall agree on an impartial umpire to decide such dispute. . . .

Employee Retirement Income Security Act of 1974 (ERISA)

Title 29 United States Code, Section 1102(a)

Establishment of Plan

a) Named Fiduciaries

> (1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.
>
> (2) For the purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary
>
> > A) by a person who is an employer or employee organization with respect to the plan or

> B) by such an employer and such an employee organization acting jointly.

Title 29 United States Code, Section 1133(2)

Claims Procedure

> In accordance with the regulations of the Secretary, every employee benefit plan shall
>
> * * *
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Title 29 United States Code, Section 1135

Regulations

> Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. . . .

Code of Federal Regulations

Title 29 Labor

29 CFR §2560.503-1 Claims procedure

> **29 CFR §2560.503-1(i)** *Timing of notification of benefit determination on review*
>
> * * *

3) *Disability claims.*

* * *

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. . . .

29 CFR §2560.503-1(l) *Failure to establish and follow reasonable claims procedures.*

In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

STATEMENT OF THE CASE

A. The Bert Bell/Pete Rozelle NFL Player Retirement Plan

The Bert Bell/Pete Rozelle NFL Player Retirement Plan is a multi-employer pension and welfare benefit plan that provides retirement and disability benefits to active and retired National Football League players. Its administration is subject to both the Employee Retirement Income Security Act (ERISA) 29 U.S.C. §1001 et seq. and the Labor Management Relations Act (LMRA) 29 U.S.C. §186(c)(5). The named fiduciary of the plan is the NFL Retirement Board. The board has six trustees, three appointed by the team owners and three appointed by the NFL Players Association (NFLPA). The plan grants discretionary powers to the board trustees.

When a claim for disability benefits is submitted, it is initially reviewed and decided by the Disability Initial Claims Committee (DICC). The DICC consists of one representative of the NFL club owners and one representative of the NFL players association. If the DICC deadlocks, the plan deems the claim denied. If the DICC denies the claim and the claimant appeals, the NFL Retirement Board is the named fiduciary that conducts the ERISA-mandated full and fair review of the denied claim. The board trustees decide reviews of denied disability claims at their quarterly meetings.

When Gene Atkins submitted his claims, there were four categories of disability benefits available to

current and former NFL players. Relevant to Atkins' claims, if an eligible retired player was found disabled by the board but his disability was found to arise from something other than NFL football, he would be paid "inactive" benefits. If the board found that his disability arose from playing professional football, he would be paid "football degenerative" benefits. A player receiving football degenerative disability benefits receives a greater monthly benefit than a player receiving inactive benefits. He is also entitled to additional monthly benefits under a supplemental disability plan established by the NFL. Once a player is found eligible for one category of benefits, in order to have his benefits reclassified he must prove by clear and convincing evidence that because of changed circumstances he is entitled to a different category of benefits.

Although not within the claims procedures of the plan, because of repeated board deadlocks two other plan provisions played a prominent role in the handling of Atkins' claims. Relevant to Atkins' claims, if there is a board deadlock over medical issues, i.e. whether a player is disabled, the player may be sent to a medical expert known as a MAP (Medical Advisory Physician), whose conclusions as to disability will be binding upon the board. If there is a board deadlock over how a player's benefits should be classified, e.g. inactive or football degenerative, the claim can be referred to an arbitrator for final decision that is binding upon the board.

When the claimant's request for review is submitted more than thirty (30) days prior to the board's quarterly meeting, the claims procedures of the plan require that the board decide the claimant's appeal at the next quarterly meeting. This plan term tracks the Secretary of Labor's time requirements for deciding a claim review submitted under a multi-employer plan. 29 CFR §2560.503-1(i)(3)(ii).

B. Atkins' Initial Disability Claim And Administrative Appeal

Gene Atkins was a hard-hitting defensive back in the NFL from 1987 until 1996. (App. 4.) In December 2004, eight years after the end of his NFL career, he submitted a claim for disability benefits to the administrators of the NFL plan. His claim was based upon 1) limited movement and pain in his right shoulder, 2) chronic constant pain in his neck that radiated through his arms and hands, causing his hands to be numb, and 3) depression and mood swings. (App. 4.)

During the course of his initial claim and appeal, the plan administrators sent Atkins to five physicians and one neuropsychologist. (App. 4-8.) All of them concluded that Atkins was impaired from his NFL career. (Id.) Some concluded that he was disabled from playing NFL football, others concluded that he was impaired but not disabled. (Id.) In 2006, following a binding opinion by a neuropsychologist MAP that Atkins was disabled due to chronic pain from playing NFL football and other impairments that

were not football-related (illiteracy, borderline mental ability, and depression), Atkins was approved for inactive disability benefits. (App. 6-7.) The plan director informed Atkins that he was approved for inactive benefits because the board found him disabled due to psychiatric impairments that did not arise from playing NFL football. (App. 7.)

C. Atkins' Reclassification Claim And Administrative Appeal

After the board's decision, Atkins was referred to Dr. Robert Cantu. (App. 9.) Dr. Cantu is a neurosurgeon who specializes in brain trauma caused while playing sports, especially NFL football. (Id.) After examining him, Dr. Cantu concluded that Atkins suffered from severe post-concussion syndrome and was "probably beyond that into early traumatic encephalopathy," impairments that were the result of his professional football career (Id.) Atkins submitted Dr. Cantu's records to the plan administrators and requested that his disability be reclassified as football degenerative. (Id.) The DICC promptly denied his claim. (App. 10.)

Atkins appealed the DICC's decision and submitted additional supporting documents, including a disability decision by an administrative law judge with the Social Security Administration who determined that Atkins was disabled due to post-concussion syndrome and frozen right shoulder. (App. 10-11, 55-56.) Atkins' reclassification appeal was

scheduled to be decided at the board's quarterly meeting on April 30, 2008. (App. 11.) By letter dated March 5, 2008, Atkins advised counsel for the plan administrators that his administrative appeal submissions were complete and he looked forward to a decision on April 30, 2008. (Atkins' Response in Opposition to Motion to Stay Pending Arbitration, Docket #8, Exhibit 4, filed 9/28/2010, W.D. Tex., Case No. 10-cv-00515-SS.)

The board tabled Atkins' claim and sent him to a neurologist in Seattle who was an NFL Medical Advisory Physician. (App. 11.) Including his trip to Seattle, Atkins logged approximately 9,000 travel miles attending physician appointments arranged by the NFL plan administrators for the purposes of deciding his disability claim. The neurologist concluded that head trauma from playing in the NFL contributed to Atkins' impairments of cognitive dysfunction, headaches, and psychiatric problems. (App. 11-12.) After considering the evidence, the board deadlocked. (App. 12-13.)

The board trustees appointed a neutral arbitrator named Richard Kasher to break their deadlock. (App. 13.) The deadlock began at the board's quarterly meeting in November, 2008, and lasted until the board's quarterly meeting on February 23, 2011, when the trustees reportedly adopted the arbitrator's decision to deny Atkins' reclassification claim. (App. 15.) Since the plan and the claims regulations required the board to decide Atkins' appeal at its April 30th, 2008 meeting, the board's decision on February

23, 2011, was two years and 299 days past the deadline.

D. Atkins Files Suit And Asks That His Administrative Remedies Be Deemed Exhausted

Atkins filed suit in 2008 but agreed to abate the lawsuit and finally dismiss it without prejudice due to the pending arbitration between the board trustees. (App. 12.) Atkins and his wife Patricia were asked to testify before the arbitrator. (App. 21.) Other than this testimony, he did not participate in the arbitration. The Fifth Circuit's statement that "Atkins participated in the entire process" is inaccurate. (App. 21.) (See Atkins' Response in Opposition to Motion to Stay Pending Arbitration, Docket #8, filed 9/28/2010, W.D. Tex., Case No. 10-cv-00515-SS.)

Atkins filed a second lawsuit in July of 2010, after the arbitrator had issued a decision in favor of the management trustees but while a request for reconsideration by the players trustees was pending. (App. 15-16.) In his 2010 lawsuit, Atkins claimed that he had exhausted his administrative remedies because of the board's unreasonable delay in deciding his appeal. (Atkins' Complaint, Docket #1, filed 7/09/2010, W.D. Tex., Case No. 10-cv-00515-SS; this claim remained in Atkins' first amended complaint, Docket #29, filed 3/04/2011, and second amended complaint, Docket #44, filed 6/02/2011.) He requested *de novo* review.

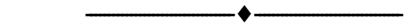
E. The Decisions Of The District Court And The Fifth Circuit Court Of Appeals

Each party filed a motion for summary judgment in the district court. Atkins requested that his reclassification claim be reviewed *de novo* for a number of reasons, including 1) the board had dramatically exceeded the plan and regulatory deadline to complete the §503(2) review, and 2) the arbitrator was not appointed as a fiduciary with discretion and therefore his decision was not entitled to deference. (App. 47-51.) The district court granted summary judgment for the plans and the owner trustees and denied summary judgment for Atkins. (App. 47-58.) The court held that the delay in deciding the administrative appeal and a non-fiduciary deciding the appeal were "procedural irregularities" that did not warrant a change in the standard of review. (App. 49-51.)

Atkins timely appealed. The Fifth Circuit affirmed the district court's decision. Rejecting Atkins' request for *de novo* review because of the board's flagrant breach of the deadline to decide his reclassification appeal, the Court held that "this circuit has rejected arguments to alter the standard of review based upon procedural irregularities in ERISA benefit determinations, such as delays in making a determination. *See S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993)." (App. 20-21.)

The Court also rejected Atkins' argument that his claim should receive *de novo* review because the arbitrator lacked discretionary authority to interpret

the plan or determine his eligibility for benefits. The Court held that the board trustees retained their control over the ultimate decision on Atkins' reclassification claim even though they required an arbitrator to break their deadlock. (App. 21-25.) The Court held that the arbitrator was not required to be a named fiduciary of the plan. (App. 24.)



REASONS FOR GRANTING THE PETITION

I. The First Issue: The Circuits Are Divided On Whether A Late Decision (Or No Decision) Is Entitled To Deference

With *Atkins*, the Fifth Circuit Court of Appeals holds that even a flagrant breach of the plan deadline for fiduciary review that is also an egregious violation of the regulatory deadline established by the Labor Secretary does not alter the standard of review. *Atkins* conflicts with the holdings in the majority of other circuits that have decided this issue. *Atkins* also conflicts with the Secretary of Labor's position that a failure to follow the claim regulations is an unreasonable claims procedure and a decision rendered after such failure should not be entitled to judicial deference.

A. Decisions Under The Prior "Deemed Denied" Regulation: A Division In The Courts Of Appeals

The Secretary's regulation addressing the consequences of a claims processing delay that applied to Atkins' claim became effective for claims submitted after January 1, 2002. 29 CFR §2560.503-1(o). This provision, the "deemed exhausted" provision, deems the plan's administrative claims procedures exhausted if the claims procedures don't meet or exceed the Secretary's minimum requirements promulgated within 29 CFR §2560.503-1(a-o). 29 CFR §2560.503-1(l). Its predecessor, the "deemed denied" provision, provided in relevant part: "if the decision on review is not furnished within such time ("such time" being the deadline set by the Labor Secretary for making the benefit decision on review) the claim shall be deemed denied on review." 29 CFR §2560.503-1(h)(4). Both regulations aim to compel an efficient fiduciary review of a denied benefit claim.

