NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?

HEARING

BEFORE THE

SUBCOMMITTEE ON
COMMERCIAL AND ADMINISTRATIVE LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JUNE 26, 2007

Serial No. 110–88

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NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?

TUESDAY, JUNE 26, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMERCIAL
AND ADMINISTRATIVE LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:07 p.m., in Room 2141, Rayburn House Office Building, the Honorable Linda T. Sánchez (Chairwoman of the Subcommittee) presiding.

Present: Representatives Sánchez, Conyers, Johnson, Delahunt, Cohen, Cannon, Feeney and Franks.

Also Present: Representative Waters.

Staff Present: Eric Tamarkin, Counsel; Stewart Jeffries, Minority Counsel.

Ms. SÁNCHEZ. This hearing of the Committee on the Judiciary Subcommittee on Commercial and Administrative Law will now come to order.

I will recognize myself for a short statement.

Due to the numerous press accounts concerning the National Football League's treatment of its retired players and the injuries many former players have suffered, we are holding today's oversight hearing to provide Congress the opportunity to consider the complex process that must be navigated in order to obtain disability benefits.

Specifically, the hearing will explore whether the process can be improved or streamlined. Additionally, we will explore the various requirements of the Retirement Plan, including in certain circumstances, arbitration-determined benefits.

This hearing is also part of the Subcommittee's larger examination of the role and impact of arbitration as an alternative dispute resolution process. In the 109th Congress, Mr. Cannon chaired a Subcommittee hearing examining how sports agents representing NFL players can be decertified under the NFL's collective bargaining agreement and how a neutral arbitrator ultimately presides over a sports agent's appeal; and earlier this month we held a hearing on mandatory arbitration agreements in consumer contracts.

After announcing this hearing and subsequent research, it has become clear that the NFL disability and pension benefits plans

have sparked a significant amount of passionate critics. The various stories relayed by the retirees demonstrate concern not only with how the plan is structured but also about how it is administered.

The NFL is considered to be the most brutal major American professional sports league. Half of all players retire because of injury, 60 percent of players suffer concussion, at least one-fourth of players suffer multiple concussions, and nearly two-thirds suffer an injury serious enough to sideline them for at least half a football season.

To be sure, these retired football players not only choose this career but they actually dedicate themselves to training and competing for jobs in this elite sports league, knowing full well about the game's violent nature. I have heard from many former players who said they would still choose to play football, even knowing of the physical toll that the game took on them. However, only 284 former players out of nearly 10,000 currently receive long-term disability benefits. That translates to less than 3 percent of retired players, a very small number for any industry, much less one as physically demanding as professional football.

The fundamental question then becomes whether this disability process is fair for the retired employees of the NFL. The evidence suggests that the vast majority of former players needing benefits do not receive them. What is even more troubling is that through projects such as the NFL films, the NFL continues to profit off those very same players who are denied benefits. Essentially, is the NFL, a multibillion dollar organization, fairly treating the employees who helped build it?

I was heartened to learn last week that the NFL and the NFLPA have reportedly taken steps to make it easier for some disabled players to collect disability benefits. As initially reported, a retiree who has qualified for a Social Security disability benefit would automatically qualify to receive an NFL disability benefit as well. While I hope this eliminates some red tape in the process, I am reserving judgment as to whether retired players will actually benefit until I have had an opportunity to carefully review this change.

To help us learn more about this issue, we have several witnesses with us this afternoon. We are pleased to have Dennis Curran, Senior Vice President and General Counsel for the NFL Management Council; Douglas Ell, a principal at Groom Law Group and today's representative for the NFL Players Association; Martha Jo Wagner, a member of the Employee Benefits and Executive Compensation Group, Venable LLP law firm; Cyril Smith, partner at Zuckerman Spaeder and lawyer for the late former NFL player Mike Webster; Mike Ditka, television commentator and former NFL player and coach for the Chicago Bears; Harry Carson, former NFL player for the New York Giants; Curt Marsh, former NFL player for the Oakland Raiders; and Brent Boyd, former NFL player for the Minnesota Vikings.

Accordingly, I look forward to hearing today's testimony; and, at this time, I would now like to recognize my colleague Mr. Feeney, for the minority opening comments. Mr. Feeney.

Mr. FEENEY. Thank you, Madam Chairman; and I am grateful for this opportunity.

I am sitting in for the Ranking Member, Mr. Cannon, who would like me to read into the record Mr. Cannon's opening statement.

Today marks the second time in 6 months that the Subcommittee on Commercial and Administrative Law has met to hear complaints by current or former NFL players about their union representation, the NFL Players Association, or NFLPA. I say that not to take sides but only to note the frequency with which these concerns seem to arise.

Today's hearing is about the process former NFL players must undergo to receive disability compensation under the NFL's Bert Bell/Pete Rozelle Retirement Plan. Those former players have a number of complaints including that the NFLPA only represents the current players' interests, often at the expense of former players. They argue the disability payments to former employers are very low, particularly in a league that makes billions of dollars annually. They also contend that the disability application process is unnecessarily complicated and that it encourages doctor shopping by the NFL and NFLPA.

For their part, the NFL and NFLPA contend many of the procedural hoops and hurdles that the players are concerned about are required by the Employee Retirement Income Security Act of 1974, otherwise known as ERISA. Broadly speaking, ERISA and the regulations promulgated by the Department of Labor provide minimum due process requirements that employers are required to develop in establishing their plans.

ERISA is a highly complicated area of the law and one over which the House Judiciary does not have jurisdiction. I am pleased, however, that we do have an expert on ERISA here today to testify, Ms. Wagner. Ms. Wagner can speak to the NFL compliance with existing ERISA laws and regulations and also provide some context as to the other types of procedures, including the use of arbitration, that are permissible under ERISA, the use of disability plans, the use of arbitration that gives rise to the Committee's jurisdiction.

It seems that these former players' complaints have already begun to have some effect, as the NFL and NFLPA have recently announced they have a plan to help streamline the disability claims process. I look forward to hearing their testimony in this regard.

I am also pleased that the league has started to take steps to limit the kind of traumatic brain injuries that afflict former players such as Mr. Mike Webster and Mr. Brent Boyd. How the NFL and NFLPA choose to compensate past players for their injuries, however, is a different matter and one that we will hear a lot about today.

Finally, I want this hearing to obtain the facts in this situation. It is understandable that this issue can engender strong feelings on both sides of the argument, but it is not helpful for either side to say, as Mr. Upshaw reportedly did recently of a certain former player, that he was going to quote, break his damn neck, end of quotes.

With any luck, all parties can learn something from this hearing and move forward with a plan which is satisfactory to all involved and will help take care of the needs of all former players.

With that, I yield back the balance of my time.

Ms. SÁNCHEZ. I thank the gentleman for his statement.

I would now at this time like to recognize Mr. Conyers, the Vice Chair of this Subcommittee and the Chairman of the Committee on the Judiciary.

Chairman CONYERS. My congratulations to you, Chairwoman Sánchez, for holding this hearing in which we look at the compensation system for retired football players and raise the question, an uneven playing field?

Arbitration is supposed to give parties an alternative means of settling differences with the help of an impartial decision making at less burden and expenses than full-blown litigation, but, to work effectively, the process has to fairly protect everybody's rights. Last December, this Subcommittee examined issues concerning whether the arbitration procedures employed by the National Football League Players Association meets this standard. Today, we examine how the League's system compensates its retired players and further considers the potential impact of arbitration not being readily available in cases of disability claims.

Now, there are three disturbing concerns I would raise to all of our distinguished witnesses. First, the NFL's treatment of its retired players with respect to disability and pension benefits is problematic. As many of us know, the average football athlete is not a marquee player but plays in the league for less than 4 years and often retires because of injury. Upon retirement, he receives only $14,500 in pension benefits, less than half the amount received by an average retired Major League baseball player.

Of 10,000 retired NFL players, it is estimated that less than 300 receive long-term disability payments. Several recent well-publicized cases highlight the resulting problems.

For example, Pittsburgh Steelers center Mike Webster. The court recently awarded his estate more than $1.1 million in disability payments that the NFL's Retirement Plan administrators claimed he was not entitled to receive.

Or take Brian DeMarco, former offensive lineman for the Jacksonville Jaguars. According to the Denver Post, Mr. DeMarco's back was broken in 17 places and he retired due to severe health problems after the 1999 season. But he has never been able to get NFL disability benefits. His disabilities were so extensive that he can't hold a telephone to his ear. In the last 4 years, Mr. DeMarco and his family have been homeless on three occasions.

Then there is the problem of brain concussions suffered by NFL players, which have justifiably received significant recent attention just last week. Sporting News ran a cover story on this distressing problem. According to a leading neuropathologist, brain damage resulting from numerous concussions suffered by Philadelphia Eagles safety Andre Waters during his career led to his depression and suicide.

Former Chicago Bears linebacker Larry Morris suffers from severe dementia, largely as a result of concussions suffered while playing football. Mr. Morris is a former teammate of one of our witnesses today, Mr. Ditka.

Finally, I am concerned about the extent to which these issues are attributable to the administration of the NFL Retirement Plan, and I am troubled by the fact that arbitration is not readily avail-

able in cases of disability claims. The process for resolving disputes concerning player benefits and submission of disputes to a benefit arbitrator does not usually apply to retirement or disability benefits. Rather, the plan's Retirement Board hears appeals of its own decisions instead of submitting appeals to an arbitrator, and this practice has drawn significant criticism.

So this Subcommittee has recognized the importance of arbitration as an alternative dispute mechanism and has considered its use in other contexts as well, and the problem we are considering today may present an opportunity for expanded use of arbitration.

I welcome all of the witnesses, and I lift my hat in a salute to those players who have given their blood and sweat and tears to the National Football League, and I thank the Chairwoman for her indulgence.

Ms. SÁNCHEZ. I thank the gentleman for his statement.

Without objection other Members' opening statements will be included for the record.

[The prepared statement of Mr. Cohen follows:]

PREPARED STATEMENT OF THE HONORABLE STEVE COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Football is almost as hallowed a national pastime as baseball. Much of the sport's status and popularity is due to the athleticism and talent of professional football players, and the growth of professional football as a business can be attributed to their hard work. Sadly, evidence suggests that many older retired players—like some of our witnesses today—are not being adequately taken care of by the groups that they helped to grow, like the National Football League and its Players Association. Many of these retired players suffer from physical injuries that they sustained during the course of their professional football careers, yet the NFL's disability and retirement plans do no sufficiently support these retired players' needs. I look forward to hearing from our witnesses today to determine how we can improve the compensation system for retired players.

Mr. DELAHUNT. Madam Chair?

Ms. SÁNCHEZ. Yes, Mr. Delahunt.

Mr. DELAHUNT. I don't want to make an opening statement, but I note the presence of our colleague from California who serves on the full Committee, as you are aware, but is not a Member of the Subcommittee. I would ask for unanimous consent that she be allowed to participate in the Subcommittee hearing today and be given the privileges of a Subcommittee Member for the purposes of this hearing.

I would also note for the record that I note her distinguished spouse is here, and I am aware of the fact that he was a former player himself in the NFL.

Ms. SÁNCHEZ. Without objection, so ordered.

Mr. FEENEY. Madam Chairman, I object. As the Chairman has been advised——

Ms. SÁNCHEZ. The gentleman will state his objection.

Mr. FEENEY. The objection is that the rules of the full Committee provide that only Members of the Subcommittee can participate without unanimous consent. The position of the minority has been so far this year and on behalf of the Ranking Member of the full Committee, Mr. Smith, I am objecting today to the participation. This is certainly not, as the gentlelady, my friend from California, knows, anything personal. I know she has a keen interest in this.

But the truth of the matter is that we had a practice from the beginning of the year to objecting to the participation of any Member. Setting a precedent that would allow one Member of a Subcommittee to participate could lead to a situation where 10 other Members might also want to participate. That would not serve the Committee well.

And, again, this is a rule adopted by the full Committee, Republicans and Democrats; and we are simply asking that the rules be followed today. House rule——

Chairman CONYERS. Would my colleague yield to me?

Mr. FEENEY. I would be happy to yield.

Chairman CONYERS. Thank you, Mr. Feeney.

I just wanted to remind you that in most of the other Subcommittees in Judiciary, this is a routine courtesy that we extend to Members who have a deep concern and interest; and in the case of the gentlelady from California, Maxine Waters, her husband is a former professional football player. I mean, give me a break.

Mr. FEENEY. Well, Mr.——

Mr. DELAHUNT. Would the gentleman yield to me for a moment?

Mr. FEENEY. Not until I respond to my friend, the Chairman of the full Committee.

The truth of the matter is, as I stated earlier, I have been asked by the Ranking Member of the full Committee to enforce their objection of the rules today. I don't have any authority to undermine his request of me, because I promised him that I would do my job and uphold his understanding of the Committee rules.

In addition, I understand that, while I am not a Member of every Subcommittee, that the precedent may or may not be as you described it. In fact, every opportunity that we have needed to object to the participation of any Member—so this is not directed at anybody today—every opportunity the minority has.

Again, at the request of the Ranking Member, we have objectively asked that the rules be followed.

So, with that, I would ask that the Committee sustain my objection.

I would be happy to yield to my friend from Massachusetts.

Mr. DELAHUNT. I can assure the Ranking Member that—he alluded to the fact that maybe 10 other Members would show up to participate; and if that would be the case, I would register an objection myself. But I think for the reasons that I and the Ranking Member articulated, that as a matter of common courtesy, and given—I am sure presented with these facts to the Ranking Member of the full Committee, one can assume that he would extend that courtesy to Ms. Waters, and I would hope that you would——

Mr. FEENEY. Reclaiming my time to answer my good friend from Massachusetts. I would hope that there would be a possibility that if a specific Member in a unique situation had, knowing full well the Ranking Member of the full Committee, Mr. Smith, had objected repeatedly, that they would go make that request. Because I have been asked to enforce the Committee rules today. I don't have any authority—having committed to do that—to do anything else.

As the gentleman from Massachusetts knows, we don't play 11 on 11 here. The minority has very few things that can protect it,

and the rules are about it. So we are in the routine of enforcing the rules, this being one of them. And if the gentlelady in the future would like to go speak to the Ranking Member, I certainly would yield to the discretion of the Ranking Member.

Ms. SÁNCHEZ. The Chair is prepared to rule. The Member correctly states the House rule and the interpretation of the House rule by the House parliamentarians. I am going to sustain your objection. But I do, however, want to point out a few things that I think are noteworthy.

Mr. FEENEY. Before the Chairman goes, could I make one—what I have asked is that if the gentlelady from California would like to either propound questions in writing or make a statement that I would not object to that request because I know she does have a specific interest here. It is more the process of the Committee in the 5 minutes and the time constraints and the fact the minority can't be everywhere at once. We have had to play zone defense. So if somebody would make that motion, Madam Chairman, I would not object to that.

Ms. SÁNCHEZ. Do I have a motion from a Member of the Committee? Okay.

Then I would ask unanimous consent that the gentlelady from California, Ms. Waters, be allowed to participate in the form of a written statement and questions to the witnesses, although she will not be allowed to participate verbally in the proceedings today.

Before we move on, though, I do want to note for the record that I did receive prior consent from the Ranking Member of the Subcommittee to allow Ms. Waters to participate in the hearing today. She obviously has an interest in this issue, as her husband is a former NFL player. And no pun intended, but I think that the minority doesn't seem to be playing in a very sportsmanlike manner today. But the objection is a proper objection, and it is sustained.

We will allow, as I said, Ms. Waters—there was no objection to the unanimous consent request that she be allowed to participate in the form of written questions and written statement.

Without objection, the Chair will be authorized to declare a recess of the hearing; and I am now at this time pleased to introduce the witnesses for the first panel of today's hearing.

The first witness on our panel is Dennis Curran, Senior Vice President and General Counsel for the NFL Management Council, the bargaining representative of the 32 members of the NFL. Mr. Curran and his staff administer the various player benefit plans, including the NFL severance plan, annuity plan, retirement and disability plans and second career savings plan.

Prior to being appointed General Counsel, Mr. Curran—am I pronouncing that correctly?

Mr. CURRAN. Yes, you are.

Ms. SÁNCHEZ. Thank you—served as Labor Relations Counsel to NFL Management Council from 1980 to 1990, and he was Labor Relations Counsel to National and then Pan American Airways.

We thank you for your presence today.

Our second witness is Douglas Ell, a principal at Groom Law Group. Mr. Ell specializes in legislative tax fiduciary and collective bargaining issues arising from the design and management of employee benefit plans. Mr. Ell has also aided the NFL Players Asso-

ciation in improving player benefits in four collective bargaining agreements.

Our third witness is Martha Jo Wagner, a member of Venable LLP's Employee Benefits and Executive Compensation Group. Ms. Wagner focuses her practice on benefit and fiduciary claims resolution and litigation, process review and redesign and lawful plan compliance. Ms. Wagner currently serves as the management co-Chair of the ABA section of Labor and Employment Law Employee Benefits Committee.

We welcome you, Ms. Wagner.

Our final witness on our first panel is Cyril Smith. Mr. Smith is a partner in Zuckerman Spaeder LLP, specializing in complex civil, criminal cases and employment and labor litigation. Mr. Smith has handled a variety of plaintiffs' cases including the lawsuit of Mike Webster, former NFL player for the Pittsburgh Steelers and the Kansas City Chiefs, against the National Football League for disability payments.

I want to thank you all for your willingness to participate in today's hearing. Without objection, your written statements will be placed into the record in their entirety; and we would ask that you limit your oral remarks to 5 minutes.

You will note that on the table there we have a lighting system that starts with a green light. At 4 minutes, it turns yellow. That is your warning that you have a minute. Then it will turn red when the 5 minutes are up. If you should still be testifying by the time the red light comes on, please finish your last thought to wrap up your testimony so that all of the witnesses will have a chance to testify.

And I want to remind our witnesses that, although we are not requiring sworn testimony, the criminal penalties relating to false statements before Congress do apply to your comments today. So keep that in mind.

After each witness has presented his or her testimony, Subcommittee Members will be permitted to ask questions subject to the 5-minute limit.

So, with that, everybody understands the rules.

One more rule that I will impose is, when you begin your testimony, make sure that you turn your microphones on so that the proceedings can be recorded.

Mr. Curran, you are up first. Would you please proceed with your testimony.

TESTIMONY OF DENNIS CURRAN, NATIONAL FOOTBALL LEAGUE, NEW YORK, NY

Mr. CURRAN. Congresswoman Sánchez, Congressman Feeney and Members of the Committee, I appreciate the invitation to be here on behalf of the National Football League today.

My name is Dennis Curran, as was just mentioned. I have been with the League for 27 years. As a Senior Vice President, I have been in charge of negotiating player benefits for the League with the Players Association, beginning in 1982 and then in 1993, 1998, 2002 and 2006.

With me today is Valerie Cross, our Director of Player Benefits, who has been with the League 25 years. She is also very familiar

with the administration of our plans, and I hope between the two of us we will be able to answer any questions you might have.

If you take a look at how this is set up, all these retirement and disability benefits are sent through collective bargaining. The Management Council of the League sits down with the union, and in each of these years we negotiate these benefits, and we have continuously improved them.

They are set by, again, the bargaining parties. The trustees that administer the plans have no discretion to change those rules. They couldn't say that age 55 is the wrong year; let's make them wait until 60. They can't say that this disability criterion is wrong; let's ignore it. The trustees have to follow what collective bargaining gives them, and we think they do that very well.

The NFL is proud of its comprehensive post-career benefits, a lot of which you just mentioned, Madam Chairwoman, in your opening statement. From leaving football when you receive severance pay to age 55 when you receive your retirement, there is a variety of post-career benefits now available to our players.

If you look back at the collective bargaining history, what comes through again and again is that this union and this League continue to improve existing benefits and add benefits to the post-career funds. As an example, if you look at the Bert Bell Plan, which is the funding vehicle for retirement and disability benefits, in 1982, when I started, there was $88 million in there. Now there is $1.1 billion done through club contributions. We don't require player contributions to retirement or disabilities. Why has it gotten so big? Because we keep on taking on more and more.

Before, players that played before 1959 had no pension, and there was no legal obligation to give them a pension. But this union and this League brought them into the Retirement Plan and have continuously improved their benefits over time.

You look to see how the players qualify in the first place. Initially, you had to have 5 years in the League. This union and this League brought down the qualifications to 3 years. So those players who have 3- and 4-year careers are now covered for pension and for disability benefits.

We have continuously raised the amount of the retirement credits, most recently by 25 percent, for those people in the League before 1982 and by 10 percent thereafter. And although not in the Bert Bell Plan, it bears mention that we have established a dementia plan called the 88 Plan which gives benefits for medical conditions dealing with dementia both at home and in institutions.

Now all of the funding for these things, all the funding that goes into this plan comes from the NFL clubs. We put in $126 million for pensions and disabilities last year; and, over the next 6 years, we are going to put $700 million more into this plan in order to fund those benefits that we promised to give.

That $826 million is committed dollars. That is what it is going to take to fund these benefits over time, and we are happy to do that.

And it should be pointed out that, once the money is in the fund, it cannot revert to the League. The monies in these funds must go for the benefit of the participants. The money we put in again under no circumstances comes back to us. There is no motivation

for us not to give benefits or retirement because it never returns to us.

Nor is this fund static. Last year alone, $55 million in pension was given out and about $20 million in disabilities.

And if you look at the level of the disabilities themselves, they have been continuously improved. The active football has gone from $100,000 to $224,000; active nonfootball from $90,000 to $134,000; and football degenerative from $75,000 to $110,000.

Again, we fund all these benefits willingly, and we are happy to do it, and we think that that is a very generous overall system for our former players.

To talk briefly about the red tape that has been discussed, the alleged red tape in the application process, again, it is run by six trustees which are fiduciaries of the plan. None of them are current players. Three appointed by the NFL, three appointed by the Players Association. Their job is to see the money is spent, but it is spent correctly on players who are either eligible for retirement or eligible for disabilities.

The fiduciary duty that they exercise is a personal one. They have to determine a series of classifications to see if disabilities are appropriate. They have to look a lot of times at the medical to see whether a person is able to play or whether he gets the requisite level of percentage disability. They have to look at why that occurred; was it football related or not? They have to look to see what time the benefit is appropriate. All those things they do with a fiduciary responsibility.

I think you will hear today from everyone here that the time limits that are observed are well within ERISA, well within Federal laws. Now, from time to time, some cases do require more time. What happens is that the medical evidence isn't clear. Perhaps the causation isn't clear. And sometimes experts have to come in or more than one doctor.

So if you don't qualify at the initial level, we appeal to the Retirement Board. You will have another doctor by Federal law. So now we have two doctors, and if it is still vague or confusing or not clear, then we have what is a tiebreaker, a medical advisory physician who will be binding on the trustees as to the medical condition.

Unfortunately, when it gets——

Ms. SÁNCHEZ. Mr. Curran, your time has expired. It goes quite quickly. But if you could finish that last thought.

Mr. CURRAN. Can we improve? Yes. We are trying to look at ways of speeding up the process. We have adopted the Social Security T and P standards, and we are looking to form an alliance with many other funds, the Players Assistance Trust, the Dire Need Fund, and NFL Charities to get money to those players who don't qualify for total and permanent disabilities but have financial needs, either medical or nonmedical.

Ms. SÁNCHEZ. Thank you, Mr. Curran.

[The prepared statement of Mr. Curran follows:]

PREPARED STATEMENT OF DENNIS CURRAN

REMARKS OF DENNIS CURRAN
SENIOR VICE PRESIDENT, NATIONAL FOOTBALL LEAGUE
BEFORE THE SUBCOMMITTEE ON
COMMERCIAL AND ADMINISTRATIVE LAW OF THE
UNITED STATES CONGRESS HOUSE OF REPRESENTATIVES COMMITTEE ON THE JUDICIARY

June 26, 2007

Chairwoman Sanchez, Congressman Cannon and Members of the Committee:

Good afternoon. My name is Dennis Curran. I am a Senior Vice President of the National Football League, where I have been employed for the past 27 years. Since 1982 I have been the lead negotiator for the National Football League with respect to player benefits. In that capacity, I have supervised the development and implementation of a comprehensive range of player benefits which were negotiated over a series of Collective Bargaining Agreements. On behalf of Commissioner Goodell and the NFL, I am pleased to have the opportunity to discuss our efforts to provide benefits for our current and former players.

Without question, the NFL is proud of the wide variety of post-career benefits available to our players. Players with as little as three years' service are guaranteed benefits for the remainder of their lives. Looking across any industry, the quality and breadth of this commitment is virtually unmatched.

Additionally, our history shows that new benefits have been added and existing benefits have been improved on a routine basis. As examples, in 1982, when I first began attending meetings for the Bert Bell/Pete Rozelle Retirement Plan ("Retirement Plan"), the trust had approximately $88 million in funding – it now totals $1.1 billion. The Retirement Plan is the cornerstone of the League's benefit program for players, providing retirement, disability, and death benefits. Since 1993, the Retirement Plan has been supplemented by other plans that provide additional retirement and disability payments. In 1982, players who played before 1959 had no retirement benefits. They now receive benefits as participants in the Retirement Plan. In addition, the number of years that a player has to play in order to qualify for a retirement benefit has been reduced from five years to three years. Since 1982, the benefit for a player who became totally and permanently disabled because of a football injury within 15 years after he left football has increased from roughly $9,000 to $110,000 per year. In 2006 alone, the Clubs contributed $126 million to the Retirement Plan. Over the next six years, the Clubs' obligation will be in excess of $700 million. Last year, the plans distributed more than $55 million in pensions to former players, and approximately $20 million in disability payments.

Mr. Ell has furnished an informative and detailed description of our benefit plans, so I will not burden the Committee by repeating it, but a listing of some of the post-career benefits available to former players will illustrate the comprehensive structure created by the NFL and the NFLPA:

- Tuition Reimbursement (up to $15,000 per year through 3 years after leaving the NFL)
- Injury Protection (up to $275,000 for the season following a significant football injury)
- Severance Pay (a payment of $12,500 per year of service after leaving the NFL)
- Continuing Family Health Insurance (for five years after retirement)
- Health Reimbursement Account (up to $300,000 for use after insurance coverage ends)
- Player Annuity Plan (contributions of $65,000 per year of service payable at age 35)
- Second Career Savings Plan (a 401(k) plan with a 2:1 NFL match payable at age 45)
- Pension (a defined benefit based on years of service, not salary, payable at age 55)
- "88" Plan (up to $88,000 per year for former players with dementia)
- Disability

--Active Football (Total & Permanent)	$224,000/yr.
--Active Nonfootball (Total & Permanent)	$134,000/yr.
--Football Degenerative (Total & Permanent)	$110,000/yr.
--Inactive (Total & Permanent)	$21,000/yr. minimum
--Line of Duty (Partial)	$18,000/yr. minimum

As you can see, many of these benefits are available to a player, either as a result of leaving football or upon reaching a specified age. Others, however, require an application process sufficient to demonstrate eligibility, as required by law, in order to protect the plan's assets for all participants. With respect to this latter group, some have recently expressed concerns regarding the amount of "red tape" in the disability benefit process. In order to provide the Committee with a clear picture, it is important that such misconceptions be addressed.

Retirement Plan distributions are overseen by six voting members of the Retirement Board, none of whom are current players. The Retirement Board must apply the standards set through collective bargaining and ensure that eligible players receive pension; that qualified players receive disability benefits, and that nonqualified players do not. As fiduciaries, the trustees are obligated to review each application carefully with respect to medical and other information. In accordance with Department of Labor regulations, the initial determination must be made within 45 days of receiving the completed application. If there is an adverse determination, the player then has 6 months to file an appeal to the Retirement Board. On occasion, the Retirement Board may enlist the expertise of one of the Medical Advisory Physicians to review the application and issue a binding medical opinion.

While this process may seem lengthy at times, the review period is absolutely necessary to ensure that the Retirement Plan follows all applicable federal rules and regulations for processing applications and that only those persons who qualify for the benefits receive them. Nevertheless, the length of the process does not result in a loss of any benefits to which the player is entitled. Regardless of when the process is completed, benefits can commence up to 42 months prior to the date the application is received by the Retirement Plan, depending on when the qualifying disability has arisen.

Understanding the necessity of the process, the NFL and the NFLPA all the same continue to search for ways to streamline the application process. For example, we have recently agreed that former players who have qualified for a disability under the Social

Security system will have that determination adopted by the Plan without requiring a new medical review. We will also look to adopt other relevant provisions of the Social Security qualification system that may clarify medical determinations or speed up the process without compromising eligibility or violating Department of Labor regulations. Rest assured, our paramount interest is to ensure that every application, in the fastest manner possible, receives the needed review for a correct decision.

As a final point, it is important to emphasize that the NFL and the NFLPA have not limited their efforts to assist players in need solely to the benefits negotiated through collective bargaining. On the contrary, we have created a number of other resources to aid players who do not fall in to a negotiated disability category or whose needs are not medical in nature. The Players Assistance Trust, the Dire Need Fund, NFL Charities and the Pro Football Hall of Fame Enshrinees Assistance Foundation have helped countless players with a variety of financial needs. To improve coordination of these efforts, we have formed an alliance of these funds to both coordinate distribution and to explore coverage for medical procedures needed by former players not currently receiving medical care. We firmly believe that this alliance will enable us to provide assistance to more players more efficiently.

Thank you again for providing the NFL with the opportunity to address the Committee and I am happy to take any questions you may have.

Ms. SÁNCHEZ. Mr. Ell, your time begins now.

TESTIMONY OF DOUGLAS W. ELL, PLAN COUNSEL TO THE BERT BELL/PETE ROZELLE NFL PLAYERS RETIREMENT PLAN, WASHINGTON, DC

Mr. ELL. Good afternoon. My name is Douglas Ell. I am with the Groom Law Group, and I have the privilege of serving as Plan Counsel to the Bert Bell/Pete Rozelle NFL Player Retirement Plan. I am here today on behalf of the NFL Players Association. We appreciate the opportunity to appear and provide testimony.

I am also pleased to have here with me today Michele Yaras-Davis, head of the Benefits Department of the NFLPA, who has helped players get benefits for many years.

I also wish to acknowledge the presence here today of David Duerson. Mr. Duerson serves as one of the six voting members of our Retirement Board. Mr. Duerson played 11 seasons in the NFL; four of those years he was all pro. He has two Super Bowl rings. Mr. Duerson is a successful businessman and has a Masters from the Harvard Business School.

Madam Chairwoman and Members of this Committee: Unfortunately, much of what has been said or written about the benefits available to NFL players is either wrong or misleading. I have described the benefits in some detail in my written statement, which also contains a variety of data. I hope we will answer many of your questions.

In my brief time here now I would like to just go over some brief points.

First, benefits from NFL players come from collective bargaining. Together, the Players Association and the NFL decide on the formula for benefits and the eligibility requirements and benefit levels for disability benefits. The collective bargaining agreement allocates a percentage of revenues for players' salaries and benefits, and all of the player benefits come out of that piece of the pie.

But the parties do not run the plans themselves. Claims are decided by the fiduciaries of the benefit plans. In other words, when someone says that the NFL refused to pay disability benefits or that the Players Association rejected a disability claim, you know immediately that statement is not accurate. Perhaps that person does not know that the plans exist.

Let me just offer a few comments on retirement benefits.