In considering a fiduciary's delay in reviewing a denied claim and its effect on the standard of review, the split in the circuits was described by the Second Circuit Court of Appeals in *Nichols v. Prudential Insurance Company of America*, 406 F.3d 98 (2d Cir. 2005):

> " . . . Our sister courts of appeal have again split on the question of whether a 'deemed denied' claim is always entitled to *de novo* review. The majority of circuits have held that, absent substantial compliance with the

> deadlines, *de novo* review applies on the grounds that inaction is not a valid exercise of discretion and leaves the court without any decision or application of expertise to which to defer. *Jebian*, 349 F.3d at 1106-07; *Gilbertson*, 328 F.3d at 632-33; *Gritzer v. CBS, Inc.,* 275 F.3d 291, 295(3rd. Cir. 2002). On the other hand, the Fifth Circuit has held that a "deemed denied" claim is still entitled to deferential review, reasoning that the decision to deny is the same whether accomplished formally or by inaction. *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993). The Eighth Circuit has marked a middle road, using deferential review unless the failure to meet the deadline raises serious doubts about the plan administrator's determination. *Seman v. FMC Corp. Ret. Plan for Hourly Employees*, 334 F.3d 728, 733(8th Cir. 2003)."[1]

The same year that *Nichols* was decided, the Ninth Circuit limited its holding in *Jebian* to "deemed denials" that occur as a result of plan language that deems a review denied if the review fiduciary does not meet the deadlines. *Gatti v. Reliance Standard Life Ins. Co.,* 409 F.3d 1061, 1065-1066 (9th Cir. 2005). Although the panel in *Gatti* was

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[1] The full citations of the cases cited within the Second Circuit's quote are as follows: *Jebian v. Hewlett Packard Co. Employee Benefits Organization Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2002); *Gilbertson v. Allied Signal, Inc.,* 328 F.3d 625 (10th Cir. 2003).

considering the "deemed denied" provision because the claim was submitted before January 1, 2002, the panel discussed the "deemed exhausted" provision that replaced it. The Court indicated that the Labor Secretary did not provide the reason for the new provision. *Id.,* at 1066-1067. This was error, since within the Labor Secretary's final rule for the changes to the claims regulations, the Secretary indicated that the "deemed exhaustion" provision was meant to "clarify that procedural minimums of the regulations are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." 65 Fed.Reg. 70246-01, 70255 (Nov. 21, 2000).

In a pre-*Firestone* case, when abuse of discretion was generally considered the default standard of review for ERISA benefit cases, the Sixth Circuit Court of Appeals held that a "deemed denied" decision was still reviewed for abuse of discretion.[2] *Daniel v. Eaton Corp*., 839 F.2d 263, 267-268 (6th Cir. 1988). The Circuit's current position is unclear, however, since subsequent to *Firestone* the Sixth Circuit wrote, without deciding the issue, that "there is undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner." *Univ. Hospital of*

[2] Pre-*Firestone* refers to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989).

Cleveland v. Emerson Elec., 202 F.3d 839, 846, n.3 (6th Cir. 2000).

B. Decisions Under The "Deemed Exhausted" Regulation: The Division Continues

The Tenth Circuit Court of Appeals has twice construed the "deemed exhausted" provision in effect for claims submitted after January 1, 2002: *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311 (10th Cir. 2009) and *LaAsmar Phelps Dodge Corp. Life, Accidental Death & Dismemberment and Dependent Life Ins. Plan*, 605 F.3d 789 (10th Cir. 2010).

In *Rasenack*, the initial decision and review decision were made several months after the plan and regulatory deadlines. The plaintiff filed suit during the pendency of the fiduciary review, approximately one month prior to the fiduciary's late decision. *Rasenack*, 585 F.3d at 1314, 1318. The Court found that the claim should receive *de novo* review, reasoning that deference to a late decision conflicts with ERISA's stated purpose of protecting the interests of participants by establishing standards of conduct for fiduciaries of employment benefits plans. *Id.*, citing 29 U.S.C. §1001(b).

As in *Rasenack*, *LaAsmar* addresses a late fiduciary review decision to which the court could defer. Unlike *Rasenack*, the claimant had not filed suit and invoked exhaustion prior to the fiduciary's late decision. *LaAsmar,* 605 F.3d at 795. The Court followed

Rasenack and held that the claimant was entitled to *de novo* review because the decision on review was untimely. *Id.,* at 798-800. The Court found that 110 days beyond the plan and regulatory deadline was not substantial compliance and did not preserve deference. *Id.*, at 800. The Court emphasized that its decision was bolstered by the Department of Labor's position that a decision rendered after a failure to comply with the Secretary's claim regulations should not be entitled to judicial deference. *Id.,* at 799, citing 65 Fed.Reg. 70246-01, 70255 (Nov. 21, 2000).

C. Another Division Within The Courts Of Appeals Regarding Factual Determinations By Plan Fiduciaries

In stark contrast, the *Atkins* decision maintains that even when a fiduciary is two years and 299 days late, discretion is retained by the fiduciary conducting the §503(2) review. (App. 20.) The claimant's invocation of exhaustion prior to the fiduciary's decision makes no difference. See Atkins' Complaint, Docket #1, filed 7/09/2010, W.D. Tex., Case No. 10-cv-00515-SS. Although *Atkins* purports to follow the Fifth Circuit precedent of *Moore*, *Moore* actually reviewed the administrator's plan interpretation *de novo*, presumably because no discretion was granted the plan administrator by the plan. *Moore*, 993 F.2d at 101.

In *Moore* the Fifth Circuit Court of Appeals indicated that the late decision did not alter the standard of review (a "deemed denial" was no different than a written denial) because of its isolated view,

formulated in *Pierre v. Conn. Gen. Life Ins. Co.,* 932 F.2d 1552 (5th Cir. 1991), that factual determinations by ERISA fiduciaries should always receive deference, regardless of whether or not the plan grants discretion to the fiduciary. This narrow interpretation of *Firestone* presents another circuit split. Other circuits have found that the absence of a discretionary grant in the plan mandates *de novo* review of the factual determinations of plan administrators. *Rowan v. Unum Life Insurance Company of America*, 119 F.3d 433 (6th Cir. 1997) ("We thus join every other circuit that has considered this issue in rejecting *Pierre*. We hold that factual determinations of plan administrators in actions brought under 29 U.S.C. §1132(a)(1)(B) are subject to de novo review.") *Id.*, at 435.

Atkins does not follow *Moore* and attempt to pigeonhole the arbitrator's decision as a factual determination or a plan interpretation. Instead, *Atkins* holds that no matter the breach of the plan's deadline for decision that is also a violation of the Secretary's claim regulation, deference is retained. This decision has broad ramifications for the processing of ERISA claims.

D. The Fifth Circuit Erred In Giving No Weight To The Labor Secretary's Stated Purpose In Enacting The "Deemed Exhausted" Regulation

In finding that deference was still due a decision that was two years and 299 days late, the Court

provides no hint that it considered the Labor Secretary's statement that the "deemed exhausted" provision was meant to clarify that no judicial deference is due a fiduciary that does not comply with the claim regulations. This was error, since considerable weight should be given to the Labor Department's construction of §503(2) and the regulations that it prescribes to define the minimum requirements of a full and fair review. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844-845, 104 S.Ct. 2778 (1984). ERISA is a statutory and regulatory scheme that the U.S. Department of Labor has been entrusted to oversee and administer.[3]

E. It Is Of National Importance That An ERISA Fiduciary Review Of A Denied Benefit Claim Be Subject To Meaningful Deadlines

A "full and fair" review of a denied benefit claim is fair only if it is made promptly. An employee who becomes disabled because of illness or injury faces a harsh horizon of no household income and perhaps increased expenses due to a disabling condition. A timely review of a plan participant's application for

[3] 29 U.S.C. §1134 gives the Secretary of Labor the authority to investigate ERISA violations; 29 U.S.C. §1135 gives the Secretary the authority to prescribe appropriate or necessary regulations; 29 U.S.C. §1136(b) gives the Secretary the responsibility and authority to detect, investigate, and refer civil and criminal violations of ERISA.

disability income, commonly 60 percent of pre-disability earnings, might determine whether the claimant can keep her house, her car, pay health insurance premiums, buy clothes for her children or keep food on the table for a family that depends upon her for financial support.[4] Timely decisions are also critical to plan participants when a fiduciary is reviewing medical care coverage that has been denied.

The number of working Americans who rely upon the safety net that ERISA plans provide heightens the national importance of the timely processing of claims by fiduciaries. As of March, 2012, the Labor Secretary reported that over 39 million private industry workers had short-term disability insurance coverage as an employment benefit and over 33 million had long-term disability coverage benefits.[5] It has been estimated that 1.9 million beneficiaries of ERISA plans have health care claims denied each year. *Metropolitan Life Insurance Company v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343, 2350 (2008) (underlying cite omitted). Allowing substantial delay without the

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[4] U.S. Department of Labor. U.S. Bureau of Labor Statistics. *National Compensation Survey: Employee Benefits in the United States, March 2012. Bulletin 2773.* Issued September 2012. Table 30 for Private Industry Workers, addressing fixed percent of annual earnings for long-term disability plans.

[5] Id. Table 16 for Private Industry Workers indicates the percentage of workers in private industry that have disability insurance coverage as an employment benefit. Appendix 2 to *Bulletin 2773* indicates the number of private industry workers represented in the compensation survey.

negative consequence of forfeiting deference is inconsistent with a fundamental purpose of ERISA, which is "to promote the interests of employees and their beneficiaries in employment benefit plans." *Firestone*, 489 U.S. at 113, quoting *Shaw v. Delta Airlines Inc*., 463 U.S. 85, 90 (1983).

F. The Negative Consequence If Deference Is Retained By The Fiduciary Despite A Late Decision Or No Decision

Construing the "deemed exhausted" provision as only a pass card that allows a claimant access to the courthouse without further delay but leaves discretionary power intact conflicts with the Secretary's claims processing regulations and the normal ERISA benefit litigation process. Delay coupled with retention of deference allows the fiduciary to preserve its reasons for denial until litigation, offering the reasons for denial through its lawyers rather than through a named fiduciary of the plan. This conflicts with the efficient, predictable, and non-adversarial review procedures that are the hallmarks of the ERISA fiduciary review process and reasons for deference. *Conkright v. Frommert*, 130 S.Ct. 1640, 1649-1650 (2010). It also conflicts with the claims review obligations that the Secretary has placed squarely upon the shoulders of the named fiduciary.

According to §503(2), the "appropriate named fiduciary" is supposed to decide the claim review. The Secretary's implementing regulations require that if

the claim is denied on review, the fiduciary is required to provide the specific reason or reasons for the adverse benefit determination, reference to the specific plan provisions on which the benefit determination is based, and any internal rules, guidelines, or protocols that were applied in making the determination. 29 CFR §2560.503-1(j)(1-5). Due to the absence of negative consequences, *Atkins* invites the conclusion that sometimes it may be preferable to delay or not decide the fiduciary review of a denied claim. This violates §503(2) and the claims processing regulations that were enacted by the Secretary in order to fulfill ERISA's purpose of establishing standards of conduct for fiduciaries of employee benefit plans. 29 U.S.C. §1001(b).

II. The Second Issue: *Atkins* Conflicts With The LMRA

A. *Atkins* Contravenes The Plan And The Relevant Provisions Of The Labor Management Relations Act

The board submitted their dispute for final and binding arbitration in accordance with the terms of the plan. (App. 21.) The appointed arbitrator, Richard Kasher, rendered the final decision that bound the board to deny Atkins reclassification claim. (App. 27-28.) Atkins requested *de novo* review, contending that there was no evidence that the arbitrator was a named fiduciary with discretionary powers to interpret the plan or determine eligibility for benefits. (App. 19.) The Court ruled that despite the fact that

Kasher's decision was binding upon the trustees, the trustees maintained control of the ultimate decision on benefits. (App. 23.) Since the board had discretionary authority, the decision was reviewed for abuse of discretion. (App. 27-28.)

When the board trustees submitted their dispute to arbitrator Kasher for final decision, they surrendered their decision-making authority and their powers of discretion to interpret the plan or determine eligibility for benefits. Under the LMRA, the impartial umpire is required by law to decide the dispute because the board trustees have reached an impasse. 29 U.S.C. §186(c)(5)(B). The plan tracks this provision. (App. 21.) By the plan and operation of the LMRA, arbitrator Kasher became the decision-making body that completed the full and fair review of Atkins' reclassification claim. In portraying the arbitrator as someone who assisted the board in making the final benefit decision, *Atkins* violates the plan language – treating a binding decision as non-binding – and fundamentally misapprehends the transfer of power that occurs when a Taft-Hartley board deadlocks and refers the matter to a neutral umpire for decision. (App. 23.)

B. *Atkins* Conflicts With *Firestone v. Bruch*

In *Firestone*, this Court followed principles of trust law in declaring that a "denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard 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*, 489 U.S. at 115. The Supreme Court did not grant deferential review to the plan administrator because there was no evidence that "under Firestone's termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference." *Id.,* at 111.

Atkins conflicts with *Firestone* because in *Atkins* the Court defers to the arbitrator's decision yet there is no evidence that he had the power to construe uncertain terms or make eligibility determinations. (App. 2-3, describing the board as the named fiduciary with discretion; App. 27-28, deferring to arbitrator Kasher's decision.)

III. The Third Issue: *Atkins* Conflicts With ERISA's Requirement That A §503(2) Review Be Conducted By A Named Fiduciary

The Court rejected Atkins' argument that his reclassification claim merited *de novo* review because arbitrator Kasher was not a named fiduciary of the plan as required by §503(2) of ERISA. In doing so, the Court indicated that there was Supreme Court authority for the proposition that plan administrators may appoint a neutral umpire to break a deadlock "without concerns over the mechanical procedures of formally designating the arbitrator as a fiduciary." (App. 24, citing *National Labor Relations Board v.*

Amax Coal Co., 453 U.S. 322, 338 (1981)). This is error. *Amax Coal* did not involve a board deadlock over an ERISA §503(2) benefit review. In fact, *Amax Coal* leads to the opposite conclusion from the one made in *Atkins*. The decision makes it clear that a Taft-Hartley trustee must follow the laws of ERISA. *Amax Coal*, 453 U.S. at 332-333. This includes the trustees' obligations to comply with §503(2) of ERISA, which means ensuring that the arbitrator who they appoint to break the deadlock is a named fiduciary of the plan.

A. A §503(2) Review Must Be Conducted By A Named Fiduciary

Within the statutory scheme of ERISA, Congress identified who had the authority to conduct the review of a denied benefit claim. Section 503(2) requires that a plan participant be given a full and fair review of a denied claim "by the appropriate named fiduciary." 29 U.S.C. §1133(2).

Section 402(a)(2) defines the "named fiduciary" as follows:

1) a fiduciary who is named in the plan instrument; or

2) someone who, "pursuant to a procedure specified in the plan, is identified as a fiduciary by a person who is an employer or employee organization with respect to the plan, or by such employer and such employee organization acting jointly." 29 U.S.C. §1102(a)(2).

The LMRA provides no exception to these statutory requirements. The NFL plan was required to identify arbitrator Kasher as a plan fiduciary who would decide the benefit review in case of a board deadlock or the board trustees were required to identify arbitrator Kasher as a plan fiduciary in accordance with a procedure specified in the plan. Neither event occurred in this case.

B. An Important Issue Of Federal Law That Should Be Settled By This Court

The facts of this case exemplify the importance of the requirement that a benefit review be completed by a named fiduciary. Atkins' benefit review was decided two years and 299 days past the deadline because arbitrator Kasher was not a plan fiduciary. If he had been a fiduciary, he would have been under legal obligation to meet the plan and regulatory deadlines. 29 U.S.C. §1104(1)(D). Plan participants, with their state law claims already displaced, shouldn't be held hostage by a non-fiduciary deciding their benefit review. Naming a deadlock-breaking decision-maker as a plan fiduciary cannot be viewed as an unnecessary formality. Instead it is a plan participant's statutory right. 29 U.S.C. §1133(2). This is an important issue of federal law that should be settled by this Court.

IV. This Is An Ideal Case To Decide These Three Issues

The egregious violation of the time frame for deciding Atkins' reclassification appeal makes this an ideal case for deciding the first issue. Neither substantial compliance with the deadline nor the argument that the delay was caused by an ongoing dialogue between Atkins and a fiduciary are present in this case. The delay was caused solely by the actions of the board trustees and the non-fiduciary arbitrator, who operated under the assumption that the plan and regulatory deadlines were meaningless. The circuit split on whether a late decision should receive deference is made ripe for review with *Atkins*, as the Fifth Circuit has held that deference is retained even when a decision is two years and 299 days late. This holding not only stands in direct opposition to other circuits that have decided the same issue, but conflicts with the Labor Secretary's stated purpose for implementing the "deemed exhausted" regulation.

The case is ideal for presenting the second issue because *Atkins* so clearly misconstrues the transfer of decision-making authority that occurs when a Taft-Hartley board must engage an arbitrator as a neutral umpire to break their deadlock.

This is an ideal case for presenting the third issue because *Atkins* holds that designating a deadlock-breaking arbitrator as a fiduciary is an unnecessary mechanical procedure. This decision directly conflicts

with Section 503(2) of ERISA, which establishes a participant's right to have his benefit claim review decided by a fiduciary. The egregious delay that occurred in this case clarifies why a board-appointed neutral must be a plan fiduciary. This case presents the opportunity to stress that if someone other than a named fiduciary as defined by Section 402(a)(2) decides the claim review, that decision is in violation of Section 503(2) of ERISA and is not entitled to judicial deference.

CONCLUSION

Gene Atkins prays that his petition for writ of certiorari be granted.

Respectfully submitted,

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IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 11-51202

GENE ATKINS,

Plaintiff-Appellant

v.

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN; THE NFL SUPPLEMENTAL DISABILITY PLAN; MANAGEMENT TRUSTEES OF THE NFL PLAYER RETIREMENT PLAN,

Defendants-Appellees

Appeal from the United States District Court
for the Western District of Texas

(Filed Sep. 11, 2012)

Before REAVLEY, SMITH, and CLEMENT Circuit Judges.

EDITH BROWN CLEMENT, Circuit Judge:

Gene Atkins, a former player for the New Orleans Saints and Miami Dolphins National Football League ("NFL") teams, filed suit seeking more generous disability benefits under the Bert Bell/Pete Rozelle NFL Player Retirement Plan (the "Plan"). The district

court granted summary judgment in favor of the Plan, affirming its benefits determinations that Atkins is only eligible for "Inactive" player disability benefits instead of the more generous "Football Degenerative" disability benefits he seeks. Atkins challenges the standard of review employed by the district court and the substantive merits of the benefits determinations. We AFFIRM.

FACTS AND PROCEEDINGS

1. The Bert Bell/Pete Rozelle NFL Player Retirement Plan

The Plan is an employee, multi-employer welfare benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1002(3)(2)(A), 1002(37)(A), and the Labor Management Relations Act ("LMRA"), 29 U.S.C. §§ 141 *et seq.*, also known as the "Taft-Hartley Act." As required by statute, the Plan is jointly administered by employee (NFL players) and employer (NFL club owners) representatives. 29 U.S.C. § 186(c)(5)(B). Three player representatives are appointed by the NFL Players Association ("NFLPA") and three club ownership representatives are appointed by the NFL Management Committee ("NFLMC") (collectively the "Retirement Board" or the "Board"). The Retirement Board, which meets quarterly, is the "named fiduciary" of the Plan and is responsible for administering the Plan. The Plan grants the Board "full and absolute discretion, authority and power" to interpret the Plan and decide

claims for benefits. The Plan also provides that, in exercising its discretionary powers, the Retirement Board "will have the broadest discretion permissible under ERISA and any other applicable laws."

The Plan provides monthly total and permanent ("T&P") disability benefits to eligible NFL players. Retired players such as Atkins may be eligible for benefits categorized as either "Football Degenerative" or "Inactive." A player may qualify for "Football Degenerative" T&P benefits if his disability "arises out of League football activities." A player may qualify for "Inactive" T&P benefits if his disability "arises from other than League football activities." Football Degenerative benefits are significantly greater than Inactive benefits. After an initial benefits determination, a player's benefit category may be altered only upon a showing of "changed circumstances" based on "clear and convincing" evidence.

A player's claim for T&P disability benefits is first reviewed by the Disability Initial Claims Committee ("DICC"). The DICC is composed of two members, one appointed by the NFLPA and one by the NFLMC. If the two members of the DICC are deadlocked, the claim is deemed denied. Decisions of the DICC are appealable to the Retirement Board. If the members of the Retirement Board are deadlocked, they may vote to submit the matter to a Medical Advisory Physician ("MAP") for a determination regarding medical issues. In the event of a deadlock concerning eligibility or entitlement to benefits, the

Retirement Board may vote to refer the dispute for final and binding arbitration.

2. Atkins' Initial Claim for Disability Benefits

Gene Atkins played professional football from 1987 until 1996, spending the majority of his time playing with the New Orleans Saints and the last several years with the Miami Dolphins. During his career he was well-recognized for his aggressive, hard-hitting play as a defensive back and he sustained a number of injuries resulting from on-field collisions.

In December 2004, Atkins submitted an application for disability benefits to the Plan administrators, claiming T&P disability as a result of three conditions stemming from his football career. The conditions Atkins listed were: (1) right shoulder ailments, including movement limitations and chronic pain; (2) chronic constant pain in his neck that radiated through his arms and hands, affecting his ability to drive, sense of touch, and ability to hold objects; and (3) depression and mood issues that limited his ability to function, due in part to his constant physical pain and inability to work. Atkins reported that he worked at a Target store for five months but had to stop because of pain, headaches, and difficulties in dealing with people.

Following receipt of his disability application, Plan administrators sent Atkins to two neutral physicians for evaluation, Keith Kesler ("Kesler"), a psychiatrist, and Tarek Souryal ("Souryal"), an orthopedist.

Kesler reported that Atkins suffered from poor cognitive function, which he stated "cannot be determined" as to whether it resulted from football. Kesler also reported that Atkins had chronic pain and headaches, as well as possible neurologic defects, all of which were the result of football. Kesler found Atkins totally disabled as a result of his impairments. In contrast, Souryal reported that Atkins suffered from neck and shoulder impairments which were the result of football, but the impairments did not render him totally disabled.

Atkins' application and Kesler's and Souryal's reports were reviewed by the DICC on June 7, 2005. The two members deadlocked and the claim was deemed denied. Atkins appealed the decision to the Retirement Board as provided for under the Plan. The Retirement Board scheduled Atkins for two additional examinations by neutral physicians, orthopedist J. Bryan Williamson ("Williamson") and neurologist Raymond Martin ("Martin").

Williamson concluded that Atkins suffered from long-term neck and right shoulder impairments due to football-related injuries. However, Williamson also concluded Atkins was not totally disabled. Martin found that Atkins was totally disabled due to a combination of problems. He concluded Atkins' physical impairments were a result of football, but his memory problems were of an unknown source. He suggested that formal neuropsychological testing would have to be done to determine the etiology of Atkins' problems with intellect, memory, and mental status.

With the benefit of Williamson's and Martin's reports, the Retirement Board considered Atkins' claim at its next scheduled quarterly meeting held on October 20, 2005. The Retirement Board deadlocked and referred the matter to a MAP. The Plan defines a MAP as a board-certified orthopedic physician or a physician in another medical discipline as designated by the NFLPA and NFLMC. A MAP has the authority to decide only those medical issues submitted by the Retirement Board. Atkins was referred to Thomas Boll ("Boll"), a Ph.D. clinical neuropsychologist, for an examination. The referral states that Boll was to evaluate the impaired body parts identified by Atkins, specifically his "head ache, numbness, shoulders, neck [and] hands."

Boll concluded that Atkins suffered from illiteracy and borderline mental ability, neither of which resulted from football. He further concluded that Atkins suffered from depression, which could not be determined to be the result of football, and pain which was the result of football. Specifically, Boll stated that "Atkins' difficulties appear to be primarily in the psychiatric arena and there is no evidence of a neurological disorder" and further concluded that Atkins' limitations are primarily the product of his "extremely limited" literacy that places him "at a substantial disadvantage with regard to a wide variety of occupational pursuits outside of those specifically related to the athletic field." Boll concluded that Atkins was totally disabled and suggested psychological and

psychiatric intervention to increase his ability to function adequately on a day-to-day basis.