Players receive a monthly pension based on the years that they play, not on how much they earn. If they are paid for three or more games in a season, they earn a credited season; and if they have three or more credited seasons, they are vested and entitled to a pension. I understand there are 2,387 retirees currently who get an average of $1,536 a month, or $18,440 a year.

Since 1993, the Players Association has fought for and achieved benefit improvements in bargaining. In 1993, the Retirement Plan was expanded to include the League's founding members, the Pre-59ers, over 700 strong, who were not previously in the plan.

Pensions were increased in 1993, 1998, 2002, and 2006. In each case, the older players got the largest increase. These increases are unprecedented.

In 2002, when the pensions of the older players were doubled, the head of the Pension Rights Center noted that "nobody has reached back and given a pension raise to retired workers of anything approaching this magnitude."

It is true that a number of former players receive small pensions; and when you look at the individual cases, I think you will find that it is often because of the voluntary choices they made. Many started at age 45, many elected to take the lion's share of their pension prior to age 62, and some have had all or a portion of their benefits assigned to their ex-spouse in divorce.

Please let me turn now to disability benefits. We believe these are the most generous disability benefits in professional sports, perhaps in the entire business world. Vested players can get total and permanent disability benefits if they are unable to work for any reason at any time, even decades after their career ends. Benefits can be as large as $224,000 a year for life.

I will let Ms. Wagner describe ERISA's rules for processing and claims.

We have 317 players on disability. I would like to emphasize that Mr. Duerson and his fellow fiduciaries are required by Federal law to follow the terms of the plan. They get to interpret the rules. They don't get to make them up.

I am amazed by some of the things written about our disability benefits. The collective bargaining process is an ongoing process, and the parties are looking for ways to improve benefits in the system. Our new 88 Plan for players with dementia is one example. Of over 45 decided cases so far, more than 90 percent of the players have received the benefit.

Allowing Social Security determinations as a separate, alternate way to get total and permanent disability benefits is a second improvement.

I would like to conclude with three points.

First, all injured players are strongly advised to file claims for workers compensation. The Players Association has a panel of lawyers to help them.

Ms. SÁNCHEZ. The time of the gentleman has expired. If you could just wrap up the final thought.

Mr. ELL. My final thought is that there are many players and beneficiaries who are grateful for what has been done here; and in that regard I would like to note the presence today of Stan White, Brig Owens, Doc Walker, Jean Fugett, Andre Collins and Ray Schoenke.

Thank you. I will be pleased to answer questions.

Ms. SÁNCHEZ. Thank you.

[The prepared statement of Mr. Ell follows:]

PREPARED STATEMENT OF DOUGLAS W. ELL

TESTIMONY OF
DOUGLAS W. ELL
PLAN COUNSEL FOR
BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
On Behalf of
NFL PLAYERS ASSOCIATION

BEFORE

SUBCOMMITTEE ON COMMERCIAL AND
ADMINISTRATIVE LAW
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

"The National Football League's System for Compensating Retired Players: An Uneven Playing Field?"

ON

June 26, 2007

Chairwoman Sanchez and Members of the Subcommittee:

Good afternoon. My name is Douglas Ell. I am with the Groom Law Group, and serve as Plan Counsel to the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Retirement Plan"). I have served in that position since 1994. I have been asked by the National Football League Players Association ("Players Association," or "NFLPA") to appear and testify in response to the Subcommittee's invitation to Gene Upshaw, Executive Director of the Players Association, who is out of the country and unable to attend today's hearing. The Players Association and I thank you for this opportunity to testify and provide information.

I'm very pleased to have with me Michele Yaras-Davis, who, as head of the Benefits Department of the NFLPA, has helped players get benefits for many years. I also wish to acknowledge the presence here today of David Duerson. Mr. Duerson serves, without pay, as a member of the Retirement Board, the named fiduciary of the Retirement Plan. He played 11 seasons for the Chicago Bears, New York Giants, and Arizona Cardinals, was All-Pro four years and won two Super Bowl rings. Mr. Duerson is a successful businessman and has a Master's from the Harvard Business School.

Unfortunately, a great deal of what has been said or written about the benefits available to NFL players has been wrong or misleading. I'll do my best to briefly describe the plans that provide retirement, medical, and disability benefits; the general structure of those benefits; and the process required by federal law for deciding claims for benefits. I'll also do my best to describe some of the complex federal laws that apply. As you will see, Mr. Duerson and his fellow Board members must comply with federal laws that require them to follow the terms of the Plan.

Player Benefits Come From Collective Bargaining

The collective bargaining agreement ("CBA") between the Players Association and the NFL provides retirement, medical, and disability benefits to former players. The CBA allocates a percentage of the League's revenues for player salaries and player benefits, and so the costs of benefits to former players come off the active players' side of the table. In other words, all of the CBA benefits, including the cost of benefits for players no longer active, reduce the amount available for salaries of active players.

In the year April 2006 to March 2007 the active players gave up approximately:

$96.5 million to fund retirement benefits for former players;

$31 million to fund health benefits for former players; and

$20 million to fund disability benefits for former players.

This total, about $147.5 million, adds up to about $82,000 from each of the NFL's roughly 1800 full-time active players.

During collective bargaining, the Players Association and the NFL agree on the benefits to be provided – such as the formula for retirement benefits and the eligibility requirements and benefit levels for disability benefits. What many people don't appreciate, however, is that the actual decisions on benefits and the payments of benefits are made by separate legal entities. The Players Association and the NFL do not decide claims. Claims are decided by the fiduciaries of the benefit plans established by the CBA. In other words – and this is very important – when someone says that the NFL refused to pay disability benefits, or when someone writes that the Players Association rejected a disability claim, you know immediately that statement is not accurate – or perhaps that person does not know that the plans exist.

Federal law does not require employers or unions to provide retirement, medical, or disability benefits. Nevertheless, the Players Association and the NFL have agreed to maintain the following benefit plans:

Retirement Benefits	Health Benefits	Disability Benefits[1]
Retirement Plan (also provides disability benefits);	NFL Players Group Insurance Plan;	Retirement Plan; and
NFL Player Second Career Savings Plan; and	NFL Player Health Reimbursement Account Plan; and	NFL Player Supplemental Disability Plan
NFL Player Annuity Program	88 Plan	

Further Information About the NFL Player Plans

Following is a summary of the key features of the NFL Player Plans listed above. We understand the Subcommittee is most interested in retirement and disability benefits, and we have provided greater detail in those areas. We believe that, in many respects, these benefits are the most generous in professional sports.

Retirement Plan

For the first six decades of organized football, and for almost 40 years after the NFL was established, there was no pension plan for NFL players. The players began efforts to organize a union as early as 1956. In 1962 the Players Association obtained its first pension agreement. This 1962 agreement established the Bert Bell NFL Player Retirement Plan – named after the NFL's second commissioner. This Plan reached back

[1] Injured players are also encouraged to file claims under Workers Compensation.

only to 1959; players who left the game before 1959 (sometimes called "Pre-59er's") received no pension.

The 1970 CBA revised this Plan and created its present structure. Players receive a monthly pension based on the years that they play, not on how much they earn. In general, a player earns a "Credited Season" if he is paid for three or more games in a football season. For each Credited Season he earns a "Benefit Credit." His monthly pension at age 55 is the sum of those Benefit Credits. At retirement, pension benefits are paid to him as long as he lives – in technical terms this is called a "single life annuity." He can elect other forms of payment, such as a joint and survivor annuity where payments will continue to a surviving spouse. These choices will result in his pension being adjusted according to actuarial tables – so that it has the same "present value." For example, if he starts his pension before age 55 the monthly benefit is reduced, and if he starts his pension after age 55 it is increased. Originally, a player needed a minimum of 5 Credited Seasons to be "vested" and thus entitled to a pension.

Under the 1970 CBA, players earned a Benefit Credit of $60 for each of their Credited Seasons from 1959 to 1965, and higher Benefit Credits in later years. At the $60 rate, a 10-year player would earn a pension of $600 a month beginning at age 55.

Even though age 55 was the "normal retirement age," many former players asked for the ability to receive their pension sooner. This was made possible in two ways. First, the 1970 Plan allowed players to receive a reduced pension as early as age 45. Many players did this, but the actuarial reduction for starting 10 years early was painful: a player who had earned an age 55 monthly pension of $600 received only 45% of that,

or about $271 a month, when he chose to start payments at age 45. Second, the Plan offered a "social security adjustment option." This option let players elect to receive the lion's share of their pension before age 62 (when social security would become available), and a token benefit of $50 a month thereafter. For example, instead of receiving $271 a month for life beginning at age 45, a player could use this social security adjustment option to receive about $384 a month from age 45 up to age 62, and only $50 a month thereafter.

The 1977 CBA reduced vesting from five years to four, so that players with only four Credited Seasons would receive a pension. Also, and again at the request of certain players, it added a third way for players to get their money earlier. It allowed them to get a lump sum "early payment benefit," or "EPB," equal to 25% of their pension, one year after leaving the NFL. This was desired by some because at that time there was no severance plan. However, for the many players who elected this "EPB," all later pension payments were smaller by 25%.

These three ways to get pension money early, and the choices made by many players,[2] are the primary reason why some older players are complaining about their pension. For example, take a player who earned 10 Credited Seasons from 1959 to 1968. His pension was originally $625 a month[3] beginning at age 55 (if taken as a single life

[2] Some players have also had a significant portion of their pension assigned to their ex-wife or ex-wives in divorce proceedings.

[3] He earned $60 Benefit Credits from 1959 to 1965, $65 Benefit Credits for 1966 and 1967, and a $75 Benefit Credit for 1968.

annuity). However, if he elected to begin receiving his pension at age 45, his monthly benefit went down to $282.50. Even worse, if he also elected the social security adjustment option, he would begin with a higher initial pension, but this would go down to a token payment of $50 a month when he reached age 62.

The 1982 CBA expired in 1987. For 1987 and 1988, the owners agreed to allow continued Benefit Credits at the rate of $150 a Credited Season. But beginning in 1989 they created their own plan, which they called the "Pete Rozelle NFL Player Retirement Plan," after the NFL's third commissioner. This Plan was similar to the Bert Bell NFL Player Retirement Plan, except that it was run totally by the owners and had no player trustees.

This was a significant change from how the original Bert Bell NFL Player Retirement Plan was managed at that time, where the union had the right to appoint three of the Plan's six voting trustees. This original plan continued to pay benefits.

The 1993 CBA may be the most important CBA for player benefits. It began the pattern, which has continued every extension since, of reaching back and improving the pension benefits of former players. For example, the $60 Benefit Credits of 1959 – 1966 became $80, and the $150 Benefit Credits of 1983 - 1992 became $210. The 1993 CBA expanded coverage to include the League's founding players – the "Pre-59er's" – with the same $80 Benefit Credits that the 1993 CBA gave for 1959 to 1966. This extended coverage to over 700 former players who were not in the Retirement Plan until that time. Vesting was reduced; so that going forward a player needed only three Credited Seasons

to receive a pension. The two pension plans were merged together to create the present Retirement Plan after the 1993 CBA was signed.

The 1993 CBA also protected new players from what critics are calling misguided elections. Players who came into the League in that year or later are not allowed to elect a 25% EPB; they are not allowed to start their pension before age 55, and they are not allowed to elect the social security adjustment option. However, because of "anti-cutback" rules in federal law, the Retirement Plan is required to offer these choices to players who earned a Credited Season before 1993. Even today, some veterans who still have a choice elect the social security adjustment option so that they can receive the lion's share of their pension before age 62; even though they are warned, and acknowledge in writing, that they will only receive a token pension after that time.

The 1993 CBA was extended in 1998, 2002, and 2006. Each time the bargaining parties followed the 1993 model of reaching back to improve benefits for players no longer active. For example, the 1998 extension raised the lowest Benefit Credits from $80 to $100, the 2002 extension doubled them to $200,[4] and the 2006 extension raised them to $250. **This has allowed many former players to receive a pension in excess of their highest salary as a player.** A player with 10 Credited Seasons from 1959 to 1968, who started with a monthly benefit beginning at age 55 of $625, now has a monthly

[4] The head of the Pension Right Center, a Washington D.C. association that works to improve pensions, has been quoted as saying, "[N]obody has reached back and given a pension raise to retired workers of anything approaching this magnitude."

pension of $2,500. The chart in Attachment 1 illustrates the history of Benefit Credits and these dramatic increases.

In 1993, 1998, 2002, and 2006 the active players were not required to forego salary so that the pensions of former players could be increased, but they did. The motto of the Players Association is "Past, Present, and Future." The following table shows the strong and repeated commitment of the active players to honor their predecessors and to help those who came before:

Year	Total Pension Liabilities Added[5]	Liabilities Added Just for Former Players
1993	$153.8 million	(unknown)
1998	$50.2 million	$45.4 million
2002	$125.6 million	$124.9 million
2006	$233.5 million	$214.5 million

In general, each time benefits have been increased, the checks of players already receiving benefits were increased by the same proportion as their total Benefit Credits were increased. For example, in 2002 when the oldest Benefit Credits were doubled from $100 to $200, the pensions of players for those seasons were exactly doubled. However, despite the repeated and enormous increases in Benefit Credits, some retired players, particularly those who voluntarily elected the "social security adjustment option," have complained. Because they elected to receive the lion's share of their pension as fast as

[5] These numbers are actuarial estimates.

possible, there is not as much now to increase. Their token $50 pension may now be about $200 a month. However, if they had elected a single life annuity beginning at age 55, in most cases their pension would now be thousands of dollars each month.

Because of the repeated increases in benefits and thus liabilities, the Retirement Plan is somewhat under funded from an actuarial point of view. Both the Players Association and the NFL view pension funding as a priority, and full funding may occur in the next few years, at least until the next negotiated benefit increase. Even without further benefits increases, a 10-year player starting today will earn a pension of $4,700 a month, or over $56,000 a year, when he reaches age 55. If he waits until age 65 – a typical corporate retirement age – to begin benefits, his yearly pension will be over $147,000. This dwarfs what he could have earned under plans of major corporations across the county for those 10 years. Of course, those players who go on to other careers may earn additional retirement benefits from those careers.

The NFL Player Retirement Plan is often contrasted with Major League Baseball's pension plan. For players who left the game some time ago, MLB's plan is somewhat richer. Baseball started earlier, thanks to the efforts of Curt Flood and others, and has historically had the better pension plan. The challenge since 1993 for NFL players has been the difficulty of playing catch up. Just as saving for retirement is much harder for people who fail to save in early years, pension funding is much harder when you get a late start. Many of the players who now complain about their pension did not view pension benefits as a priority when they were playing, and did not agree to make sacrifices in bargaining to improve either their pensions or the pensions of those who

came before them. Again, prior to 1993 there was no pension for Pre-59ers, and benefits once earned had never been increased.

The assets of the Retirement Plan are held in trust. None of its assets may ever revert to or be used by the League, the NFL Clubs, or the Players Association.

Medical and Dental Benefits

Under the CBA, active NFL players and their families receive comprehensive group medical and dental benefits. If a player has three or more Credited Seasons and is thus "vested," he receives five years of post-career coverage after he leaves the game, at no cost to him or his family. In a recent 12 month period, this post-career coverage cost the active players $11.5 million.

The 2006 CBA created a new plan – the NFL Player Health Reimbursement Account Plan -- that provides additional medical benefits to former players after the five free years of coverage end. Eligible players are credited with accounts that can be used to pay medical costs (including insurance premiums) for them, their spouses, and their dependents, for as long as they or their eligible beneficiary is alive.

The 2006 CBA also created a new medical benefit for players with dementia. This plan is called the "88 Plan," in honor of former Baltimore Colts player and Hall of Fame member John Mackey, whose jersey number was 88. As far as we know, this is the first plan in the country that provides special benefits for employees who are afflicted with dementia, even when that dementia occurs decades after their employment has ceased. In May of this year, NFLPA Executive Director Gene Upshaw and Harold Henderson of the

NFL Management Council were honored by the Alzheimers Association in New York for this achievement.