After receiving Boll's report, the Retirement Board considered Atkins' appeal in a meeting conducted on February 9, 2006. The minutes of the meeting reflect a decision to approve Inactive T&P disability benefits, retroactively effective to June 1, 2005. In a letter dated February 23, 2006, the Plan director explained the award of Inactive T&P benefits was for psychiatric impairments which did not "arise out of League football activities" under the language of the Plan. Atkins was informed his T&P disability benefits were therefore not categorized as Football Degenerative.

3. Atkins' Multiple Requests for Reconsideration

Atkins submitted another appeal to the Retirement Board by way of a letter dated March 3, 2006. In the letter, Atkins requested reclassification into the Football Degenerative category, stating that he believed his disability resulted from football activities. However, Atkins did not submit any additional evidence or argument in support of his reclassification request. On May 10, 2006, the Retirement Board tabled its consideration of the appeal to allow additional time for Atkins to be evaluated by a neutral physician.

Atkins was examined by neurologist Robert W. Gilbert, Jr. ("Gilbert") on June 12, 2006. Gilbert found that Atkins suffered from the impairments of right

shoulder pain with limited motion, cervical spasms with neck and arm pain, and carpal tunnel syndrome. Gilbert concluded all of the impairments resulted from football, but also concluded that Atkins was not totally disabled as a result of his impairments.

After receiving Gilbert's report, the Retirement Board reviewed Atkins' appeal on July 19, 2006. The minutes of the meeting reflect that the Retirement Board denied the request for reclassification to Football Degenerative T&P disability benefits. A July 26, 2006, letter from the Plan director stated:

> By report dated June 12, 2006, Dr. Gilbert stated that you are not totally and permanently disabled by your head, neck and right arm conditions. The Retirement Board noted that Dr. Gilbert's report is consistent with earlier medical reports insofar as it states that your physical impairments are not, by themselves, totally and permanently disabling. The Retirement Board further found that Dr. Gilbert's report is consistent with its earlier conclusion that you are permanently and totally disabled by your psychiatric/psychological condition, which for the reasons described above, qualifies you for the Inactive category. In sum, the Retirement Board once again concluded that the Inactive category is the correct category for your T&P benefits based on the medical evidence in your file.

> You should regard this letter as a final decision on review within the meaning of Section 503 of the Employee Retirement Income Security Act. . . . You have the right to bring an action under section 502(a) of the Employee Retirement Income Security Act.

After receiving the letter, Atkins did not exercise his right to bring an action under ERISA § 502 to challenge the Retirement Board's benefits determination.

Following the Retirement Board's denial of his request for reclassification, Atkins sought the advice of noted neurosurgeon Dr. Robert Cantu ("Cantu"), an expert on brain trauma caused by athletics, including chronic traumatic encephalopathy ("CTE") suffered by former NFL players. After examining Atkins, Cantu opined that Atkins suffered from severe post-concussion syndrome and was "probably beyond that into early traumatic encephalopathy." Cantu also concluded that Atkins was unable to work indefinitely due to a "demented mental status."

Based on Cantu's findings, Atkins submitted a letter to the Retirement Board on August 23, 2007, in which he requested reconsideration of the denial of his reclassification request for Football Degenerative benefits. Cantu's report was submitted with the letter. The Board treated the letter as a request for reclassification of benefits from Inactive to Football Degenerative.

On October 4, 2007, the DICC considered and denied the request. An October 5, 2007, letter from the Plan director stated:

> After reviewing the available information, the Committee determined that you are totally and permanently disabled due to a psychiatric/psychological condition which precludes an award of Football Degenerative T&P disability benefits. The Committee also reviewed Plan section 5.6 regarding reclassification requests, and concluded that you have failed to present clear and convincing evidence that you qualify for Football Degenerative T&P benefits because of changed circumstances. Specifically, the Committee determined that the new evidence presented . . . relate[s] to the same condition that was the basis for the original classification. Accordingly the Committee denied your request for reclassification.

In December 2007, Atkins received a favorable decision from the Social Security Administration in response to his application for disability insurance benefits ("DBI") and supplemental security income ("SSI"). The administrative law judge ("ALJ") presiding over Atkins' social security claim relied on the findings of Cantu and Dr. Ronald DeVere ("DeVere"), a neurologist appointed to assist the ALJ in determining whether Atkins was disabled. DeVere's findings indicated that Atkins had "a number of problems," including "evidence of some cognitive disorder, which . . . may be partially related to multiple head trauma

he sustained over a nine-year career of professional football." The ALJ found Atkins to be disabled under the Social Security Act and awarded him benefits dating to January 1, 1998.

After receiving the decision from the ALJ, Atkins requested an appeal of the DICC's October 2007 decision by letter dated February 11, 2008. In support of the appeal, Atkins submitted additional documentation, including the ALJ's decision and DeVere's medical findings. On April 30, 2008, the Retirement Board tabled its consideration of Atkins' appeal to allow additional time for Atkins to be evaluated by a neutral MAP, neurologist James Gordon ("Gordon").

Gordon examined Atkins on June 25, 2008. He found that Atkins suffered from impairments of: (1) cognitive dysfunction; (2) depression; and (3) chronic and post-concussion headaches. Gordon concluded that the chronic and post-concussion headaches resulted from football, but that the other two impairments were only "in part" the result of football. Gordon also concluded that Atkins was totally disabled as a result of the impairments.

Gordon explained his diagnostic impressions:

> Mr. Atkins' overall picture includes elements of psychiatric dysfunction, cognitive dysfunction, and headache that most likely result from a combination of constitutional and environmental factors, none of which, alone, would explain his current condition. There is little doubt that recurrent head trauma of a

> concussive and sub-concussive type contributes to these disorders, though relative effect of head trauma is difficult to quantitate. . . . It is impossible to distinguish the precise extent to which head injury causes, rather than exacerbates, Mr. Atkins's headaches, cognitive and behavior problems, given preexisting neuropsychological limitations and psychiatric predispositions. What is clear, however, is that he suffers disabling chronic headache, depression and cognitive limitations, and that recurrent head trauma resulting from his role as an NFL defensive back contributed significantly to his current condition, even if that contribution cannot be reliably quantitated. In his current condition, he cannot be gainfully employed.

4. Lawsuits and Arbitration

Before the Retirement Board could meet in November 2008 to consider Atkins' appeal and Gordon's findings, Atkins filed suit against the Plan in district court on August 29, 2008, seeking benefits under ERISA. *Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, No. 1:08-CV-651-SS, Dkt. 1 (W.D. Tex. Aug 29, 2008) (the "First Lawsuit"). The suit was ultimately dismissed without prejudice based on a stipulation of the parties in light of the ongoing appeal being considered by the Retirement Board. (*Id.*, Dkt. 29).

When the Retirement Board finally met to consider Atkins' appeal on November 11, 2008, the Board

deadlocked on Atkins' request for reclassification and referred the issue for final and binding arbitration pursuant to section 8.3(b) of the Plan.

On June 18, 2009, an arbitration hearing was conducted before Richard Kasher ("Kasher"). A number of exhibits, including the deposition testimony of Cantu and Gordon, were introduced. In addition, Atkins and his then-wife Patricia Atkins testified at the hearing. Kasher conducted an additional hearing on August 17, 2009, at which Boll testified and more evidentiary exhibits were introduced. The arbitration record ultimately included more than 4,000 pages. Kasher issued his decision on April 12, 2010, finding there was insufficient evidence to conclude Atkins had proven his level of benefits should be reclassified under the Plan. In a lengthy opinion, Kasher reviewed the medical evidence and testimony presented during the hearings. In pertinent part, the opinion stated:

> In this Arbitrator's opinion it is also significant to note that Dr. Cantu candidly testified that he was not able with "100% percent accuracy" to diagnose Mr. Atkins with CTE. More importantly, Dr. Cantu testified that Mr. Atkins has "all three aspects of the triad" of CTE; and thus Dr. Cantu testified that he has a "high index of suspicion" that Claimant Atkins suffers from CTE. Again, Dr. Cantu testified candidly that he could not "say with . . . scientific certainty" that Mr. Atkins has CTE, and could only do so "when his brain is studied."

Dr. Cantu's opinion is qualified by his finding that Mr. Atkins' CTE is based upon a "more probably than not" diagnosis. Such an opinion, as well-founded as it is by Dr. Cantu, a highly-qualified and well-respected medical practitioner, does not, in this Arbitrator's opinion, meet the "clear and convincing" standard of proof required to sustain Mr. Atkins' claim.

. . .

The findings of Doctors Cantu, DeVere and Gordon regarding Mr. Atkins' history of head trauma are, as the Owner Trustees have correctly pointed out, all premised upon the reports made by Mr. Atkins some nine to ten years after those alleged incidents. The incidents are not set in time and do not reference which teams the Saints were playing, nor is there any evidence that the incidents were reported to the Saints or the Dolphins trainers or Club physicians.

Therefore, the resolution of the issues in this case require the analysis of the two plausible medical opinions/diagnoses of Gene Atkins' cognitive dysfunction.

In this Arbitrator's opinion, neither the opinions of Doctors Cantu, Gordon and DeVere on the one hand and Dr. Boll on the other rise to the level of clear and convincing evidence. And, as noted above, this Arbitrator is bound by that standard of proof.

> Therefore, Mr. Atkins's claim falls into the realm of "probability", as both Doctors Cantu and Boll have implicitly acknowledged.
>
> It is "probable" that Gene Atkins experienced more than one concussion event/incident during his ten year career as a professional football player; and that one of those probable events/incidents, . . . may have resulted in some postconcussive symptoms, albeit they were not reported, recorded or treated.
>
> That being said, this Arbitrator finds insufficient evidence to conclude that Gene Atkins has proven that his level of benefits should be reclassified under the provisions of the Bert Bell/Pete Rozelle NFL Player Retirement Plan.

Accordingly, this Arbitrator is compelled to deny Mr. Atkins' claim.

The NFLPA trustees requested reconsideration of Kasher's decision. On November 29, 2010, Kasher denied the request. In so doing, he noted that he had "fully considered the contradictory medical opinions and the evidence of Mr. Atkins' injuries and symptoms" and was not prepared to reopen the record. Subsequently, and in accordance with section 8.3 of the Plan, the Retirement Board adopted Kasher's decision at its February 23, 2011 meeting.

While the NFLPA trustees' request for reconsideration was still pending, Atkins filed the lawsuit that forms the basis for this appeal on July 9, 2010 (the "Second Lawsuit"). Atkins filed several motions

seeking to compel discovery regarding aspects of the Plan's claim handling process, potential conflicts of interests involving members of the Retirement Board, and the Plan's handling of other T&P disability benefits claims, as well as challenging the scope of documents designated as part of the administrative record. The district court denied the majority of the motions with the exception of allowing discovery regarding some of the Plan's handling of prior claims.

In November 2011, the district court granted summary judgment in favor of the Plan and denied Atkins' motion for summary judgment. *Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan et al.*, No. 10-CV-515, slip op. at 18 (W.D. Tex. Nov. 10, 2011). While Atkins argued that the district court should review the benefits determinations under a *de novo* standard of review, the court agreed with the Plan, citing Supreme Court precedent, that abuse of discretion is the proper standard of review when considering an ERISA plan's fiduciary's benefits determinations. *Id.* at 12-14. The district court then considered the merits of Atkins' challenges to the Plan's benefits determinations and held that the Retirement Board, under the Plan provisions, had not abused its discretion by awarding Atkins T&P disability benefits under the Inactive category instead of the Football Degenerative category. *Id.* at 15-16. Additionally, the court found that Atkins failed to establish that Kasher's arbitration decision was procedurally unreasonable. *Id.* at 17.

On appeal, Atkins challenges the district court's decision to apply abuse of discretion instead of *de novo* review to the Plan's benefits determinations and he challenges the merits of the specific benefits determinations made by the Retirement Board in 2006 and 2011 and by arbitrator Kasher in 2010.

STANDARD OF REVIEW

"Standard summary judgment rules control in ERISA cases." *Cooper v. Hewlett-Packard Co.*, 592 F.3d 645, 651 (5th Cir. 2009) (quoting *Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 225 (5th Cir. 2004)). We review the grant of summary judgment *de novo*, applying the same standard as the district court. *Pub. Citizen Inc. v. La. Att'y Disciplinary Bd.*, 632 F.3d 212, 217 (5th Cir. 2011). Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a).

We also review *de novo* the district court's selection of the appropriate standard of review to be applied to an ERISA administrator's eligibility determination. *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 213 (5th Cir. 1999). Unless the terms of the plan give the administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan[,]" an administrator's decision to deny benefits is reviewed *de novo*. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101,

115 (1989). However, if the language of the plan does grant the plan administrator discretionary authority to construe the terms of the plan or determine eligibility for benefits, a plan's eligibility determination must be upheld by a court unless it is found to be an abuse of discretion. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 111 (2008) (citing *Firestone Tire & Rubber Co.*, 489 U.S. at 111, 115). Independent of the administrator's ultimate authority to determine benefit eligibility, factual determinations made by the plan administrator during the course of a benefits review will be rejected only upon a showing of abuse of discretion. *Meditrust Fin. Servs. Corp.*, 168 F.3d at 213.

In the ERISA context, "[a]buse of discretion review is synonymous with arbitrary and capricious review." *Cooper*, 592 F.3d at 652. This standard requires only that substantial evidence supports the plan fiduciary's decision. *Ellis v. Liberty Life Assur. Co. of Boston*, 394 F.3d 262, 273 (5th Cir. 2004). Substantial evidence is "more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quoting *Deters v. Sec'y of Health, Educ. & Welfare*, 789 F.2d 1181, 1185 (5th Cir. 1986)). "A decision is arbitrary only if made without a rational connection between the known facts and the decision or between the found facts and the evidence." *Holland v. Int'l Paper Co. Ret. Plan*, 576 F.3d 240, 246 (5th Cir. 2009) (citing *Meditrust Fin. Servs. Corp.*, 168 F.3d at 215). Moreover, this court's "review of the administrator's decision need not be particularly

complex or technical; it need only assure that the administrator's decision fall[s] somewhere on a continuum of reasonableness – even if on the low end." *Corry v. Liberty Life Assur. Co. of Boston*, 499 F.3d 389, 398 (5th Cir. 2007) (quoting *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc)).

DISCUSSION

1. Abuse of discretion review of the Retirement Board's 2011 benefits determination

Atkins argues the Retirement Board's benefits determination in 2011, in which the Board adopted Kasher's arbitration decision that Atkins failed to prove changed circumstances for reclassification to Football Degenerative benefits by clear and convincing evidence, should be reviewed *de novo* due to two procedural irregularities. Atkins asserts that because Kasher did not have discretionary authority to make a benefits determination under the Plan and because the Retirement Board's decision to adopt Kasher's decision was untimely under the Plan's claims procedures, the district court erred by using abuse of discretion instead of *de novo* review.

Atkins made similar arguments to the district court in seeking *de novo* review of the Board's 2011 decision. He challenged, among other things, the Retirement Board's referral of his appeal to Kasher and the delay in making a benefits determination. In a well-reasoned rejection of these arguments, the district court cited Supreme Court and Fifth Circuit

precedent for the proposition that the deferential abuse of discretion standard of review granted to ERISA plan decisions should not be altered absent a finding that the plan administrator "acted in bad faith or would not fairly exercise his discretion to interpret the terms of the Plan." *Conkright v. Frommert*, 130 S. Ct. 1640, 1648 (2010).

We agree with the district court's reasoning. This circuit has rejected arguments to alter the standard of review based on procedural irregularities in ERISA benefit determinations, such as delays in making a determination. *See S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993). Absent potential wholesale or flagrant violations that evidence an "utter disregard of the underlying purpose of the plan," this court does not heighten the standard of review from abuse of discretion to *de novo*. *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 159 (5th Cir. 2009) (quoting *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th Cir. 2006) (en banc)); *see also Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 538 (5th Cir. 2007) ("[Appellant] encourages us to heighten our standard of review due to the procedural irregularities in the handling of his [ERISA] claim. . . . [Appellant] has cited no direct authority by the Supreme Court or the Fifth Circuit dictating a change in the standard of review based upon procedural irregularities alone, and we see no reason to impose one.").

Neither the delay in Atkins receiving a final decision nor the use of an arbitrator rises to the level

of a flagrant violation or utter disregard of the Plan that might require a heightened standard of review. While there was a lengthy delay of more than two years between the filing of Atkins' 2008 appeal and the eventual final decision in 2011, Atkins was informed of the claim's status and he participated in the entire process, including testifying and introducing evidence at the arbitration proceeding. He also voluntarily dismissed the First Lawsuit in order to allow the arbitration process to proceed. Furthermore, the use of an arbitrator is fully compliant with the terms of the Plan itself, which expressly authorizes such a procedure. Section 8.3(b) of the Plan states:

> If the voting members of the Retirement Board are deadlocked with respect to a decision as to whether or to what extent any person is eligible for or entitled to benefits under this Plan, the Retirement Board may by an affirmative vote of three voting members submit such dispute for final and binding arbitration in accordance with the procedures and practices in use prior to the CBA.

Accordingly, the district court did not err by applying abuse of discretion review to the Retirement Board's 2011 benefits determination.

2. Consideration of Kasher's arbitration decision

Atkins argues that the district court erred by according deference to Kasher's arbitration decision

and instead should have reviewed his decision *de novo*. Specifically, Atkins claims that because "[t]he plan did not grant Mr. Kasher discretion to decide benefit claims," the district court should not have treated Kasher's decision with deference by applying an abuse of discretion standard. Rather, because Kasher was not named as a fiduciary of the Plan, Atkins argues his decision should have been reviewed *de novo*.

Atkins' argument is misguided because it attempts to construe the Retirement Board's appointment of Kasher in an overly narrow and mechanical way. Atkins focuses on the absence of explicit documentation from the Board's meetings that he claims was required to grant Kasher the discretion to decide benefit claims by being officially designated as a Plan fiduciary. He also takes issue with the absence of specific meeting minutes reflecting the Board's adoption of Kasher's decision. Without such explicit documentation, Atkins argues that the Retirement Board improperly delegated the benefits determination to a non-fiduciary, and he cites several cases for the proposition that when an ERISA plan allows a benefits decision to be made by a non-fiduciary, the court reviews the benefits decision *de novo*.

Atkins is correct to the extent that this circuit has stated that only decisions by Plan fiduciaries and administrators that have been given discretionary authority are accorded deference and reviewed under an abuse of discretion standard. If no discretionary authority is given, *de novo* review is proper. *Sweatman*

v. Commercial Union Ins. Co., 39 F.3d 594, 599-600 (5th Cir. 1994) (citing *Firestone Tire & Rubber Co.*, 489 U.S. at 115). However, this circuit has also held that as long as a company or plan maintains control of the ultimate decision on benefits, it can rely on experienced agents to assist in the determination and the decision will still be reviewed under an abuse of discretion standard. *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1014 (5th Cir. 1992).

The problem with Atkins' argument is that it ignores this subtlety in conjunction with the plain language of the Plan. The Board did not delegate the ultimate decision on benefits but instead used its discretion under the plan to utilize Kasher to break a deadlock, as established under the terms of the Plan and in compliance with ERISA. Section 8.3(b) of the Plan provides for the exact process the Retirement Board used in selecting Kasher to arbitrate Atkins' request for reclassification that resulted in a deadlocked Board. "If the voting members of the Retirement Board are deadlocked with respect to a decision as to whether . . . any person is eligible for . . . benefits under this Plan, the Retirement Board may . . . submit such dispute for final and binding arbitration. . . ."

This language complies both with the statutory requirements that an ERISA plan must designate an impartial process by which to resolve deadlock scenarios, and with precedent that affords deference to plan administration decisions, provided the benefit plan grants discretionary authority to determine

eligibility for benefits, including the use of an arbitrator to resolve deadlock scenarios. With respect to payments of benefits, the Taft-Hartley Act permits an ERISA plan with both employee and employer representatives to utilize an impartial third party to break a deadlock. "[U]pon and in the event the employer and employee groups deadlock on the administration of such fund and there are no neutral persons empowered to break such deadlock, such agreement provides that the two groups shall agree on an impartial umpire to decide such dispute. . . ." 29 U.S.C. § 186(c)(5)(B). Section 8.3(b) of the Plan explicitly provides for this scenario.

Similarly, the Supreme Court and this court have reinforced the propriety of plan administrators' utilization of a neutral arbitrator to break a deadlock without concerns over the mechanical procedures of formally designating the arbitrator as a fiduciary. "[I]n the adjustment of employee grievances against the employer . . . a trustee deadlock over eligibility matters, like any other deadlock, *must* be submitted to the compulsory resolution procedure established by § 302(c)(5) [of the Taft-Hartley Act]." *N.L.R.B. v. Amax Coal Co.*, 453 U.S. 322, 338 (1981) (emphasis added) (wherein § 302(c)(5) of the Taft-Hartley Act refers to 29 U.S.C. § 186(c)(5)). This court has reached the same conclusion, holding that when ERISA plan trustees are given the power to consider adjustments to the level of benefits for a plan's beneficiaries, and are also empowered to refer a deadlocked decision to arbitration, plan trustees are acting within their

powers when utilizing a neutral arbitrator. *Hauskins v. Stratton*, 721 F.2d 535, 537 (5th Cir. 1983). Therefore, despite Atkins' arguments to the contrary, the district court did not err in using abuse of discretion instead of a heightened standard of review when considering Kasher's decision.

3. Substantive review of the Retirement Board's 2006 and 2011 benefits determinations

Lastly, Atkins challenges the district court's decision affirming the Retirement Board's 2006 and 2011 benefits determinations on the merits under the abuse of discretion standard. With respect to the Retirement Board's 2006 benefits determination that he was only eligible for Inactive T&P disability benefits, he asserts there was "no evidence to support [the] conclusion" that his disability "was caused by psychiatric impairments that had no connection to his football career." He also argues that the Board's 2011 benefits determination was an abuse of discretion "due to the combination of insubstantial evidence and plan and procedural violations."

Given the deferential standard of review, Atkins' argument that the Board's 2006 benefits determination was an abuse of discretion is without merit. While Atkins claims the Retirement Board abused its discretion by "cherry picking" and "extracting" particular findings from the reports of doctors Boll and Kesler, these allegations view the assembled evidence too narrowly.

By the time the Retirement Board made its benefits determination in 2006, it had Atkins' application for benefits and the examination findings of five doctors: Kesler, Souryal, Williamson, Martin, and Boll. Viewing the doctors' opinions in the aggregate, there is no conclusive result regarding whether Atkins was or was not totally disabled, and if he was, whether his disability arose from football activities.

Two doctors appear to support Atkins' view of his disability, at least in part. Kesler reported that Atkins was totally disabled but his conclusions on the basis for total disability were mixed, noting that it could not be determined if his cognitive issues were football related while finding Atkins' chronic pain and possible neurologic defects were football related. Similar to Kesler, Martin found that Atkins was totally disabled from a combination of issues, noting that Atkins' physical impairments were the result of football but the source of his cognitive issues was unknown. Martin also suggested further neuropsychological testing to better understand the source of Atkins' impairments.

On the other hand, the other three doctors' opinions support the Plan's decision, at least in part. Souryal noted that Atkins suffered from neck and shoulder impairments but concluded that he was not totally disabled. Similarly, Williamson concluded that Atkins had neck and shoulder issues resulting from football but that he was not totally disabled. Finally, Boll reported that Atkins was totally disabled and that he suffered from pain as a result of football but

that his primary difficulties stemmed from psychiatric issues that were not the result of football.