Disability Benefits

Together, the Players Association and the NFL have created the most generous disability benefits in professional sports, and possibly in the entire business world. Since 1993 – when the current structure was put in place – about $138 million has been paid to disabled players.

The Retirement Plan awards both "total and permanent," or "T&P," disability benefits and partial disability benefits. Total and Permanent disability benefits are paid to eligible players who are substantially unable to work, and for whom this condition is expected to last at least 12 months. There are four categories of T&P benefits:

> Active Football -- $224,000 a year if a player becomes totally and permanently disabled due to NFL football shortly after he stops playing.
>
> Active Nonfootball -- $134,000 a year if a player becomes totally and permanently disabled from any other cause shortly after he stops playing.
>
> Football Degenerative -- $110,000 a year if a player becomes totally and permanently disabled due to NFL football within 15 years after he stops playing.
>
> Inactive – $18,000 a year ($21,000 for new applications), or, if higher, the pension the player would receive at age 55, if he becomes totally and permanently disabled and does not qualify for one of the other categories.

T&P benefits in the last two categories above are paid only to "vested" players.

What may be most unusual is that these benefits are paid even where inability to work occurs many years after a football career has ended, and even where NFL football

did not cause the inability to work. Someone who once worked for IBM or General Motors does not expect to get – and does not get – disability benefits if he or she becomes unable to work many years after leaving that employer. Yet vested former NFL players who became unable to work decades later, for whatever reason, receive a disability benefit. We think these are the most generous disability benefits ever negotiated, and possibly the most complex. In many cases the Retirement Plan has to decide whether a player is unable to work, when the inability to work occurred, and what caused the inability to work.

The Retirement Plan also pays a partial disability benefit to players who suffer a "substantial disablement." Whether a player has a substantial disablement is generally determined using the rating system created by the American Medical Association for measuring impairments. To receive this partial benefit a player must apply within 48 months after his NFL career ends. Partial disability benefits are paid for up to 90 months.

Claims Processing

Claims for benefits are made to and processed by the plan involved. In general, the bargaining parties each appoint three voting members to each plan's governing board,[6] but again the Players Association and the NFL do not administer the plans or decide claims for benefits.

[6] The Players Association appoints only one board member to the Group Insurance Plan.

Claims for pension and disability benefits are decided by the Retirement Plan. Mr. Duerson is one of the six voting trustees on the governing board of the Retirement Plan. Mr. Duerson and his fellow Retirement Board members do not receive, and have never received, compensation for taking on the potential personal liability of being fiduciaries under federal law, and having to decide claims for benefits.

The Retirement Plan is governed by complex federal laws, including the Employee Retirement Income Security Act, or "ERISA." The Internal Revenue Service and the Department of Labor are the primary federal agencies that interpret and oversee these laws. Both the IRS and the DOL demand that Mr. Duerson and his colleagues follow the terms of the Retirement Plan. They have to interpret the rules, but they don't get to make them up. Were they to do so – such as to award disability benefits to a player who does not qualify – they could be personally liable as a fiduciary. Also, under IRS rules, any failure to follow the terms of the Retirement Plan could result in the loss of the Retirement Plan's qualified status and the imposition of millions in taxes and penalties. These rules exist to preserve plan assets, so that money will be there to pay benefits to those who do qualify.

A player seeking disability benefits begins by completing a written application and sending it to the Plan's administration office in Baltimore. The Plan office has a toll-free number that players call to ask questions and get forms, and also has a website for downloading forms. The player is then sent to a nearby physician approved by the Retirement Board for an examination. These physicians are called neutral physicians and they provide a written report.

Disability claims are decided at the first level by a separate committee, the Disability Initial Claims Committee. Since 2002 the Department of Labor has required the existence of this separate committee. If a player is dissatisfied in any way with the decision of the Committee, he has the right to appeal to the full Retirement Board. Players who appeal are sent to a different second Neutral Physician, as required by federal law. If a player is dissatisfied in any way with the decision of the Retirement Board, he has the right to file suit in federal court.

The Plan has two ways of resolving deadlocks – 3 to 3 votes – of the Retirement Board. If the issue is medical, such as whether the player is substantially unable to work, either side can elect to send the player to one of the Plan's top three doctors – called "Medical Advisory Physicians," or MAPs – for a final decision that is binding on the Retirement Board. In rare cases – and this has happened only once in the last 14 years – the deadlock is resolved by arbitration.[7] But this arbitration is solely between members of the Retirement Board – the player is not a party to arbitration.

Table 1 summarizes the disability decisions of the Retirement Plan since July 1993, when the present disability categories were created.

[7] A second arbitration is pending.

Table 1

Total disability applicants	**1052**
Approved at initial stage[8]	358
Denied at initial stage	675
Awaiting initial decision	19
Applicants Denied at Initial Stage who Appealed	**223**
Approved on appeal	69
Denied on appeal	132
Appeal Pending	22
Applicants Who have Sued	**32**
Retirement Board Upheld	24
Retirement Board Reversed	1
Lawsuit pending	7
Overall Disability applicants	**1052**
Cases pending	48
Benefit approved	428
Benefit denied	576

We recognize that the Subcommittee has received complaints from some former players that the system takes too long. But one man's "red tape" is another man's due process. The Department of Labor has set out how the process must work and the time periods for claims, appeals, and decisions. The Initial Claims Committee and the Retirement Board work hard to comply with these rules and apply the terms of the Plan to each application.

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[8] Prior to January 1, 2002, initial decisions were made by the Retirement Board. After January 1, 2002, initial decisions are made by the Disability Initial Claims Committee. The Disability Initial Claims Committee has deadlocked on whether to grant a benefit 37 times.

In many cases this process helps players qualify for disability benefits, as no doubt the Department of Labor intended it to do. Sometimes the first doctor will say that a player can work, but the second doctor disagrees and the Retirement Board grants benefits. There have even been cases where the first two neutral physicians said a player did not qualify for disability benefits, but the player was sent to a MAP for a third examination, and benefits were granted because the MAP resolved the medical issue in favor of the player. We understand some players view this process as "red tape"; but to the Retirement Board, and probably to the players who ultimately qualify, it is due process.

We agree that, in some cases, the system takes too long. The parties have been discussing what can be done to simplify and speed up the process. They recently agreed to immediately grant T&P benefits to players already receiving social security disability benefits. The benefit package for NFL players is an evolving process, and efforts are ongoing. The new 88 Plan to address the needs of players with dementia is one of many recent improvements.

You will note from the above table, if you didn't know already, that a number of players have sued the Retirement Plan, usually over disability benefits. Such large benefits – again, up to $224,000 a year for life in some cases – may encourage players and their attorneys to file suit. Since 1993, the Retirement Board has generally succeeded in protecting the Plan in litigation, winning 24 of 25 cases. This record demonstrates the care that the Initial Claims Committee and the Retirement Board put into deciding pension and disability claims. Under federal law, the members of the Retirement Board

have a fiduciary duty to protect and defend the Plan from claims that the Retirement Board believes can not be granted.

It probably also will not surprise you to learn that some disgruntled players hide the facts when talking to reporters. I am here representing the Union, and I take no joy in criticizing our former players who still are members of the NFL family. However, one former player has repeatedly complained – and his complaints are repeatedly written up by reporters – that despite his extensive injuries the Plan refuses to admit those injuries are related to football, and the Plan refuses to pay him disability benefits. What he somehow seems to never mention is that, in 1992 while represented by an attorney, he agreed to accept a lump sum payment of $295,000 in return for giving up all rights to disability benefits. Since then, three federal courts have told him he is bound by the agreement, and the courts have told him that another lawsuit will result in sanctions. Another player publicly badmouths the Retirement Plan yet has never filed a claim for disability benefits – even though he has been sent several applications. Another player complains that his retirement benefit is too small, but doesn't mention that he 1) choose to retire at age 45 with a 45% actuarial reduction, 2) elected the social security option providing the lion's share of his pension up front, 3) knew that he would only receive a token pension when he became 62, and 4) was ordered by a divorce court to share his pension with his ex-wife. Many a player has failed to mention that the Retirement Board had no choice but to deny his claim because a one of the Plan's top doctors found that he could work, and that decision was binding on the Retirement Board. I also wish to add that, despite what may be written, neither Gene Upshaw, nor myself, nor my firm decide

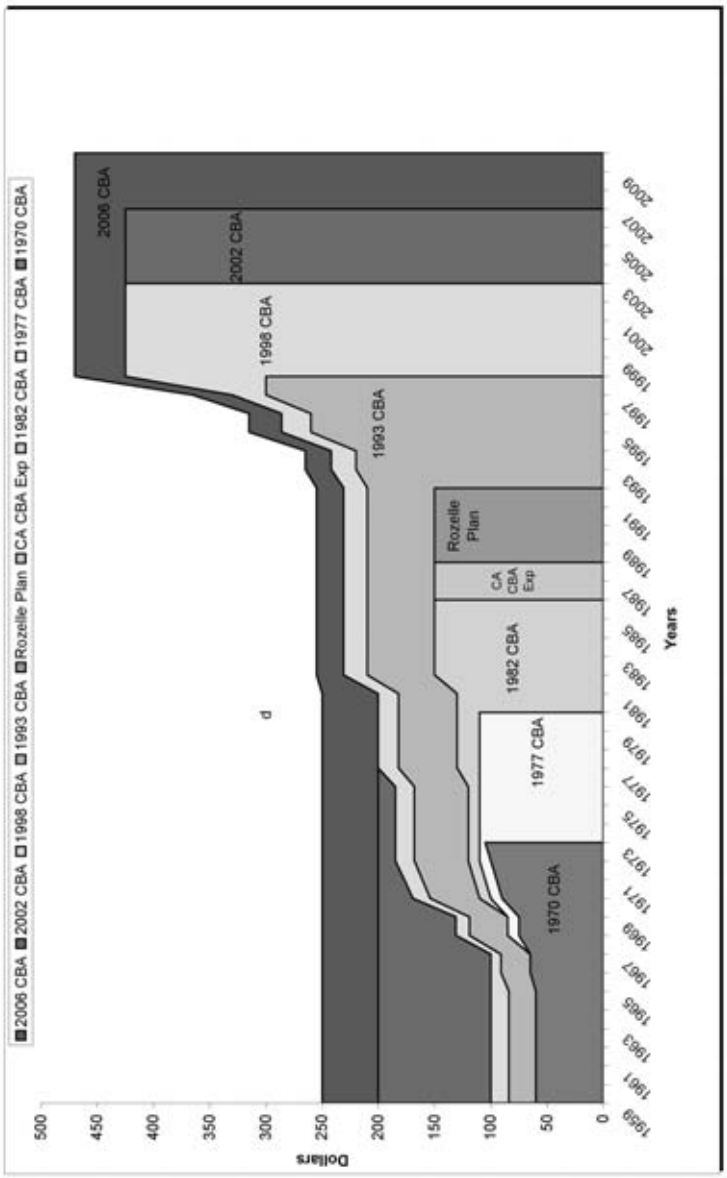
applications for disability or benefits. I do have the privilege of defending the Retirement Board in litigation.

Before concluding, I wish to note three brief points. First, the parties have negotiated for Workers Compensation benefits to be provided to all players. Over the past twenty-five years the NFLPA has established a panel of qualified lawyers to help players file and pursue their claims. The NFLPA strongly advises each player to preserve his rights under Workers Compensation for life-time medical care for his football injuries. Any player who claims that his football injuries have not been adequately addressed and that he cannot get proper medical attention who has not pursued the Workers Compensation remedy has ignored that repeated advice. The parties have also agreed that there is no reduction in other disability benefits when a player also receives Workers Compensation. The cost of Workers Compensation comes out of the players' share of League revenues, like other health and disability benefits.

Second, in addition to all of the above benefits, the Players Association has long had a fund, called the "Players Assistance Fund," that provides up to $20,000 to players in need. Last year alone the Players Assistance Fund paid over $1 million to 146 players in need, and provided almost $500,000 for scholarships and grants to charities.

Finally, I would like to state for the record that many players and beneficiaries appreciate what has been done to improve benefits. I believe some of those persons are here today.

Again, on behalf of the Players Association and myself, I sincerely thank the Subcommittee for the opportunity to appear. I hope my testimony has been helpful.


ATTACHMENT 1
Benefit Credit History Through 2006 CBA Extension
2006 CBA
2002 CBA
1998 CBA
1993 CBA
Rozelle Plan
CA CBA Exp
1982 CBA
1977 CBA
1970 CBA
Dollars
Years
Douglas EB Attachment.XLS
6/25/2007

Ms. SÁNCHEZ. Ms. Wagner, you are up.

TESTIMONY OF MARTHA JO WAGNER, ESQUIRE, VENABLE LLP, WASHINGTON, DC

Ms. WAGNER. Thank you.

Good afternoon, Madam Chairwoman, Members of the Subcommittee. Thank you for inviting me to testify today.

As noted, my name is Martha Jo Wagner and I am a partner in the Employee Benefits and Executive Compensation Group of Venable LLP in Washington, DC. I have practiced law in the area of employee benefits for 25 years. Throughout that period, I have advised plan administrators about their responsibilities under the laws and regulations that apply to benefit claims review and have litigated benefit claims cases nationwide.

I was asked to testify today regarding whether the disability claims procedures described in the Bert Bell/Pete Rozelle NFL Player Retirement Plan and the NFL Player Supplemental Disability Plan were required by the Employee Retirement Income Security Act of 1974, as amended. My written testimony addresses the review procedures in both the retirement and supplemental disability plans, but my oral testimony today will address only the disability claims procedures described in the current Retirement Plan documents. Neither my oral nor written testimony addresses how the disability claims procedures have been implemented.

My oral testimony will cover two areas: first, the claims procedure required by ERISA and the claims procedure regulation promulgated by the Department of Labor; and, second, several of the significant claims review procedures in the Retirement Plan.

ERISA sets out very broad parameters for reviewing and granting or denying claims for benefits. ERISA requires a benefit plan to provide adequate written notice to every claimant whose claim for benefits has been denied. ERISA also requires that every claimant whose benefit claim has been denied be provided a reasonable opportunity for a full and fair review of the denial by the appropriate fiduciary named in the plan. Finally, ERISA requires benefits be granted or denied only in accordance with the terms of the plan and other governing plan documents.

Effective January 1, 2002, for plans such as those at issue here, the Department of Labor issued a significantly revised claims procedure regulation setting forth minimum requirements for claims review, including at least two levels of mandatory review. The regulation includes detailed time frames for decision making, detailed requirements for the contents of adverse benefit determinations and other detailed procedural requirements. In addition, ERISA permits plans to supplement the claims procedure required by the regulation and, for practical reasons, plans generally do so.

I will now briefly highlight five of the significant provisions of the Retirement Plan relating to disability claims review.

First is arbitration of certain deadlocked disputes. The Retirement Plan includes a two-step review process involving initial review of a disability claim by a Disability Committee and review on appeal by the Retirement Board. If the two voting members of the Disability Committee are deadlocked, the claim is deemed to be denied. In contrast, if the six voting members of the Retirement

Board deadlock, three members of the Retirement Board can affirmatively vote to submit the matter to binding arbitration.

These arbitration positions are not specifically required by ERISA or the regulation. However, I believe the Labor Management Relations Act of 1947, commonly referred to as the Taft-Hartley Act, requires arbitration of trustee deadlocks concerning administration of a benefit fund.

Second is retroactive limits on claims. Under the Retirement Plan, disability benefits will not be paid for certain periods that precede receipt of a written application for benefits unless the player is physically or mentally incapacitated in a manner that substantially interferes with the filing of the claim. Such limits are not specifically required or precluded by ERISA or the regulation.