Given this set of mixed medical opinions and a standard that requires us to uphold a plan's benefits determination absent an abuse of discretion, we must affirm the district court's judgment affirming the Retirement Board's decision to award Inactive benefits. While we are sympathetic to Atkins' plight, the Board's decision does not meet the standard for an abuse of discretion given the mixed collection of evidence that could have been construed to support an award of either Inactive *or* Football Degenerative benefits. The Board's decision was far from "arbitrary" under the standard set forth in *Holland v. International Paper Co. Retirement Plan*, which would mean that the Board made its decision "without a rational connection between the known facts and the decision or between the found facts and the evidence." 576 F.3d at 246. The mixed bag of medical opinions simply do not provide a clear answer as to whether Atkins' disabling injuries did or did not arise from football and therefore the Retirement Board's discretion cannot be termed an abuse of discretion.

The Retirement Board's 2011 decision to adopt the arbitration decision by Kasher also does not meet the abuse of discretion standard. Like the 2006 benefits determination, Kasher had a mixed set of doctors' reports before him when determining if Atkins could demonstrate changed circumstances by clear and convincing evidence in support of his request to be reclassified to Football Degenerative benefits. In

addition to the inconclusive doctors' reports from the 2006 determination, Kasher noted that Gilbert concluded that Atkins' impairments resulted from football but that he was not totally disabled. Gordon on the other hand concluded that while Atkins was totally disabled, two of the three bases upon which he found Atkins disabled were only "in part" the result of football. And finally, while Kasher acknowledged the Social Security Administration's finding of disability and Cantu's findings that Atkins was "probably beyond [post-concussion syndrome] into early traumatic encephalopathy," he also explained that these findings failed to meet the high bar of clear and convincing evidence for changed circumstances required for a benefits reclassification. Therefore, while Atkins' claim fell into the realm of "probability," the evidence was insufficient for granting Atkins' claim.

Like the 2006 benefits determination, Kasher's decision and the Retirement Board's adoption thereof in 2011 do not reach the level of arbitrary and capricious that is required for reversal under an abuse of discretion standard. While Atkins argues the 2011 decision was predicated on "insubstantial evidence," his claim is not supported by the record evidence and is without merit in light of the deferential standard of review that requires the court to affirm the Board's decision given "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Ellis*, 394 F.3d at 273.

CONCLUSION

We AFFIRM the district court's grant of summary judgment in favor of the Plan.

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS AUSTIN DIVISION

GENE ATKINS,
Plaintiff,

-vs-

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN, THE NFL SUPPLEMENTAL DISABILITY PLAN and the MANAGEMENT TRUSTEES OF THE NFL RETIREMENT PLAN,
Defendants.

Case No. A-10-CA-515-SS

ORDER

(Filed Nov. 10, 2011)

Before the Court are Plaintiff's Motion for Summary Judgment, filed September 12, 2011 [#57]; Defendants' Memorandum of Law in Support of Motion for Summary Judgment and Response to Plaintiff's Motion for Summary Judgment, filed October 17, 2011 [#59]; and Plaintiff's Response to Defendants' Motion for Summary Judgment, filed October 31, 2011 [#61]. Having considered the motions, responsive pleadings, the case file as a whole and the applicable law, the Court enters the following opinion and orders.

I. Background

Plaintiff Gene Atkins ("Atkins") brings this action against Defendants the Bert Bell/Pete Rozelle NFL Player Retirement Plan (the "Plan"), the NFL Supplemental Disability Plan and the Management Trustees of the NFL Retirement Plan. Atkins played in the National Football League ("NFL") beginning in 1987 until his retirement in 1996. He alleges he became disabled due to his years of playing professional football. Atkins eventually sought benefits from the Plan. A series of decisions, appeals and an arbitration followed. By way of this action, Atkins challenges the determinations made by Defendants concerning the benefits due him under the Plan.

Plaintiff and Defendants have now filed motions for summary judgment, responsive pleadings and the record of the administrative proceedings previously conducted (hereinafter designated "GA"). The matters are now ripe for determination.

II. STANDARD OF REVIEW

Summary judgment is appropriate under Rule 56(c) of the Federal Rules of Civil Procedure only "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with 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). A dispute is genuine only 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, 254, 106 S. Ct. 2505, 2513 (1986).

The party moving for summary judgment bears the initial burden of "informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrates the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett,* 477 U.S. 317, 323, 106 S. Ct. 2548, 2553 (1986). The burden then shifts to the nonmoving party to establish the existence of a genuine issue for trial. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.,* 475 U.S. 574, 585-87, 106 S. Ct. 1348, 1355-56 (1986); *Wise v. E.I. Dupont de Nemours & Co.*, 58 F.3d 193, 195 (5th Cir. 1995). The parties may satisfy their respective burdens by tendering depositions, affidavits, and other competent evidence. *Topalian v. Ehrman,* 954 F.2d 1125, 1131 (5th Cir. 1992).

The Court will view the summary judgment evidence in the light most favorable to the non-movant. *Rosado v. Deters,* 5 F.3d 110, 122 (1993). The nonmovant must respond to the motion by setting forth particular facts indicating that there is a genuine issue for trial. *Mississippi River Basin Alliance v. Westphal,* 230 F.3d 170, 174 (5th Cir. 2000). "After the non-movant has been given the opportunity to raise a genuine factual issue, if no reasonable juror could find for the non-movant, summary judgment will be granted." *Id.*

III. SUMMARY JUDGMENT EVIDENCE

The Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act ("ERISA") and the Labor Management Relations Act or "Taft-Hartley Act". The Plan provides monthly total and permanent disability benefits ("T&P") to eligible players. (GA 003061-65). Retired players may be eligible for benefits categorized as either "Football Degenerative" or "Inactive" benefits. In pertinent part, a player may qualify for "Football Degenerative" benefits if his disability "arises out of League football activities." A player may qualify for "Inactive" benefits if his disability "arises from other than League football activities." (GA 003061). A player's benefit category may be altered only on a showing of "changed circumstances" based on evidence found to be "clear and convincing." (GA 003064).

As required by statute, the Plan is jointly administered by employee and employer representatives. 29 U.S.C. § 186(c)(5)(B). Three representatives are appointed by the NFL Players Association ("NFLPA") and three by the NFL Management Committee ("NFLMC") (collectively the "Retirement Board"). (GA 003045, GA 003070).

Claims for T&P benefits are first reviewed by a two member Disability Initial Claims Committee ("DICC"). The DICC is composed of two members, one appointed by the NFLPA and one by the NFLMC.

(GA 003072). If the members of the DICC are deadlocked, the claim will be deemed denied. (GA 003073).

Decisions of the DICC are appealable to the Retirement Board. (GA 003072). The Plan grants the Retirement Board "full and absolute discretion, authority and power" to interpret the Plan and decide claims for benefits. (GA 003070). The Plan also provides that, in exercising its discretionary powers, the Retirement Board "will have the broadest discretion permissible under ERISA and any other applicable laws." (GA 003074). If the members of the Retirement Board are deadlocked, they may vote to submit the matter to a Medical Advisory Physician ("MAP") for a determination regarding medical issues. (GA 003071-72). In the event of a deadlock concerning eligibility or entitlement to benefits, the Retirement Board may vote to refer the dispute for final and binding arbitration. (GA 003072).

Atkins applied for T&P benefits by application received on December 17, 2004. In the application he describes three conditions he believed prevented him from working:

> Unable to lift right shoulder or move arm to functional positions cannot reach up or more than 90 degrees to either side. Had several dislocated shoulder injuries and eventually had a pin inserted to keep shoulder in place. The pin was removed in 1996 because of chronic pain in the area. I have trouble driving because it's difficult to turn the steering wheel . . .

> Chronic constant pain at the base of head and neck. Pain sometimes radiates through arms and my hands, feels like plastic. Everything I touch feels numb and I drop objects I try and pick up. Unbearable pain most days. I had several stingers while playing but did not feel any affects until I turned 38 years old . . .
>
> Mood swings – because of my inability to function without constant pain, my mood has been effected. Depression over the physical condition of my body and not being able to work.

(GA 000105). Atkins also submitted a cover letter with the application. In the letter he states in pertinent part:

> The base of my head at the back of my neck hurts constantly. I first thought the pain was from my shoulder, but now realize that it is radiating from my neck. Its get so bad that the pain goes down my arms and my hands become numb and feel like plastic when I touch objects. . . . Lying down is the only position that helps to lessen the pain at the base of my neck and gives me some relief from the pain. I was know for my hard hits, and suffered several dingers/stingers during my career that f believe is responsible for this condition.
>
> I suffer from depression, and probably have for several years, but was in denial. I have not sought any medical attention, because of

> my lack of insurance coverage. I have not been able to work, therefore I am not covered by any insurance.

(GA 000101).

Atkins was examined by a neutral psychiatrist, Keith Kesler ("Kesler"), and a neutral orthopedist, Tarek Souryal ("Souryal"). Kesler reported Atkins suffered from poor cognitive function, which he stated "cannot be determined" as to whether it resulted from football. Kesler also reported Atkins had chronic pain and headaches, as well as possible neurologic defects, all of which were the result of football. Kesler found Atkins totally disabled as a result of his impairments. (GA 000145-46). Souryal reported Atkins suffered from neck and shoulder impairments which were the result of football, but was not totally disabled as a result. (GA 000126-27).

The reports of Kesler and Souryal, as well as Atkins' completed application, were reviewed by the DICC on June 7, 2005. The claim was deemed denied because the members were deadlocked. (GA 000153-56). Atkins appealed the decision to the Retirement Board (GA 000159). The Retirement Board scheduled Atkins for examinations by two additional neutral physicians, orthopedist J Bryan Williamson ("Williamson") and neurologist Raymond Martin ("Martin"). (GA 000162-63).

Williamson concluded Atkins suffered from long term neck and right shoulder impairment due to injury resulting from football. However, Williamson

also concluded Atkins was not totally disabled. (GA 000164-65). Martin found Atkins was totally disabled due to a combination of problems. Martin concluded Atkins' physical impairments were a result of football, but his memory problems were of an unknown source. Martin suggested formal neuropsychological testing would have to be done to determine the etiology of Atkins' problems with intellect, memory and mental status. (GA 000179-85).

The Retirement Board considered Atkins' claim at a meeting held on October 20, 2005. The Retirement Board deadlocked and referred the matter to a MAP. (GA 000196-99). The Plan defines a MAP as a board-certified orthopedic physician or other physician designated by the NFLPA and NFLMC. (GA 003048, 003077). Nonetheless, Atkins was referred to Thomas Boll ("Boll"), a clinical neuropsychologist, for an examination. The referral states the MAP would evaluate the impaired body parts identified by Atkins, specifically "head ache, numbness, shoulders, neck hands." (GA 000212).

Boll concluded Atkins suffered from the impairments of illiteracy and borderline mental ability, not as the result of football. He further concluded Atkins suffered from depression, which could not be determined to be the result of football, and pain which was the result of football. Specifically, Boll stated "Atkins' difficulties appear to be primarily in the psychiatric arena and there is no evidence of a neurological disorder." (GA 000213, 000218). Boll found Atkins was totally disabled. (GA 000214).

The Retirement Board considered Atkins' appeal in a meeting conducted on February 9, 2006. The minutes of the meeting reflect a decision to approve T&P benefits. (GA 000222-24). In a letter dated February 23, 2006, the Plan director explained the award of T&P benefits was for psychiatric impairments which did not "arise out of League football activities." Atkins was informed his T&P benefits were thus not categorized as Football Degenerative. (GA 000229-30).

Atkins appealed by way of a letter dated March 3, 2006. In the letter Atkins stated he believed his disability resulted from football activities and requested reclassification. (GA 000242). On May 10, 2006, the Retirement Board tabled its consideration of Atkins' appeal to allow additional time for Atkins to be evaluated by a neutral physician. (GA 000272).

Atkins was examined by neurologist Robert W. Gilbert, Jr. ("Gilbert") on June 12, 2006. Gilbert found Atkins suffered from the impairments of right shoulder pain with limited motion, cervical spasm with neck and arm pain, and carpal tunnel. Gilbert concluded all of the impairments resulted from football, but also concluded Atkins was not totally disabled as a result of the impairments. (GA 000278-83).

The Retirement Board reviewed Atkins' appeal on July 19, 2006. The minutes of the meeting reflect the Retirement Board denied the request for reclassification to Football Degenerative T&P benefits. (GA

000291-94). A July 26, 2006 letter from the Plan director stated:

> By report dated June 12, 2006, Dr. Gilbert stated that you are not totally and permanently disabled by your head, neck and right arm conditions. The Retirement Board noted that Dr. Gilbert's report is consistent with earlier medical reports insofar as it states that your physical impairments are not, by themselves, totally and permanently disabling. The Retirement Board further found that Dr. Gilbert's report is consistent with its earlier conclusion that you are permanently and totally disabled by your psychiatric/psychological condition, which for the reasons described above, qualifies you for the Inactive category. In sum, the Retirement Board once again concluded that the Inactive category is the correct category for your T&P benefits based on the medical evidence in your file.
>
> You should regard this letter as a final decision on review within the meaning of Section 503 of the Employee Retirement Income Security Act . . . You have the right to bring an action under section 502(a) of the Employee Retirement Income Security Act.

(GA 000298). Atkins did not exercise his right to bring an action under section 502.

On August 23, 2007, Atkins submitted a letter in which he requested reconsideration of the denial of his request for Football Degenerative T&P benefits.

(GA 000376-78). The letter was treated as a request for reclassification of the category of his benefits from Inactive to Football Degenerative. (Ga 000379, 000384). On October 4, 2007, the DICC considered and denied the request. (GA 000389-95). An October 5, 2007 letter from the Plan director stated:

> After reviewing the available information, the Committee determined that you are totally and permanently disabled due to a psychiatric/psychological condition which precludes an award of Football Degenerative T&P disability benefits. The Committee also reviewed Plan section 5.6 regarding reclassification requests, and concluded that you have failed to present clear and convincing evidence that you qualify for Football Degenerative T&P benefits because of changed circumstances. Specifically, the Committee determined that the new evidence presented by Mr. Dahl relate to the same condition that was the basis for the original classification. Accordingly, the Committee denied your request for reclassification.

(GA 000394).

By letter dated February 11, 2008, Atkins requested an appeal of the October 2007 decision. (GA 000406-07). On April 30, 2008, the Retirement Board tabled its consideration of Atkins' appeal to allow additional time for Atkins to be evaluated by a neutral MAP. (GA 00041924).

Atkins was examined by neurologist James Gordon ("Gordon") on June 25, 2008. Gordon found Atkins suffered from the impairments of cognitive dysfunction, depression, plus chronic headaches and post-concussion headaches. Gordon concluded the third of Atkins' impairments resulted from football, but the first two impairments were only "in part" the result of football. Gordon also concluded Atkins was totally disabled as a result of the impairments. (GA 000436-37). Gordon explained his diagnostic impression:

> Mr. Atkins' overall picture includes elements of psychiatric dysfunction, cognitive dysfunction, and headache that most likely result from a combination of constitutional and environmental factors, none of which, alone, would explain his current condition. There is little doubt that recurrent head trauma of a concussive and sub-concussive type contributes to these disorders, though relative effect of head trauma is difficult to quantitate. The neuropsychological consequences of frequent sub-concussive brain injury (for example, professional soccer players who "head" the ball aggressively and frequently) are increasingly recognized in the medical and neurological literature. Mr. Atkins played high-level competitive football through high school and college, and he played professionally at a position, defensive back, that involves frequent high-speed, head-first impact with other, often bigger, players who are also moving at high speed. Numerous low-grade concussions

> have been documented by examiners, and over the course of a career there are undoubtedly more frequent, brief events that arc accepted without further notice as a natural consequence of hard "hitting." It is impossible to distinguish the precise extent to which head injury causes, rather than exacerbates, Mr. Atkins's headaches, cognitive and behavior problems, given preexisting neuropsychological limitations and psychiatric predispositions. What is clear, however, is that he suffers disabling chronic headache, depression and cognitive limitations, and that recurrent head trauma resulting from his role as an NFL defensive back contributed significantly to his current condition, even if that contribution cannot be reliably quantitated. In his current condition, he cannot be gainfully employed.

(GA 000441).

On August 29, 2008, prior to consideration by the Retirement Board of Atkins' pending appeal, Atkins filed suit in this Court against the Plan seeking benefits due him under ERISA, *Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Pan,* cause number A-08-CV-651 SS (the "First Lawsuit"). On November 11, 2008, the Retirement Board deadlocked on the classification issue raised by Atkins' appeal and referred the issue for final and binding arbitration pursuant to the Plan. (GA 000809-11). On April 29, 2010 the parties submitted a joint stipulation of dismissal

of the First Lawsuit in light of the pending arbitration.

On June 18, 2009 an arbitration hearing was conducted before Richard Kasher ("Kasher"). A variety of exhibits, including the deposition testimony of Drs. Cantu and Gordon, were introduced. In addition, Atkins and his then wife Patricia Atkins testified at the hearing. (GA 000819-1349). On August 17, 2009 another hearing was conducted. Boll testified and other exhibits were introduced. (GA 001359-595).

On April 12, 2010 Kasher issued his decision finding there was insufficient evidence to conclude Atkins had proven his level of benefits should be reclassified under the Plan. In a lengthy opinion Kasher reviewed the medical evidence and testimony presented during the hearings. In pertinent part, Kasher stated:

> There is no doubt that Claimant Atkins suffers from cognitive dysfunction, depression and that he experienced, at times, lack of impulse control. However, by his own testimony and that of Mrs. Atkins there is a question as to whether at the current time Claimant Atkins has an impulse control problem. One can better describe his current condition, not as lack of impulse control, but of his being in a state of languor.
>
> * * *
>
> It is also significant in this Arbitrator's opinion to observe that it has been generally agreed that Mr. Atkins, more than likely, suffers

from bipolar disorder, Dr. Cantu acknowledged that one who has bipolar disorder will suffer from depression and mood swings. Mr. Atkins manifests both of these conditions.

Additionally, Dr. Cantu acknowledged that mood swings will ordinarily involve "going from manic to very lethargic." It is clear from the testimony of Mr. Atkins and Patricia Atkins that lethargy is another one of Mr. Atkins' current conditions.

In this Arbitrator's opinion it is also significant to note that Dr. Cantu candidly testified that he was not able with "100% percent accuracy" to diagnose Mr. Atkins with CTE [chronic traumatic encephalopathy].. More importantly, Dr. Cantu testified that Mr. Atkins has "all three aspects of the triad" of CTE; and thus Dr. Cantu testified that he has a "high index of suspicion" that Claimant Atkins suffers from CTE. Again, Dr. Cantu testified candidly that he could not "say with . . . scientific certainty" that Mr. Atkins has CTE, and could only do so "when his brain is studied."

Dr. Cantu's opinion is qualified by his finding that Mr. Atkins' CTE is based upon a "more probably than not" diagnosis. Such an opinion, as well-founded as it is by Dr. Cantu, a highly-qualified and well-respected medical practitioner, does not, in this Arbitrator's opinion, meet the "clear and convincing" standard of proof required to sustain Mr. Atkins' claim.

Another of the pillars upon which the foundation of Mr. Atkins' claim lies is found in the Player Trustees' contention that Mr. Atkins was able, at the time he was playing, to memorize and follow the complicated defensive schemes in the Saints' extensive playbook.

* * *

However, one strong area of memory does not nullify the findings of Dr. Boll who, after an extensive psychoneurological examination, found that Gene Atkins had demonstrated many cognitive deficits over the course of his lifetime.

* * *

The findings of Doctors Cantu, DeVere and Gordon regarding Mr. Atkins' history of head trauma are, as the Owner Trustees have correctly pointed out, all premised upon the reports made by Mr. Atkins some nine to ten years after those alleged incidents. The incidents are not set in time and do not reference which teams the Saints were playing, nor is there any evidence that the incidents were reported to the Saints or the Dolphins trainers or Club physicians.

Therefore, the resolution of the issues in this case require the analysis of the two plausible medical opinions/diagnoses of Gene Atkins' cognitive dysfunction.

In this Arbitrator's opinion, neither the opinions of Doctors Cantu, Gordon and DeVere on

> the one hand and Dr. Boll on the other rise to the level of clear and convincing evidence. And, as noted above, this Arbitrator is bound by that standard of proof.
>
> Therefore, Mr. Atkins's claim falls into the realm of "probability", as both Doctors Cantu and Boll have implicitly acknowledged.
>
> It is "probable" that Gene Atkins experienced more than one concussion event/incident during his ten year career as a professional football player; and that one of those probable events/incidents, . . . may have resulted in some postconcussive symptoms, albeit they were not reported, recorded or treated.
>
> That being said, this Arbitrator finds insufficient evidence to conclude that Gene Atkins has proven that his level of benefits should be reclassified under the provisions of the Bert Bell/Pete Rozelle NFL Player Retirement Plan.
>
> Accordingly, this Arbitrator is compelled to deny Mr. Atkins' claim

(GA 004130-34).

The NFLPA trustees requested reconsideration of Kasher's decision. (GA 004135-42). On November 29, 2010 Kasher denied the request. In so doing, Kasher noted he had "fully considered the contradictory medical opinions and the evidence of Mr. Atkins' injuries and symptoms" and was not prepared to reopen the record. (GA 004206). At its February 23, 2011 meeting,

the Retirement Board adopted Kasher's decision. (GA 004207).

IV. ANALYSIS

Plaintiff brings this action seeking to overturn the benefits determination made by Defendants. ERISA permits a person denied benefits under an employee benefit plan to challenge that denial in federal court. *See* 29 U.S.C. § 1132(a)(1)(B) (beneficiary may bring suit to enforce rights under benefit plan); *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105, 108, 128 S. Ct. 2343, 2346 (2008) (person denied benefits may challenge denial in federal court). The Supreme Court has recognized review of the administrator's denial of benefits is *de novo,* unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115, 109 S. Ct. 948, 956-57 (1989). Where a plan governed by ERISA grants the administrator " 'discretionary authority with respect to the decision at issue," review of a denial of benefits is for abuse of discretion. *Corry v. Liberty Life Assurance Co.*, 499 F.3d 389, 397 (5th Cir. 2007); *Vercher v. Alexander & Alexander, Inc.*, 379 F.3d 222, 226 (5th Cir. 2004).

It is undisputed in this case that the terms of the Plan give the Retirement Board discretionary authority. Nonetheless, Plaintiff argues the Court should apply a *de novo* standard of review, rather than abuse of discretion. According to Plaintiff,

Defendants committed numerous significant breaches of the terms of the Plan in making his benefit determination. In sum, the alleged breaches are: (1) using of non-physician Boll as a MAP; (2) permitting Boll's evaluation to exceed the scope of the referral to him; (3) failing to follow the entire recommendation of Boll; (4) failing to timely decide Atkins' appeal in April 2008; (5) failing to properly consider the medical evidence in the November 2008 deciision; (6) referring the final decsion to an arbitrator; (7) refusing to follow the decision of MAP Gordon; (8) hiring Boll as an expert after his evaluation was relied upon by the DICC; (9) interpreting Atkins' request for reconsideration as a request for reclassification, resulting in the improper application of the clear and convincing evidence and changed circumstances standards; (10) failing to adequately review the decision of the arbitrator and the evidence underlying his decision; and (11) the lack of meeting minutes evidencing official adoption of the arbitrator's deicision. (Plf. Mot. 5-10). Plaintiff argues these breaches describe such a breach of trust law as to deprive Defendants of the normal deference granted them under ERISA.

The Supreme Court has recently reiterated the deferential standard to be granted ERISA plan administrators, rejecting the notion that the standard was "susceptible to ad hoc exceptions." *Conkright v. Frommert,* ___ U.S. ___, 130 S. Ct. 1640, 1646 (2010) (explaining plan's interpretation will not be disturbed if reasonable). The Supreme Court did imply deference might not be warranted on a finding that a plan

administrator "had acted in bad faith or would not fairly exercise his discretion to interpret the terms of the Plan." *Conkright,* ___ U.S. ___, 130 S. Ct. at 1648.