Third is required medical examinations. A player may be required to submit to periodic medical examinations by a medical dispute arbitrator or a competent physician selected by a reviewing entity. These provisions are not required by ERISA or the regulation but are commonly included in disability plans.

Fourth is a claims review process. The Retirement Plan includes detailed timetables for review of claims, detailed requirements for the content of adverse benefit determinations and other procedural requirements. These provisions conform to the minimum requirements of the regulation with two exceptions which are discussed in my written testimony.

Fifth is the application of the standard of review. Reviewing courts either apply the de novo standard of review or the abuse of discretion standard of review, depending in part upon the language of the plan and other governing plan documents. Based on the grants of discretionary authority to both reviewing entities under the plans, I would expect their determinations to be reviewed under the abuse of discretion standard of review. Neither ERISA nor the regulation require or preclude such grants of discretionary authority.

In summary, the initial claims review process and the review process on appeal described in the Retirement Plan is for the most part specifically required by the ERISA claims procedure regulation. The provisions requiring arbitration of certain deadlocked disputes, retroactive limits on claims, required medical examinations, and grants of discretion in the Retirement Plan are not specifically required or precluded by ERISA or the regulation. However, arbitration of certain deadlocked disputes in the Retirement Plan may be required by the Taft-Hartley Act, and other plan provisions may be necessary for practical reasons.

I thank the Subcommittee for its time and attention, and will be happy to take questions when appropriate.

Ms. SÁNCHEZ. Thank you for your testimony, Ms. Wagner.

[The prepared statement of Ms. Wagner follows:]

PREPARED STATEMENT OF MARTHA JO WAGNER

Testimony of
Martha Jo Wagner, Esq.
Venable LLP
Presented before the
U.S. House of Representatives
Committee on the Judiciary
Subcommittee on Commercial and Administrative Law
"The National Football League's System for Compensating Retired Players:
An Uneven Playing Field?"
June 26, 2007

Good afternoon, Madame Chairwoman and Members of the Subcommittee. Thank you for inviting me to testify today. My name is Martha Jo Wagner and I am a partner in the Employee Benefits and Executive Compensation Group of Venable LLP in Washington, D.C. I have practiced law in the area of employee benefits for 25 years. Throughout that period, I have advised plans and plan administrators about their responsibilities under the laws and regulations that apply to benefit claims review and have litigated benefit claims cases nationwide. I am a Fellow of the American College of Employee Benefits Counsel, Management Co-chair of the Employee Benefits Committee of the American Bar Association Section of Labor and Employment Law, and an adjunct professor of law at Georgetown University Law Center.

I was asked to testify today by the Subcommittee regarding whether the claims procedures described in the Bert Bell/Pete Rozelle NFL Player Retirement Plan and the NFL Player Supplemental Disability Plan that apply to disability benefit claims were required by the Employee Retirement Income Security Act of 1974, as amended. I will refer to the act as ERISA and I will refer to the two plans at issue here, respectively, as the Retirement Plan and the Supplemental Disability Plan.[1]

My testimony today addresses only the disability claims procedures described in the plan documents that currently apply to players in general, and

[1] I reviewed a copy of the Retirement Plan as amended and restated effective April 1, 2001 and amendments to that plan that were dated or effective April 1, 2001, January 15, 2004, November 18, 2004, December 16, 2004, January 13, 2005, April 6, 2005, February 9, 2006, September 12, 2006, and October 4, 2006. I reviewed a copy of the Supplemental Disability Plan as amended and restated effective April 1, 2001. I have not reviewed any amendments to the Supplemental Disability Plan. I have also not reviewed prior versions of either plan, nor any collective bargaining agreements.

does not address how those claims procedures are implemented. My testimony will cover three areas: first, the claims procedure required by ERISA and the claim procedure regulation promulgated by the Department of Labor pursuant to ERISA; second, the significant provisions of the claims procedure in the Retirement Plan; and third, the claims procedure in the Supplemental Disability Plan.

ERISA and the Department of Labor Claims Procedure Regulation

ERISA sets out very broad parameters for reviewing and granting or denying claims for benefits. ERISA requires a benefit plan to provide adequate written notice to every participant and beneficiary whose claim for benefits has been denied. This notice is statutorily required to include the specific reasons for the denial and be written in a manner calculated to be understood by the recipient. ERISA also requires that every participant and beneficiary whose benefit claim has been denied be provided a reasonable opportunity for a full and fair review of the denial by the appropriate fiduciary named in the plan. Finally, ERISA requires benefits be granted or denied only in accordance with the terms of the plan and other governing plan documents.[2]

Effective January 1, 2002, for plans such as those at issue here, the Department of Labor issued a significantly revised claims procedure regulation. The regulation sets forth minimum requirements for claims review, including at least two levels of mandatory review. Specifically, the claims procedure regulation includes detailed time frames for decision making, detailed

[2] The plan and other governing documents must, of course, be consistent with the statute.

requirements for the contents of adverse benefit determinations, and other detailed procedural requirements. The regulation does not require particular substantive rights, such as making disability benefits available. Moreover, ERISA permits plans to supplement the required claims procedure and, for practical reasons, plans generally do so.

Retirement Plan's Claims Procedures

In a nutshell, the significant provisions of the Retirement Plan's disability claims procedure generally involve the following terms and conditions.

Reviewing Entities. The Retirement Plan includes a two step mandatory claims procedure, involving initial review of a disability claim by the Disability Initial Claims Committee, which I will refer to as the Disability Committee, and review on appeal by the Retirement Board. The Disability Committee is made up of two voting members, one appointed by the NFL Players Association and one appointed by the NFL Management Council. The Retirement Board is made up of six voting members and the Commissioner of the NFL, a non-voting member. Three of the voting members of the Retirement Board are appointed by the NFL Players Association and three by the NFL Management Council. The Retirement Board is the named fiduciary of the Retirement Plan and, within certain limitations, has the power to amend the claims procedure in the plan. Neither ERISA nor the claims procedure regulation requires this evenly divided, jointly trusteed Retirement Board. However, in passing I would note that, in addition to ERISA, the Retirement Plan is subject to the Labor Management Relations Act of 1947, which I will refer to as the Taft-Hartley Act. The structure of the Retirement

Board, involving equal representation by labor and management, is consistent with the requirements of the Taft-Hartley Act.

Types of Disability Claims. Under the Retirement Plan there are two types of disability claims: claims for total and permanent disability benefits and claims for line-of-duty disability benefits. Neither ERISA nor the claims procedure regulation requires these benefits be made available to the players.

Total and Permanent and Line-of-Duty Disability Defined. Subject to certain limitations, a player is deemed to be totally and permanently disabled if the reviewing entity finds that the player is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit. In addition, according to news reports, last week the NFL Commissioner and the Executive Director of the NFL Players Association agreed that any player who qualifies for Social Security disability benefits will automatically be approved for NFL disability benefits.[3]

A player who incurs a substantial disablement arising out of league football activities is entitled to line-of-duty disability benefits. A substantial disablement is defined to include, for example, a permanent disability that results in a 50% or greater loss of speech or sight. A permanent disability is one that has persisted or is expected to persist for at least 12 months. A disability that arose out of any football game or other football activity supervised by a league team would constitute a disablement arising out of league football activities.

[3] Presumably the NFL disability benefits that would be automatically approved if a player was granted Social Security disability benefits would include total and permanent disability benefits under the Retirement Plan and also might include line-of-duty disability benefits under certain circumstances. Social Security disability determinations provide deference to the treating physician, which is not required by ERISA or currently provided for under the Retirement Plan.

Neither ERISA nor the claims procedure regulation requires or precludes a plan from using a particular definition of disability.

Arbitration of Certain Deadlocked Disputes. If the two voting members of the Disability Committee deadlock over, for example, a determination of whether a player is totally and permanently disabled, the claim is deemed denied. In contrast, if the six voting members of the Retirement Board deadlock over this or any other issue, three members of the Retirement Board can affirmatively vote to submit the matter to binding arbitration. Medical disputes regarding whether a player is entitled to total and permanent or line-of-duty disability benefits are submitted to a physician jointly designated by the NFL Players Association and the NFL Management Council. As I understand this process, the player whose disability is at issue is not a party to the arbitration. Other disputes are submitted to an arbitrator according to certain past practices and/or procedures depending upon the nature of the dispute. These arbitration provisions are not specifically required by ERISA or the claims procedure regulation. However, I believe that the Taft-Hartley Act requires arbitration of trustee deadlocks concerning administration of a benefit fund.

Retroactive Limits on Claims. Disability benefits will not be paid for periods that precede receipt of a written application for benefits by more than 42 months in the case of total and permanent disability benefits or by more than 48 months in the case of line-of-duty disability benefits, unless the player is physically or mentally incapacitated in a manner that substantially interferes with the filing of a claim. Limits on retroactive payments are not specifically required or precluded by ERISA or the claims procedure regulation.

Required Medical Examinations. A player may be required to submit to periodic medical examinations by a medical dispute arbitrator or a competent physician selected by a reviewing entity. Refusal to submit to any such medical examination is grounds for denial of the player's benefit claim. These provisions are not specifically required by ERISA or the claims procedure regulation but are commonly included in disability plans.

Initial Claims Review Process. The Disability Committee has 45 days to initially review a claim for disability benefits under the Retirement Plan. Two 30 day extensions of this time frame are available under certain circumstances. If the Disability Committee fails to notify the player within these time frames, the Disability Committee is deemed to have denied the player's claim and the appeals procedures discussed below are available.[4] On the other hand, the parties may extend the applicable time frames by mutual agreement. Players are given at least 45 days in which to provide additional information requested by the Disability Committee. The Disability Committee's notice of an adverse benefit determination, such as a denial of disability benefits, must set forth certain information, such as the specific reasons for the determination and reference to specific plan provisions on which the determination is based. These plan provisions conform to the minimum requirements of the claims procedure regulation, except for the mutual agreement and deemed denial provisions.

With respect to providing a mutually agreed upon extension, nothing in the claims procedure regulation or ERISA specifically requires or precludes such a

[4] The amendment to the Retirement Plan adding this provision was effective April 1, 2001, before the current claims procedure regulation was effective.

provision. With respect to the deemed denial, at least one court has held that the current claims procedure regulation allows a participant whose initial claim has not been timely denied to proceed directly to court, rather than requiring the participant to exhaust the appeal process. Linder v. Byk-Chemie USA Inc., 313 F. Supp. 2d 88, 94 (D. Conn. 2004).

Claims Review Process on Appeal. The player has 180 days from receipt of an adverse benefit determination to file an appeal and may submit written comments, documents, and other information in support of his claim. The Retirement Board will review all the information provided, regardless of whether it was available to the Disability Committee. For claims involving medical judgments, the consulting health care professional will be independent of any consulting health care professional used to review the initial claim. Upon request, the identity of any consulting health care professional will be provided to the player. Decisions on appeal will be made at the first quarterly meeting of the Retirement Board after the claim is received, unless the appeal is received within 30 days preceding the date of that quarterly meeting. Determinations of such appeals will be made at the second quarterly meeting of the Retirement Board, unless special circumstances require an extension. If an extension is required, the Retirement Board will provide notice to the player before the extension begins and will make its determination at the third quarterly meeting of the Retirement Board following receipt of the appeal. Players will be notified of the results of the review within five days of the Retirement Board's determination. An adverse determination by the Retirement Board will set forth certain information, such as the specific reasons for the determination and references to specific plan

provisions on which the determination is based. These plan provisions conform to the minimum requirements of the claims procedure regulation.

Grants of Discretion and Standard of Review. With respect to adverse benefit determinations, reviewing courts apply one of two standards of review – de novo or abuse of discretion – depending upon, in part, the language of the plan and other governing documents. If an adverse benefit determination is litigated, based on the grants of discretionary authority to both the Disability Committee and the Retirement Board, I would expect the determinations of both entities to be entitled to deference from the court under the abuse of discretion standard of review. I would note, however, that these grants of discretion are not specifically required or precluded by ERISA or the claims procedure regulation.

Contractual Statute of Limitations. ERISA does not include a statute of limitations for benefit claims. Therefore, if there is no contractual statute of limitations in a benefit plan, the most analogous state law statute of limitations applies. Such state law statutes of limitations generally run from one to fifteen years. Under the terms of the Retirement Plan, no lawsuit regarding an adverse benefit determination may be commenced more than 42 months from the date of the final decision on appeal. Such a contractual statute of limitations is not specifically required or precluded by ERISA or the claims procedure regulation.

Supplemental Disability Plan's Claims Review Procedures

The Supplemental Disability Plan automatically provides additional disability benefits to players who qualify for total and permanent disability benefits under the Retirement Plan and, as a result, there is no claims review procedure for those determinations in the Supplemental Disability Plan. A player

who does not qualify for disability benefits under the Supplemental Disability Plan because he was not determined to be totally and permanently disabled under the Retirement Plan must utilize the claims procedure in the Retirement Plan to question his adverse benefit determination. All other determinations under the Supplemental Disability Plan are subject to a claims procedure that conforms to the applicable minimum requirements of the claims procedure regulation.

Conclusion

In summary, the initial claims review process and the review process on appeal described in the Retirement Plan and the claims process in the Supplemental Disability Plan are, for the most part, specifically required by the ERISA claims procedure regulation. The structure of the reviewing entities, the types of disability claims that are available, the definitions of total and permanent and line-of-duty disability, arbitration of certain deadlocked disputes, retroactive limits on claims, required medical examinations, grants of discretion, and contractual statutes of limitation in the Retirement Plan are not specifically required or precluded by ERISA or the claims procedure regulation. However, the structure of the reviewing entities and arbitration of certain deadlocked disputes may be required by other laws, and other plan provisions may be necessary for practical reasons.

I thank the Subcommittee for its time and attention.

Ms. SÁNCHEZ. I would like to welcome Mr. Smith to begin his testimony at this time.

TESTIMONY OF CYRIL V. (CY) SMITH,
ZUCKERMAN SPAEDER LLP, BALTIMORE, MD

Mr. SMITH. Madam Chairwoman, Ranking Member Cannon, Members of the Subcommittee, thanks for the opportunity to testify today.

As you know, I am Cy Smith; and I am an attorney in private practice in Baltimore at the firm of Zuckerman Spaeder. I have represented a number of individuals and pension plans in disputes over pension benefits under ERISA, but for the last 3 years I have had the honor of representing the family of Mike Webster, his estate, in finally obtaining full disability benefits from the NFL's pension plan.

I note that Mike—who is no longer with us—that Mike's son, Garrett, is with us today.

As many of you probably know, Mike played center for the Steelers. He was on their Super Bowl teams. He was named to the NFL's all-time team, and he was both a great player and person.

It was very clear the violent world of NFL football had given him repeated concussions and disabling brain injuries. Unfortunately, it took him 7 years from the time that his first application was filed with the pension plan to a final court ruling which awarded him full benefits. Four years of that were just to get a final decision from the plan, even before he got to Federal court, to the point that he died in 2002 before he actually got a final decision from the plan.

In his case, there was unanimous medical evidence about whether he was totally and permanently disabled, why that happened and when it happened. A psychologist, a psychiatrist, a neurologist who were appointed by the pension plan all found that he had multiple head injuries.

But, despite this overwhelming evidence, the pension plan refused to pay him full benefits. They refused to credit what his treating physician said. They relied on observations by Mike's oncologist, his cancer doctor, about whether he had a brain injury. They tried to discredit their own doctor, who is a board-certified neurologist.

The bottom line in my experience was that at every turn the plan delayed and erected barriers to prompt and fair consideration of his claim. He had no choice but to go to Federal court in Baltimore in 2004.

Over the next 3 years, four different Federal judges agreed that the plan was not just wrong but had abused its discretion. One judge said that, given the overwhelming evidence, the plan's decision indicates culpable conduct, if not bad faith. Mr. Ell said that statements that he had heard about the plan were wrong or misleading. I will let the judicial record speak for itself.

Another judge said it would require a leap of faith to rule for the plan.

In the end, Mike Webster won, although he died before he could actually enjoy that victory. But, along the way, the plan spent hundreds of thousands of dollars for attorneys fees, both their attor-

neys fees and Mike Webster's. That is money that could have gone to player benefits but was used to try and defend against Mike's meritorious claims.

It would be terrific if I could say to all of you today that the NFL's pension plan learned a lesson from this review, that it is on the way to reform. Sadly, that is not the case. The day after the Fourth Circuit Court of Appeals ruled in favor of Mike and his estate, Gene Upshaw, who picks one-half of the members on the Retirement Board—the other half are picked by the NFL—said that he would do exactly the same thing the next day. It is unfortunate that Mr. Upshaw can't be here today to explain his remarks.

Since the courts ruled in Mike Upshaw's case, I have reviewed dozens of other claims. All too often, I see the same pattern of obstruction by the plan in the case, in many cases much worse than other disability benefit schemes that I have reviewed: lengthy delays, doctor shopping, a system whereby one objection can deny benefits for an individual, a refusal to consider the testimony of treating physicians or a clear majority of the medical evidence.

Ms. Wagner in her remarks properly noted that she wouldn't address implementation of the plan, but that is one of the big problems that we have here. In many ways, Mike Upshaw's case was a warning sign, a warning bell and a loud one, that the disability plan here is broken, badly broken and that it urgently needs repair, as the former players who will testify today will tell you.

How can the plan be fixed? There are some basic changes that are needed for starters.

One would be a short deadline for the plan to decide claims, not 4 years but maybe 45 days. Many other disability plans are able to do that. They should give deference to what treating physicians tell them, and they should increase the use of neutral arbitrators to decide issues.

With respect to changes that have been recently discussed in the way the plan works, the Social Security standard, the devil is always in the details. Of course we don't know what those details are. But let me tell you one thing. It is absolutely clear that if you had the Social Security standard in effect, it wouldn't have changed the result in Mike Webster's case because it is a question of how the plan is implemented.

What is really needed is something that can't be accomplished through either litigation or legislation, and that is to have new leadership on the Retirement Board that is genuinely committed to giving players a fair shake here. Whatever it costs, it costs. The NFL can afford to honor the commitments that are in the plan document already without having to change them.

Let me just sum up by saying that I am here on a panel with other lawyers. Some of my best friends are lawyers. Many of you are lawyers, and I like practicing law. And there are going to be more lawsuits, there is going to be more litigation, but nothing will change the fundamental problem here until the league and the union decide that they want to come through on the commitments that are already there in the plan document, spelled out in the plan document. I hope that this Committee's hearings are an important first step in that effort, and I would be happy to answer any questions. Thank you

Ms. SÁNCHEZ. Thank you, Mr. Smith.
[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF CY SMITH

WRITTEN STATEMENT OF

CY SMITH

ZUCKERMAN SPAEDER LLP

FOR HEARINGS BEFORE THE

HOUSE SUBCOMMITTEE ON COMMERCIAL AND

ADMINISTRATIVE LAW

"The National Football League's System for Compensating

Retired Players: An Uneven Playing Field?"

June 26, 2007

Madam Chairwoman, ranking member Cannon, and members of the Subcommittee, thank you for the opportunity to testify today. My name is Cy Smith, and I am a partner in the law firm of Zuckerman Spaeder LLP, where my practice emphasizes complex civil and criminal litigation. For the past twenty years, I have tried cases in state and federal courts around the country, and I have particular experience representing participants in pension plans which are governed by the federal pension statute, the Employee Retirement Income Security Act, or ERISA.

For the last several years, it's been my privilege to represent the family of Mike Webster (along with attorney Bob Fitzsimmons) in a lengthy battle with the pension plan sponsored by the National Football League and its union, the NFLPA, the Bert Bell-Pete Rozelle NFL Players Retirement Plan. Today, I would like to describe my experience, and discuss some changes that might help retired players get the benefit of their bargain with the League and their union – namely, fair disability pension benefits.

I.

MIKE WEBSTER'S

RIGHT TO A DISABILITY PENSION

Mike Webster was a Hall of Fame National Football League player who spent almost his entire career at center for the Pittsburgh Steelers. Because of the NFL-record number of games he played, the rules then in force, and the intensity with which he performed, Mike Webster received over the course of his career thousands of high-speed, high-impact hits to his head. By the time he retired in 1990, Mike Webster had – according to the NFL's own physician – "multiple head injuries" and "a dementing illness" that "result[ed] in complete disability in terms of being gainfully employed." In

short, he was "punch drunk." Before his death in 2002, he sought a fair disability pension from the NFL's pension plan, which is designed to cover exactly these sorts of disabilities caused by the violent world of pro football. The NFL's pension plan denied him a full payment, claiming that his disabilities – the result of almost two decades of conflict on the Steelers' offensive line – were not the result of an "active" football injury, and that those disabilities did not begin until long after the end of Mr. Webster's career. The NFL did so despite the overwhelming evidence (including evidence from the NFL's own expert doctor) that Mr. Webster's disabilities began early and were the direct and active result of Mr. Webster's years of service as center -- one of the most exposed and defenseless positions on the football field.

Mike Webster was born on March 18, 1952 in Tomahawk, Wisconsin. He grew up on a 640-acre potato farm and – although he did not play football until his junior year in high school – received a scholarship to the University of Wisconsin. By all accounts, he was a bright, compassionate and proud man. He played professionally for the Pittsburgh Steelers for 15 seasons, from 1974 until 1988, the vast majority as center on the Steelers' offensive line. He endured numerous shots to the head and multiple concussions. During one stretch, Mr. Webster (known as "Iron Mike" by fans and teammates alike) played six consecutive seasons without missing a single offensive down, and for 177 consecutive games. His 245 games were the most ever by a center, and the fifth most in NFL history. In his career, the Steelers' offensive and defensive lines led the team to four Super Bowl wins in the 1970s. Mike Webster was elected Captain of the Steelers during three of their Super Bowl years and made All-Pro numerous times. At the end of his career, Mr. Webster played for two seasons with the

Kansas City Chiefs, retiring after the 1990 season. In 1997, Mike was inducted into the Pro Football Hall of Fame in Canton, Ohio, and in 2000 he was elected to the NFL's all-time team.

The center position is one of the most exposed and unprotected positions on the football field. Unlike every other player, the center must hold the ball to the ground until the snap. As a result, he is uniquely exposed to blows from defensive linemen. For example, the "head slap" (invented by Roosevelt Grier, but perfected by Deacon Jones of the (then-Los Angeles) Rams "Fearsome Foursome") was until 1977 part of a defensive linemen's standard moves. Using the head slap, defensive linemen ranging up to 6'8" and 300 pounds or more would begin their rush by slapping the center and other offensive linemen on the sides of their helmets to disorient them. Even after 1977 (when the head slap was outlawed, according to the NFL, precisely because of its risk to offensive linemen), players continued to use the technique. And, even without the head slap, NFL centers and other linemen remained exposed to a wide variety of blows to the head, both intentional and unintentional. One study has shown that during the course of a game, the average college football player (who is, of course, far smaller and slower than his NFL counterpart) is hit some fifty times with a force of 40 Gs, equivalent to being struck by a boxer. And at least once or twice a game, there is a catastrophic impact of 120 Gs – the same force as a car crash. The same study showed that among all football players, offensive linemen received the most hits to the head.

Mike Webster's days after football were dictated by the disabilities he suffered playing the game. He was unable to hold steady (or gainful) employment. He was homeless, often sleeping in his car. He was often reclusive. His marriage broke up,

and he lost money in a series of bad investments. In 1999, he pled guilty to forging prescriptions for Ritalin, which he used to treat the symptoms of his NFL brain injuries. Because Mike also had an intensely private personality, and because his pride prevented his admitting that he was facing these extraordinary difficulties, the fact and extent of his disabilities remained a secret to many for a number of years after his retirement from football.

Mike Webster tried several forms of work after his 1990 retirement, including serving as a commentator on a sports talk show. He failed at each one. For example, upon retiring from the Chiefs after the 1990 season, Mike auditioned for a TV announcer job with NBC. He was assigned two preseason games in the summer of 1991, neither of which was broadcast. In the end, he never worked a game for the network. As the NFL's own private investigator discovered, his "career at NBC . . . [was] over before it started."

He earned no more than $3,500 in wages in 1991, and none in 1992 or 1993. Later, out of sympathy, the Kansas City Chiefs made him an assistant strength and conditioning coach, even though (as a result of the disabilities caused by his playing career) he was never capable of fulfilling the responsibilities of that job. Indeed, he lived for a period of time in the Chiefs' equipment room. (Such employment by NFL teams, under the NFL Plan's express rules, is not disqualifying for purposes of determining disability.)

In 1999, around the time of his Ritalin arrest, he was finally diagnosed with brain damage resulting from the long-term head trauma of his NFL career. His attorney, Bob Fitzsimmons of Warwood, West Virginia, filed an application on Mike's behalf with the

NFL Plan for "total and permanent disability" ("TPD") benefits, under Articles 5.1(a) and 5.2 of the NFL Plan's Plan Document. Article 5.2 states that a player will deemed to be TPD if the Retirement Board finds that:

> he has become totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit . . . A Player will not be considered to be able to engage in any occupation or employment for profit . . . merely because such person is employed by the League or an Employer, manages personal or family investments, is employed by or associated with a charitable organization, or is employed out of benevolence.

Section 5.1(a) of the Plan provides for "Active Football" disability benefits, defined as a disability resulting "from League football activities, [which] arises while the Player is an Active Player, and causes the Player to be totally and permanently disabled 'shortly after' the disability first arises." The Plan Document also provides for Football Degenerative benefits, under § 5.1(c), which are substantially less generous.

If a Player becomes TPD within six months after his disability first arises, § 5.1 of the Plan creates a conclusive presumption that the Player became TPD "shortly after" the disability arose. If the Player becomes TPD six to twelve months after the disability arises, then it is up the NFL Plan's Retirement Board to determine whether the "shortly after" standard is satisfied. And if the Player becomes TPD more than twelve months after the disability arises, then he is conclusively deemed not to have satisfied the "shortly after" requirement.

Under § 5.2 of the Plan Document, the Plan has the right to select a highly-qualified neutral physician to perform a medical examination of a player who is applying for a disability, for the purpose of determining whether the disability arose from NFL

play, and when it arose. Upon information and belief, pursuant to the Plan Document, the Plan maintains a national network of highly-qualified physicians to review each claim for disability benefits.

As part of his 1999 application for disability benefits, Bob Fitzsimmons also requested that the date of onset of Mr. Webster's disability be set at 1991 or earlier, with payment of benefits retroactive to that date. He supplied the Plan with Mr. Webster's affidavit stating that although he was on the payroll of the Kansas City Chiefs after 1990 as an "assistant coach," he was completely unable to fulfill the duties of that position. Simply stated, Mr. Webster was paid a salary because the Chiefs' general manager liked and respected him and his contributions as a player.

As part of the Plan's review of his claim, Mike was required to undergo a medical examination – at the Plan's expense – by Dr. Edward Westbrook, a board-certified neurologist in Cleveland chosen by the Plan. Dr. Westbrook's form reporting the examination found that Mike Webster's disability occurred "3/91 [March 1991] or before" – that is, within three months of his December 1990 retirement from pro football. Dr. Westbrook's accompanying written report stated that the disability occurred prior to 1990, and he provided a letter to the NFL stating that Mike Webster had suffered "multiple head injuries" and had "a dementing illness" that "result[ed] in a complete disability in terms of being gainfully employed."

By letter dated November 25, 1999, however, the Plan refused to grant Mr. Webster an Active Football disability pension, without explaining why it had ignored the finding of its own, hand-picked physician. Notably, the Plan had no contrary evidence suggesting that the disability occurred after 1990.

Mr. Webster's attorney immediately requested that the NFL Plan reconsider its finding. By letter dated May 8, 2000, the Plan again refused to award Active Football benefits, asserting that Mike had been "self-employed" from 1991 until 1994 – even though there was no evidence that he had actually done work or been capable of working after he left the Kansas City Chiefs in 1990. The Plan also shrugged off the evidence of its own expert, Dr. Westbrook, claiming that Dr. Westbrook's report merely stated that Mike's disability began before 1991, not that he was totally and permanently disabled before that date.

By letter dated July 5, 2000, the Plan's decision was appealed, including the refusal to award both (a) Active Football benefits, and (b) benefits retroactive to 1990, when Mr. Webster became totally and permanently disabled.

In support of his appeal, the Plan was given a three-page letter from a clinical psychologist, Fred Krieg, who provided an opinion to a reasonable degree of professional certainty that Mr. Webster was totally and permanently disabled as of March 1991.

In addition, in a letter to the Plan dated October 5, 2000, Dr. Westbrook (the Plan's hand-picked examining physician) supplied the following medical opinion:

> It is clear that [Mr. Webster] had significant trouble playing football in 1990 and officially retired in 1991. It would appear on that basis that he was completely and totally disabled as of the date of his retirement and was certainly disabled when he stopped playing football sometime in 1990. There is nothing to [suggest] that he had a progressive neurological illness unrelated to repetitive trauma from football. His executive [mental] abilities are significantly damaged and had been at that time. If indeed he tried to do coaching or some type of menial task around the football league, it was not significant in terms of gainful employment. He has remained completely and totally disabled for any occupation

> beginning in approximately . . . 1990 and will not be expected to improve.

Despite this explicit opinion from its own physician, the NFL Plan refused to reconsider its decision. Instead, the Plan requested a series of documents from Mr. Webster, as further evidence that he was incapable of work from 1990 forward. Mike's representatives responded to every request, gathering evidence from the Internal Revenue Service, the Social Security Administration, the Commonwealth of Pennsylvania, the Kansas City Chiefs and Pittsburgh Steelers teams, the Department of the Treasury, psychologists and other health care professionals, and individuals for whom Mr. Webster had attempted to work after his retirement, among others. The NFL even hired a private investigator to shadow Mr. Webster; the investigator found no evidence that Mike Webster had been capable of employment after he stopped playing for the Chiefs in 1990.

As part of the appeal, the Plan was given yet another opinion by a mental health specialist, Dr. Jonathan Himmelhoch of the University of Pittsburgh. Dr. Himmelhoch, having reviewed all of Mike's medical records, along with the NFL Plan Document and the Plan's initial May 8, 2000 benefit letter, reached the following conclusions "to a reasonable degree of medical certainty":

> (1) Michael L. Webster suffers a disability as a result of multiple head blows received while playing Center in the NFL which caused him to suffer from traumatic encephalopathy;
>
> (2) The multiple head blows to Michael L. Webster resulted from league football activities and arose while he was an active player in the NFL;
>
> * * *

> (4) Mr. Webster's traumatic encephalopathy first arose or manifested itself between the end of the 1990 football season, i.e., November/December 1990, and March, 1991; [and]
>
> (5) Mr. Webster was totally and permanently disabled as of March, 1991, to the extent that he was substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit . . .

While the NFL continued to review Mike's claim, he died on September 24, 2002. After an extraordinary delay of almost three years (from July 2000 until March 2003), the NFL Plan finally decided Mike's 2000 request for reconsideration by letter dated March 17, 2003, six months after his death. In its March 17, 2003 letter, the Plan once again refused to award Mr. Webster Active Football benefits. It established the effective date of those benefits as September 1, 1996.

When the Plan reached this decision, it had before it three reports by mental health professionals: a neurologist (Dr. Westbrook, chosen and retained by the Plan); a psychologist (Dr. Krieg); and a psychiatrist (Dr. Himmelhoch). The three experts agreed that Mr. Webster's disability began while he was playing football; resulted from multiple head injuries; and caused Mr. Webster to be totally and permanently disabled no later than March 1991. The Plan had no contrary medical evidence about the date of onset of Mr. Webster's unquestioned disability.