As Plaintiff acknowledges, the Fifth Circuit has already rejected the notion that delay by an ERISA administrator in making a determination alters the standard of review. *See S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993) (standard of review is no different whether claim is actually denied or deemed denied by failure to act before plan deadline). Plaintiff argues the decision in *Moore* is no longer good law because it was decided under a older regulatory scheme and because his claim was actually decided, not deemed denied, by the Retirement Board. However, as Defendants point out, Plaintiff has cited to no authority rejecting the continuing viability of the decision in *Moore*.

More to the point, the Fifth Circuit has addressed the propriety of altering the standard of review since its decision in *Moore*. The Fifth Circuit was asked to alter the standard of review in an ERISA action based on procedural irregularities in the underlying benefit determination in *Lafleur v. Louisiana Health Serv. & Indem. Co.*, 563 F.3d 148 (5th Cir. 2009). The court noted there was no binding precedent for altering the standard of review based on procedural violations of ERISA. *Lafleur,* 563 F.3d at 159 (noting prior decision in which plaintiff had "cited no direct authority by the Supreme Court or the Fifth Circuit dictating a change in the standard of review based upon procedural irregularities alone"

thus "see[ing] no reason to impose one"). The court did recognize the Ninth Circuit has held "[w]hen an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, [the court will] review de novo the administrator's decision to deny benefits." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th Cir. 2006). The *Lafleur* court found the procedural irregularities before it fell far short of flagrant. Thus it specifically declined to express an "opinion on whether flagrant procedural violations of ERISA can alter the standard of review" as the issue was not before it. *Lafleur,* 563 F.3d at 159. In so doing the court also noted "the paradigmatic example of flagrant procedural violations" was a case in which "defendants failed to comply with virtually every applicable mandate of ERISA" including "no summary plan description, no claims procedure, and no provision to inform participants in writing of anything." *Lafleur,* 563 F.3d at 159 n.24 (quoting *Blau v. Del Monte Corp.,* 748 F.2d 1348, 1353 (9th Cir. 1984)).

The Court declines to alter the standard of review based on the procedural shortcomings identified by Plaintiff for two reasons. First, Plaintiff has not cited any binding precedent allowing for an alteration of the standard of review on such a basis. Indeed, the Fifth Circuit has specifically declined to opine on the issue. Second, the irregularities cited by Plaintiff fall far shot of the flagrant violations noted by the *Lafleur* court. The voluminous record in this case does reflect

a lengthy process. However, it also reflects Plaintiff was informed of the status of his claim, afforded opportunities to present evidence and permitted to testify to the arbitrator.

Nor does the Court find compelling Plaintiff's contention that the use of an arbitrator was a sufficient violation of ERISA to alter the standard of review. ERISA mandates a plan must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). Plaintiff maintains use of an arbitrator violated this provision because the review was not undertaken by the "named fiduciary."

Plaintiff has already urged this Court to find Defendants' use of arbitration a violation of ERISA in his motion to designate the administrative record. Specifically, he argued the arbitration was an impermissible breach of the Plan's fiduciary duty. The Court first noted Atkins had by all appearances voluntarily participated in the arbitration. The Court then concluded the arbitration provision in the Plan specifically complied with the pertinent provisions of ERISA. Plaintiff has not presented compelling authority to reconsider that decision. Accordingly, he has failed to show the use of arbitration is a sufficient basis for altering the applicable standard of review from abuse of discretion. The Court will thus turn to the merits of Plaintiff's challenge to the benefits determination.

Under the abuse of discretion standard, "[i]f the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail." *Ellis v. Liberty Life Assurance Co.*, 394 F.3d 262, 273 (5th Cir. 2004). "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* "An arbitrary decision is one made without a rational connection between the known facts and the decision or between the found facts and the evidence." *Bellaire Gen'l Hosp. v. Blue Cross Blue Shield,* 97 F.3d 822, 828 (5th Cir. 1996).

Plaintiff first argues the initial 2006 determination that he was disabled due to psychiatric impairments, rather than physical pain, is flawed. Atkins contends the one common denominator among all of the examining experts is that he is impaired due to pain resulting from football. Plaintiff is correct that all of the expert testimony confirms he is physically impaired. Impairment is not however, the ultimate question of the T&P benefit determination. Rather, the question is whether the impairments are totally disabling. *See* GA 003061 (T&P benefits paid to player determined to be "totally and permanently disabled"). As of the 2006 determination, the Retirement Board had evidence from six separate experts, Souryal, Kesler, Williamson, Martin, Boll and Gilbert. Although each of them found Atkins suffered from pain or physical impairments, three of them concluded Atkins was not disabled. Accordingly, substantial

evidence was presented to the Retirement Board to support a finding that Atkins was not totally and permanently disabled as a result of his physical pain and impairments.

Plaintiff next argues the Retirement Board abused its discretion by failing to follow the opinion of Gordon. According to Atkins, the Retirement Board has always followed the decisions of physicians appointed as a MAP, until his case. As set forth above, Gordon was appointed by the Retirement Board during the reclassification process. Significantly, the standard to be applied under the Plan required Atkins to make a showing of clear and convincing evidence of changed circumstances.[1] Although Gordon did conclude Atkins was disabled as a result of "psychiatric dysfunction, cognitive dysfunction, and headache," Gordon was also clear that the contribution of "recurrent head trauma resulting from [Atkins'] role as an NFL defensive back . . . cannot be reliably quantitated." (GA 000441). The ultimate question facing the Retirement Board, that is whether Gordon found

[1] Plaintiff maintains the application of the clear and convincing standard was improperly applied by the Retirement Board and thus should not be considered by this Court. He asserts he did not ask for reclassification but simply reconsideration of the classification of his benefits. The flaw in Plaintiff's argument is clear. Under his view of the Plan, the clear and convincing standard would never be applied because players would simply perpetually ask for reconsideration under the more lenient standard. The label applied by a beneficiary should not determine the applicable standard of review.

clear and convincing evidence of changed circumstances, was not addressed in Gordon's opinion. Thus, the Court disagrees that the Retirement Board did not follow Gordon's opinion or otherwise abused its discretion in reviewing Gordon's opinion.

Plaintiff further maintains the Retirement Board erred in failing to give substantial weight and deference to the opinions of Cantu and Gordon and in giving substantial weight to the opinion of Boll. Atkins characterizes Cantu as "one of the preeminent authorities on head injuries in sports, especially football" and Gordon as "one of the most trusted of plan physicians." (Plf. Mot. at 30, 33). He contends Boll was not a licensed physician and thus his opinion could not be considered.

Atkins is correct that "[p]lan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence." *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 834, 123 S. Ct. 1965, 1972 (2003). However, it is also true that a "plan administrator abuses its discretion where the decision is not based on evidence, even if disputable, that clearly supports the basis for its denial." *Holland v. Int'l Paper Co. Retirement Plan,* 576 F.3d 240, 246 (5th Cir. 2009). The evidence provided by Cantu and Gordon was considered and addressed by the arbitrator Kasher. His opinion makes clear it was not simply arbitrarily rejected. Rather, Kasher specifically stated his reasons for failing to conclude the evidence presented was clear and convincing evidence that Atkins' impairments were the result of football. Plaintiff has

failed to show the weighing of the evidence in this case was an abuse of discretion. *See Anderson v. Cytec Indus., Inc.,* 619 F.3d 505, 511 (5th Cir. 2010) (administrator did not abuse discretion in denying benefits where underlying evidence was mixed); *McDonald v. Hartford Life Group Ins. Co.*, 361 F. App'x 599, 613-14 (5th Cir. 2010) (administrator had discretion to investigate claim and draw conclusions based on evidence presented); *Holland v. Int'l Paper Co. Retirement Plan,* 576 F.3d 240, 250 (5th Cir. 2009) (job of weighing conflicting evidence is job of ERISA plan administrator, administrator not legally obligated to weigh any specific opinion more than another). *See also West v. Unum Provident,* 275 F. App'x 292, 295 (5th Cir. 2008) (finding no error in consultation of variety of experts, including occupational therapist).

Plaintiff next maintains Defendants erred in deciding his claim contrary to that of the decision of the Social Security Administration issued December 27, 2007. An administrator's failure to acknowledge an agency determination in direct conflict with its own determination may be procedurally unreasonable. *Schexnayder v. Hartford Life & Acc. Ins. Co.*, 600 F.3d 465, 471 (5th Cir. 2010) (citing *Glenn,* 554 U.S. at 118, 128 S. Ct. at 2352). In pertinent part, the decision of the Social Security Administrative Law Judge states:

> The claimant has the following severe impairments: post concussion syndrome and frozen right shoulder. . . . {T}he claimant's ability to stand/walk/sit is unaffected, but he

> can only occasionally climb, balance, reach, finger, and feel. The claimant is unable to understand, remember, and carry out simple routine instructions on a sustained basis and respond appropriately to supervisors and co-workers in jobs that require independent decision making.

(GA 000403). The decision relies on the opinions of Cantu and DeVere as to Atkins' impairments. The judge concluded Atkins had been disabled beginning on January 1, 1998. (GA 000405).

Kasher's decision following the arbitration does note Atkins was determined to be disabled by the Social Security Administration, and that an express finding was made that he had not engaged in substantial gainful activity since January 1, 1998. (GA 004111, 004118). As set forth above, Kasher focused on whether the evidence presented to him met the clear and convincing standard necessary to reclassify Atkins' as entitled to Football Degenerative T&P benefits. In so doing, he carefully reviewed the opinions of Cantu and DeVere and explained his reasons for concluding they did not provide clear and convincing evidence of changed circumstances sufficient to reclassify Atkins' T&P disability benefits. (GA 004130-34).

The undersigned concludes Plaintiff has not established Kasher's decision was procedurally unreasonable. The decision does acknowledge the Social Security Administration decision to grant Atkins benefits. Further, Kasher addresses the evidence underlying

that decision. Moreover, it is not at all clear the decision of the Social Security Administration was in direct conflict with Kasher's decision. In fact, Atkins has been determined to be disabled by Defendants and is receiving benefits. The Social Security Administration's determination, uinlike Kasher's, was not subject to a clear and convincing stardard of proof. Plaintiff has not, therefore, shown an abuse of discretion on this basis.

Finally, Defendants have also moved for summary judgment as to Atkins' claim for equitable relief under section 502(a)(3) of ERISA. He asks the Court to strike various pieces of the administrative record and make a benefits decision in his favor or remand the action with specific directions to the Retirement Board for considering his claim.

Section 502(a)(3) of ERISA is intended as a "catch-all" provision. *Verity Corp. v. Howe*, 516 U.S. 489, 511, 116 S. Ct. 1065, 1077 (1996). However, a plan beneficiary cannot seek equitable relief under section 502(a)(3) if adequate relief is available for failure to pay benefits. The Fifth Circuit has made clear the right to bring suit for benefits provides an adequate remedy, barring a clam under section 502(a)(3). *See Musmeci v. Schwegmann Giant Super Markets, Inc.,* 332 F.3d 339, 349 n.5 (5th Cir. 2003) (because plaintiffs have remedy at law for denial of benefits they are foreclosed from equitable relief under section 502(a)(3)); *Tolson v. Avondale Indus., Inc.,* 141 F.3d 604, 610 (5th Cir. 1998) (agreeing plaintiff had adequate redress for disallowed claim through suit on

that basis, thus he had no claim for breach of fiduciary duty under section502(a)(3)). Accordingly, the undersigned concludes Plaintiff has not met his summary judgment burden and is entitled to no relief in this action.

In accordance with the foregoing:

IT IS ORDERED that Plaintiff's Motion for Summary Judgment [#57] is DENIED;

IT IS FURTHER ORDERED that Defendants' Memorandum of Law in Support of Motion for Summary Judgment [#59] is GRANTED;

SIGNED this the 10th day of November 2011.

/s/ Sam Sparks
SAM SPARKS
UNITED STATES
DISTRICT JUDGE