In addition, the Plan (having commissioned a private investigator's report) had access to Mr. Webster's "income tax filing records, medical history, court records and employment records." The Plan's investigator interviewed former teammates and colleagues at both the Steelers and the Chiefs, "as well as former business associates at a variety of failed business ventures pursued by Mr. Webster during the relevant

period." According to the Plan's own investigator, Mr. Webster supposedly attempted to work as a television broadcaster for two football games in 1991, and then, from 1992 until 1994-95, "Mr. Webster attempted to work at a variety of business ventures." In the Plan's own words, those attempts were "unsuccessful."

One witness told the NFL's private investigator that Mike Webster lived with her and her husband for three months beginning in 1994 because he "was tired of sleeping in his car." The same witness "spent the majority of the time during the over one-hour telephone interview talking about Mr. Webster's poor health," beginning in 1993 when she met him. The witness described Mike's "strange habits," noted that he "looked worse and worse," and stressed the fact that he experienced "many physical and mental problems."

In short, the Plan's investigation confirmed what Mike Webster had told it: after he left football, he was unable to work. Whatever he tried, failed. He was unable to obtain or hold a paying job.

Rather than rely upon actual employment by Mike after his 1990 retirement, the stated basis for the Plan's 2003 decision was the observation by an oncologist treating Mike in 1996 that "Mr. Webster's life 'had really deteriorated recently' and that he was living out of a car." Not surprisingly, Mike's cancer specialist offered no opinion about whether his brain injury had prevented him from working before 1996. And the Plan's March 17, 2003 letter said nothing about the unanimous findings of all three mental health specialists, including the one chosen by the NFL Plan, who agreed that Mr. Webster had become totally and permanently disabled as of March 1991.

This time, because Mike had died while his appeal was pending, the Administrator of his Estate appealed, pointing out the omissions from the March 17 finding. In a letter dated July 25, 2003, the Plan finally addressed the findings of its physician, Dr. Westbrook, by disavowing its own expert. The Plan's letter stated: "The Retirement Board notes that Dr. Westbrook did not examine Mr. Webster until 1999, and therefore the Board found the opinions offered in Dr. Westbrook's October 5, 2000 letter regarding Mr. Webster's prior condition to be speculative and conclusory." The Plan did not explain, of course, why it had asked Dr. Westbrook in 1999, four years earlier, to provide an opinion about Mike Webster's mental status (his "prior condition") in 1991.

In 2004, we filed suit in federal court to get a fair disability pension for Mike's family. The standard for a court reviewing an a disability pension decision is very high – the plan participant has to show an "abuse of discretion." It's not enough to show that the NFL Plan was wrong, or that a judge would have decided differently. As a result, these cases are hard to win. But in April 2005, Judge William Quarles of the federal court in Baltimore found that the Plan had done just that – abused its discretion by ignoring the unanimous medical evidence. In a later November 7, 2005 opinion, he wrote that "[g]iven the overwhelming evidence supporting Webster's claim, the Plan's decision indicates culpable conduct, if not bad faith." That's strong language by any standard. As a result, the NFL Plan was required to pay Mr. Webster's attorneys' fees and costs in the trial court.

The Plan refused to settle and filed an appeal. But in December 2006, a unanimous three-judge panel of the U.S. Court of Appeals for the Fourth Circuit affirmed

Judge Quarles's ruling in a 35-page opinion. The appeals court held that the Plan "offered no relevant medical or employment evidence to contradict the unanimous medical opinion of examining experts" that Mr. Webster was entitled to full Active Football benefits. Again, that's strong language

The appeals court also found that it would require "a leap of faith" to rule for the Plan. And once again, the NFL Plan had to pay Mr. Webster's estate for attorneys' fees and costs incurred on their unsuccessful appeal. All told, the Plan paid several hundred thousand dollars for Mike Webster's attorneys' fees – money that could have gone for retirement benefits – not to mention the money the Plan spent on its own attorneys. Finally, the judicial system worked for Mike Webster's family – but at a great cost.

II.

MAKING THE NFL PLAN WORK FOR OTHER PLAYERS

I wish I could tell you that the court decisions in the Webster case taught the NFL Plan a lesson. Unfortunately, I cannot. Immediately after the appeals court ruled for Mike's estate, on December 14, 2006, Gene Upshaw, the president of the NFL players' union (who appoints the union's members to the Retirement Board) announced to the New York Times that "if the six-member board was presented with a similar situation with another retired player, it would follow the same course of action it took with Webster." More recently, Mr. Upshaw responded to criticism by a respected former player by threatening to "break his . . . damn neck," according to remarks published in the Philadelphia Daily News.

I also wish I could tell you that Mike Webster's case was an aberration, and that other players have been treated fairly by the Plan. Sadly, that is not the case either. I am sure that you will hear testimony today by and about other retired players and the way the Plan has handled their claims. Since 2005, Bob Fitzsimmons and I have personally reviewed dozens of other players' claims or case files, who sought disability pension benefits based on their football injuries. In too many of these cases, the players appear to have solid claims, which have been wrongly denied by the NFL Plan. The problem for many of these players is that the legal standard is so high – "abuse of discretion" – that they have little or no legal recourse when the Plan makes the wrong decision.

Still, in some cases, even this deferential standard of review will not protect the Plan. In a case that will be filed this week, just like Mike Webster's, the Plan denied active football benefits to a player whose real, disabling health problems trace directly to his on-the-field injuries. Just like in Mike Webster's case, the Plan claimed that the effective date" of his disability should be set years after he stopped playing football. And just like Mike Webster's case, the unanimous medical evidence – including the findings by the Plan's own doctors – shows that this man's health problems go back to the day he was hurt playing pro football.

But obvious, even shocking, cases like this are likely to be the exception, not the rule. Much more common are cases where a clear majority of the medical evidence favors the retired player, but there is a shred of evidence that may be interpreted – if one has a mind to do it – against coverage. In such cases, the federal ERISA statute – as interpreted by the courts – will often favor the interpretation offered by the pension

plan. The courts are fond of saying that it is up to the pension plan to resolve conflicts in the medical evidence, and the NFL Plan has taken those rulings to heart.

My concern that Mike Webster's case was not exceptional, and that the NFL Plan has not turned over a new leaf, is heightened by several tactics that the NFL Plan has relied on in recent years when deciding disability claims. The first is the Plan's creation of a two-person Disability Initial Claims Committee to screen all disability pension claims. (The Plan itself is governed by a six-person Retirement Board.) Every disability claim must be reviewed by this two-person committee. All it takes is one member to rule against the retired player, and the claim will be denied. Then the player is forced to appeal the denial to the entire Retirement Board, which often involves a new medical examination. This adds substantial delay to the process, and increases the risk that the player's claim will be denied in the first place.

The second, related problem, is the Plan's use of multiple doctor reports in an effort to find – or create – conflicts in the medical evidence. In many cases, members of the Plan's Retirement Board or the Disability Initial Claims Committee will vote to deny a request for benefits because they claim to see a conflict in the medical evidence. (As explained above, the courts have been sympathetic to pension plans in many such cases.) Because of the supposedly conflicting medical evidence, the NFL Plan often requires a retired player to undergo multiple medical examinations.

Based on my experience, these examinations have two effects. The first, as I suggested above, is to add substantial delay to the process. The Retirement Board meets only four times a year, and often will not consider claims or evidence that are

submitted a month or so before the meeting. Thus, each new medical report can add three or even six months to the time involved.

The second effect can be even worse. The greater the number of medical examinations, the greater the chance that the Retirement Board will find some piece of evidence – even taken out of context – on which to base a denial of benefits. Recall that in Mike Webster's case, the Board relied on a report from Mike's oncologist to decide that he had not suffered from a brain injury.

The approach taken by the NFL Plan has even extended to relatively small items. Historically, for example, the Plan had required that physicians appointed by the Plan complete a "Physician's Report" form which asked the examining doctor to determine "When did present disability occur?" The point of this question was to determine the date to which disability benefits should be retroactive, so that the retired player can receive all the benefits to which he is entitled. More recently, the Plan has changed its form to delete this question. It's hard to understand why the Plan wouldn't want as much information as possible. The effect, if not the purpose, of this change was to permit the Plan's Retirement Board and DICC to claim uncertainty about the onset date of players' total and permanent disability, and thus to deny them benefits to which they were entitled.

I could go on with examples, but I believe the point is clear: both the procedures at the NFL Plan, and the people who design them and carry them out, are not serving the purposes for which the Plan was created, or the retired players who participate in the Plan. It's essential to remember, as I'm sure other witnesses will tell you today, that professional football is a violent game. Players have short careers. The whole point of

a disability pension for NFL players should be to recognize these facts and also to recognize that many players will need disability pensions and that they have to be substantial. A man crippled by pro football – even after a few years in the league – will often find it very difficult to take on other work.

I'd now like to discuss some of the alternatives that have been suggested to improve the system and make it fair for retired players. Last week, on the eve of these hearings, there was discussion by the union's president, Mr. Upshaw, about changing the standard under the Plan so that anyone found disabled by the Social Security Administration would also be deemed disabled under the NFL Plan. We should always be skeptical about "reform" proposals that are announced at the eleventh hour, and this suggestion requires the same scrutiny – particularly because the details of the change will inevitably be important, and we don't know any of them today. Indeed, the Social Security disability process has itself been criticized by knowledgeable observers as being inconsistent and even unfair

But even if this change made it easier to prove disability, it would still leave decisions about the effective date of the benefits in the hands of the Retirement Board. Those decisions have historically gone against the player, and for reasons that are hard to justify, as in Mike Webster's case. Also, I claim no expertise in Social Security law, but I'm told that employees are typically unable to claim disability benefits more than five years after they stop working. That won't be much help to many of the older retired players. And finally, there have been press reports that the NFL Plan sought to prevent the courts from applying key parts of this very Social Security standard to ERISA plans. At this point, skepticism is warranted.

There has also been some discussion about enhancing the role of arbitration under the NFL Plan to decide disputed disability claims. Currently, the Plan gives the Retirement Board (but not the retired player) the right to use arbitration to decide claims where the Board is deadlocked. I'm not aware of any evidence that this procedure has been used often, or is effective. For arbitration to work, the arbitrators must be fair, neutral, and seen as such by all the participants. Problems can arise when an arbitrator is used frequently by one side to the dispute, or makes his or her living deciding claims presented by one side or the other.

I can see situations in which arbitration might improve the process here. For example, when a retired player's claim is denied, he is often (but not always) required to appeal that decision within the NFL Plan's procedures. Currently, those appeals are heard by the Retirement Board. But what about a system where appeals are heard by neutral medical experts? And to make sure that these arbitrators are actually neutral, what about allowing the player and the Plan each to appoint one arbitrator, and permitting those individuals to pick a third? (To be effective, the Plan would have to pay the costs for the medical experts – but surely that would be less expensive than the attorneys' fees that the Plan pays today.) Such "party arbitrator" systems are often used to resolve commercial disputes, and this approach could work here.

Another problem is the extraordinary delays faced by players who apply for disability benefits. These delays – like the ones experienced by Mike Webster – can stretch to two, three or even four years. A valuable step would be to require the NFL Plan to decide all claims within six months. If the Plan didn't act in that time, the claim would be approved. This would create appropriate incentives to decide claims both

quickly and fairly. Another key change would be to require that the Retirement Board give deference to the views of the retired player's treating physician on both the disability and its effective date.

But long-lasting, effective reform will require more than changing the procedures at the NFL Plan. The fundamental problem here is the lack of commitment to injured retired players. The actions of the NFL Plan, as shown by Mike Webster's case, often seem designed to build barriers to fair treatment for NFL retirees. Until both the league and union decide that they want to spend the required money for benefits, and make sure that all injured retired players can live their lives out in dignity, it is hard to see a lasting solution. The courts have interpreted the federal pension statute to give substantial deference to pension plans in making benefit decisions because the courts assumed that this discretion would be exercised wisely and fairly. Mike Webster's case shows that this assumption was not correct in many instances. The real need here is for new or more enlightened leadership at the top, so that the NFL Plan may finally live up to the promises it has made to retired players.

Thank you for the opportunity to testify today. I would be pleased to answer any questions the members of the subcommittee may have.

Ms. SÁNCHEZ. The Chair is going to declare a brief 5-minute recess, which will be 5 minutes, so don't wander off, so we can impanel our second panel of witnesses. So we will be in recess for 5 minutes.

[Recess.]

Ms. SÁNCHEZ. I would please ask the media to clear the well so we can begin.

Mr. COHEN. Madam Chair?

Ms. SÁNCHEZ. Yes.

Mr. COHEN. I would like to request that Congressman Waters be allowed to be on the taxi squad.

Ms. SÁNCHEZ. Pardon me? The Chair is unfamiliar with the term "taxi squad." could you enlighten her?

Mr. COHEN. Well, that is for folks who can't officially be on the team, but they kind of hang around the team, and if there is an injury, they get to come in sometimes.

Ms. SÁNCHEZ. I believe that that issue will be allowed shortly, if you will indulge the Chair.

Mr. COHEN. Thank you, Madam Chair.

Ms. SÁNCHEZ. It is now my pleasure to introduce our second panel of distinguished witnesses. We have with us this morning—this afternoon rather, Brent Boyd, who will be our first witness. Mr. Boyd was drafted by the Minnesota Vikings in 1980 and remained with the team until 1986. Mr. Boyd has sought disability payments from the NFLPA for injuries suffered during his football career, and has become an advocate for fellow players with problems resulting from head trauma.

Mr. Ditka was inducted into the Pro Football Hall of Fame in 1988. He is a former NFL player and coach. He is the only person in the 75-year history of the Chicago Bears to have won Super Bowl championships as both a player and a head coach. He is currently a commentator on ESPN's NFL Live and CBS Radio Westwood—pardon me, CBS Radio Westwood One's Monday Night Football Pregame Show. I want to welcome you.

We also have with us today Harry Carson, former NFL player for the New York Giants. During his 13-year stint with the New York Giants, one of the longest tenures in club history, Mr. Carson won the NFL Super Bowl championship in 1986 against the Denver Broncos. He is currently a member of the New York Giants preseason broadcasting team, and is a regular season broadcast analyst and cohost of Giants Game Plan.

Lastly we have with us Curt Marsh. In 1981, Mr. Marsh was a first-round draft pick of the Oakland Raiders, and with that team won the Super Bowl in 1983. Mr. Marsh's career was cut short in 1987 due to a severe ankle injury, which eventually led to the amputation of his right foot and ankle in 1994. Following his NFL career, Mr. Marsh worked for the city of Everett in Washington, retiring from that service as superintendent of recreation. He is currently a motivational speaker and writer.

I want to thank all the witnesses on our second panel for their willingness to be with us this afternoon and testify today.

Mr. Boyd, would you please proceed with your testimony at this time?

TESTIMONY OF BRENT BOYD, RETIRED NFL PLAYER, RENO, NV

Mr. BOYD. I can try to work this. Madam Chairwoman, Ranking Member, and Members of the Committee, hopefully before my clock starts, I would like to take a moment for explanation. I do have brain damage, and when under stress the damaged part of my brain receives less instead of more blood. And this qualifies as being under stress, testifying before Congress. But as the doctors say, the harder I try, the harder it gets. So I beg for your patience and understanding. I have a lot to tell you. It shouldn't be much more than 5 minutes. So am I on the clock?

Ms. SÁNCHEZ. We understand. We will begin your time now, and if you need a little extra time, be assured that you will receive it.

Mr. BOYD. Thank you.

Well, now that they put the lipstick on the pig, I want to tell you what the reality is for the NFL disabled players. First of all, thank you for inviting me, and thank you for having the courage to take on the rich and powerful NFL. It is my hope that these are the first of many hearings, with the end result being a punishment of the corruption of Gene Upshaw, Tom Condon, and Groom Law, and drastic changes ordered upon the National Football League.

My name is Brent Boyd, and I played for the Vikings from 1980 to 1986. I am on Social Security disability for football-related concussions. I am here today with my wife Gina, a mechanic for the U.S. Postal Service, and my 18-year-old son Anders couldn't make it. He is a firefighter in training, and is fighting wildfires this summer for the BLM. And I think he is up at that big Tahoe fire right now, so I am more scared about that than anything else. My son, however, has been the biggest victim of this crime.

Tom Condon and Doug Ell have purposely, maliciously caused great harm to us, using their tactics of delay, deny, and hope that I put a bullet through my head to end their problem. My written statement gives great detail about the travesty of this fraud and corruption, so I hope you read it, and I recommend to those listening to read my written statements.

I was always an overachiever, straight A student in La Habra, California, graduated with honors from UCLA. I was drafted in the third round by the Vikings. These accomplishments took a great deal of hard work and dedication, and full mental capacity, qualities that would be washed away by NFL concussions.

The NFL is hoping I go away and die, delaying and delaying benefits, while all the reports were in my favor. Meanwhile, I want to point out to everyone it was a group of Major League Baseball players who came together to keep a roof over my son and I when my son was in elementary school and then kept us alive. Baseball agent Barry Axelrod gathered a group of baseball greats, including Mark Grace, Rick Sutcliffe, Jeff Bagwell, as well as former Bruins Bill Walton of the NBA and his brother Bruce. And I was kept spiritually alive by North Coast Presbyterian Church of Encinitas, California.

There are too many details to fit in this 5 minutes, but it took in 1999 for doctors to link my symptoms to concussions. Brain scans have located the exact location of that brain damage. The NFL is trying to distance themselves from liability for all the car-

nage left behind by our NFL concussions, just as tobacco companies fought like hell to deny links between smoke and cancer. I filed my claim, and I was told by the NFLPA not to bother filing, and here is the quote, because the owners will never open that can of worms by granting a claim for concussions. Shortly after that statement, my Vikings medical files disappeared. I believe Groom Law had destroyed any contemporary—that word——

Ms. SÁNCHEZ. Contemporaneous.

Mr. BOYD [continuing]. Contemporaneous evidence to clear the path for their manipulation of this process. Just for time I am going to leave out—I hope you ask me details of the first two NFL doctors they sent me to, because they both enthusiastically approved my claim. So I will cross that out because of the time. But they sent me to their own neurologist; totally approved my claimed, checked the boxes, yes, that my concussions were NFL-caused. And the second psychiatrist was equally enthusiastic. And I understand their own neurologist voluntarily called me back for a second day of testing because he suspected I had vertigo as a result of my concussions, and on his own he brought me back a second day and confirmed that I do have vertigo.

Condon and the NFL were told that, but that meant absolutely nothing to the Disability Board. They only seek reasons to deny a claim, not to approve a claim. They did agree on I am totally and permanently disabled, but despite the overwhelming evidence before them to the contrary, they only gave me the lowest nonfootball-related disability.

After an 8-month lull, which I was reliant on charity, they insisted I see Barry Gordon of Johns Hopkins and only Barry Gordon of Johns Hopkins. They wanted this expert in autism to act as a concussion expert and give me a very complex neuropsychological exam. But Gordon didn't give me this exam I was flown coast to coast for. Instead, this is important, this was a test that was going to decide the fate of me and my son. It was given to me by a young linguistic student named Laura Atalla, who told me she had never seen this neuropsychological test until the day before, took it home and practiced it on her boyfriend. This is a test that should be given by a Ph.D. and neuropsychologist. Her tests were paired with Barry Gordon's written opinion, ridiculous as it is, that concussions could not cause headaches, concussions could not cause depression, dizziness, or fatigue.

Now my case, which at this point had stretched out for years, while all doctors' opinions were in my favor, was denied within days. After the ninth circuit, I found a medical journal from 1990 with an article by our same Barry Gordon of Johns Hopkins. This time he wasn't paid by the NFL. This was an independent medical research. His research says that my same symptoms, right there in the first paragraph, are the most common symptoms of concussions. And he makes it easier for you by creating table 1, a chart, and all my symptoms that he wrote for the NFL weren't possible to be caused by concussions, when he is writing for a review by his medical peers are now suddenly the most common symptoms of concussion. If that is not proof of fraud and corruption, then we need to remove the words "fraud" and "corruption" from our vocabulary.

I hope to answer questions and thank you.
Ms. SÁNCHEZ. Thank you, Mr. Boyd.
[The prepared statement of Mr. Boyd follows:]

PREPARED STATEMENT OF BRENT BOYD

Madam Chairwoman, Ranking Member Cannon, Members of the committee

My name is Brent Boyd. I played for the Minnesota Vikings from 1980–86. I am a native Southern Californian, was raised in La Habra, CA, graduated WITH HONORS from UCLA and am a proud resident of Reno, NV since 2002. I am here today with my wife Gina, who is a mechanic for the U.S. Postal Service. My 18 year old son Anders couldn't come, he is home fighting wildfires for the BLM. I am on social security disability due to my post concussion injuries from the NFL, but receive only the minimum "non-football related" disability benefits from the NFL.

First of all, Thank you for having the courage to hold these hearings. It's long overdue and I am sure what you hear today will lead to immediate further hearings and big changes demanded by Congress onto the NFL leadership. It's high time to expose the corruption of the NFL Disability Board, especially with Groom Law Firm's absolute power and members like Tom Condon, whose unforgivable co-chairmanship is responsible for all this needless suffering that lead to you calling this hearing.

I would also like to thank Jennifer Smith and the Gridiron Greats for making my travel here today possible. We could never have afforded to be here and I am grateful for their assistance.

I am here today because I have a remarkable but true story about my claim denial, doctor shopping and fraud. And betrayal by the League I love. My case also involves the subject of concussions. Just like the tobacco companies fought like hell to deny any link between smoking and cancer, the NFL is desperately fighting to avoid any liability for all the carnage left behind by these NFL concussions.

Joe Montana was recently asked about my NFL concussions disability claims denial by Mike Sullivan of San Diego's North County Times,

"Once they say there's an issue, then they have to fix it," Montana said. "As long as they never admit that there's one, then they never have to fix it.

"They're never going to admit it because then they have to go about and try to correct it."

End quote

I am here to illustrate for you how the NFL disability process is corrupted, how Tom Condon, Gene Upshaw, the NFL, and Doug Ell of Groom Law orchestrate these fraudulent decisions, and I am sure if I can walk you thru my experience you will get a feel for the travesty that has befallen countless other disabled players.

Before I get to the details of my case, I would be remiss if I didn't point out to you that another loser when we are denied benefits are the hard working American taxpayers. These 32 NFL billionaire team owners hire their "dream team" of attorneys to get them out of paying their legal obligation. So we are then cast upon the taxpayers, thru Social Security and Medicare, and our communities through local charities and churches. The same Taxpayers who are already paying for the stadiums they can't afford to go watch a game in, are the poor people stuck with the bill every time the NFL's money buys them a disability denial in court.

Plus, our court cases set legal precedents that make it harder for the average truck driver, saleswoman, office worker, mechanics and so on to ever collect a disability claim. The NFL Disability Board isn't just sticking it to football players, they are sticking it to the American workers and taxpayers as well.

My concussions started in August 1980 . . . that was one of only God knows how many concussions I suffered. This one sticks out in my memory because I temporarily lost sight in my right eye and became very frightened. We didn't even count concussions or keep track of them back then, a concussion was not considered a serious injury, as opposed to an injury to a weight bearing bone. A concussion was a "nuisance" injury, like getting hit in the funny bone. It's a pain in the butt, hurts like heck for a while. But like a hit to the funny bone the symptoms faded away soon and you never considered it again once it subsided . . . you surely didn't think getting "dinged" was going to affect you the rest of your life, and in fact in my case, destroy my life

A little background info about myself first,

I was an "A" student growing up in La Habra, CA.

A month prior to going to my first NFL training camp, I graduated WITH HONORS from UCLA, June 1980. That took a tremendous amount of drive and determination. I was drafted in the third round to Minnesota, a feat which also requires

a great deal of effort and self sacrifice. My whole life up to that point was of hard work, dedication, and an ability to set goals and successfully reach them.

As a rookie, we had only nine days between the start of training camp and our first exhibition game. We didn't have all the off-season practices they have today. In those nine days as a rookie I was able to learn and play all five offensive line positions, something I'm told hasn't happened often if at all in the NFL.

The end of that month was when that first concussion occurred in a preseason game in Miami, that's the concussion I remember most because of going temporarily blind, but there were so many more in the seven years that I played.

When I complained to the medical staff about headaches, I was told it was from the anti-inflammatory medications I was taking for my knees. Mainly a drug called Indocin, which was notorious for giving headaches but worked miracles on injured knees. I kept asking for a brain scan because of my headaches. . . . I think I was more afraid I had a brain tumor, because I was never told my concussions would have these long lasting effects. I was always denied the brain scan.

Upon being released mid-season 1986, I was given an "exit exam". I was released because of poor performance and lackadaisical effort. I had been complaining of a sore leg all season, and was told it was just shin splints. On my exit exam I asked for both a leg x-ray and a brain scan.

Again, I was denied a brain scan for headaches, but was granted the x-ray. The leg x-ray showed I had been playing eight weeks on a broken leg. This was never announced to the media or my coaches or teammates, they were left to think I was dogging it, physically with my leg and mentally with my inability to retain plays and keep the energy and focus required to play in the NFL.

I continued to take Indocin until the mid to late 1990's, dealing with the headaches but still believing it was from Indocin. When I stopped taking Indocin, my headaches never subsided.

I tore my knee again around 1996 while playing with my son at Disneyland, and had more surgery. A friend told me about the NFL disability plan and said if anyone qualified, I might because of my knee. In 1996 or 97, I called the union, Miki Yaras-Davis helped me write a letter, and they sent me to a doctor, who said I didn't qualify. I left it at that, I thought this was some informal process between ex-players and NFLPA. I don't believe I even submitted my own doctor's reports, it was not presented to me as any legal thing, I was never told to get an attorney or about this behemoth called ERISA that a few years later would rule my life. I simply asked if my knee qualified, they said no, and that was that. I didn't even know I was allowed to appeal.

After a life of hard-driven success, suddenly the 1980's and 1990's were nothing but one failure after another for me. I couldn't concentrate, I always felt sick—dizzy, a little nauseous, and always very tired. I had a splitting headache that never went away, but was eased through self medication. In the 80's, before the news my son was conceived, I was like many 20-somethings and used cocaine, in my case I was desperate for the energy to make up for my fatigue. (my cocaine use was stopped for good in 1987 with news of a son on his way.)

And the alcohol numbs my headaches and physical pains.

I spent years searching for a medical answer, doctors could find nothing wrong below the neck. They were also trying to treat depression, which they came to believe was the cause of my fatigue . . . over the years I took every anti-depressant in every dosage and in every combination with other drugs.

I stopped drinking for many years with no positive change in my symptoms.

From mid to late '90's I was checked for every form of cancer, and had every organ x-rayed, MRI'd and ultrasounded. I had tubes and cameras stuck up both ends.

After years of hoping to find relief but not getting any better, one day one of my psychiatrists told me a probable reason NONE of these drugs had any effect could be if I had an organic brain injury. He then asked if I ever had a concussion? That was in 1999, and that was the first time any doctor had ever asked me about concussions.

I was sent to neurologists and had brain scans and SPECT scans and all kinds of testing done. The scans showed the exact location of the brain injury, and they explained how the areas damaged correlated to the symptoms I was having, both the temporary loss of sight in 1980 and the lingering symptoms of depression, headaches, fatigue, dizziness. They said the concussions also gave me "trauma-induced A.D.D."

I was relieved to find a medical cause after all those years. For over 15 years I had been stung by words like "lazy", "crazy", "alcoholic" , "failure", and all this was from my loved ones! My employers were even harder on me. Worst of all, I came to believe it myself. I thought my failures were from a character flaw.

I lost my home , my car, my first marriage, and job after job after job. I was then a single father, and we were scrambling for a roof over our heads. (I divorced in 1992, and was a single Dad until marrying Gina in 2004) We lived in some nice places sometimes, but we were homeless at others. We lived in cheap motels and even had to pitch a tent in a campground more than once.

My son went without getting his needs met, my son Anders is the REAL victim of this crime. Even in the years after we filed our disability claim, and the NFL knew we were in dire straits, my son lost teeth because of lack of basic dental care, he had a significant vision problem that needed surgery in kindergarten and glasses thereafter. He went to school every day with old beat up scratched glasses that no man could see thru. He has learning disorders that I could not afford tutoring help for, and he was always grading poorly in school.

But this kid has tenacity, he still showed up to school everyday with a smile, did homework without argument, got straight "O's" for Outstanding citizenship but D's and F's for the class grade. He never quit, never gave up, never gave in and took up drugs or any of the temptations of this era . . . and he is now a fine young man, a high school grad in 2006 and a fireman in training. He is spending this summer fighting wildfires for the BLM. My son Anders has suffered so greatly , so much of it purposefully at the hands of Tom Condon and the NFL, and I love and admire him for his perseverance.

When I think of what the corrupt NFL Disability Board needlessly put my child through is when I get my angriest!

We did get help from the NFL Players Assistance Trust, but it was $5,000 that could not be given directly to me. It helped pay past doctor bills, yes, but it did not alleviate the stress and fear of where would we sleep tomorrow and how was I going to feed and clothe my son.

Now to what I'm here to describe, the fraud and corruption of the NFL Disability process.

Once my team of treating doctors concluded clearly that I had suffered organic brain damage from NFL concussions, and that I was total and permanently disabled, we filed my claim with the NFL. I was helped by a good friend and fellow UCLA alum Barry Axelrod. Barry is both an attorney and a prominent sports agent, but he was neither to me. He was just a friend helping a friend, for free. We submitted piles of doctor's reports and brain scans.

Upon filing my claim, I was told by Miki Yaras-Davis of the NFLPA not to bother filing, her exact words were "the owners will never open that can of worms" by granting a claim for concussions.

Shortly after that, my Vikings medical files mysteriously "disappeared". The courts were never made aware of this. Medical files are sacred to a player, we were not ever allowed in the same room with them. We had to trust that after our career the NFL would store the files and present them in the event of a claim.

In essence, they destroyed the evidence that would have easily proven my claim. The 9th circuit would mistakenly hold that against ME, not them, and said without any contemporaneous notes the disability board could send me from one doctor to another.

There were contemporaneous notes, I believe Groom Law destroyed them to clear their path for manipulation of the process.

Now starts the process of seeing an NFL doctor to see if he agrees or disagrees with my claim. I am living in San Diego, they send me to an NFL chosen neurologist in San Diego, Dr J Sterling Ford. Dr Ford not only totally agrees with my doctor's and approves my claim, this NFL doctor voluntarily asks me to come back a second day to test for vertigo, which he suspected I was suffering as a result of the concussions. His testing confirmed his suspicions; according to the NFL's own neurologist I do have vertigo caused by head injury.

So at this point we have several of my treating physicians and the NFL's own doctor all agreeing, we feel that will mean automatic approval.

Barry Axelrod organizes a group of his Major League Baseball clients and friends and other UCLA alumni to create a charity to move my son and I out of the cheap motel we were living in and into an apartment near his school. They believe, with all of this overwhelming evidence in my favor, it will only be a matter of weeks until the next Board meeting that they will need to support me. There was no way I could be denied my claim! These guys were not doing this for publicity, quite the opposite. The individual identities of this group from 2000–2002 was not known to me, other than Barry Axelrod, until last February's ESPN report.

The group included the great baseball players Mark Grace, Rick Sutcliffe, Jeff Bagwell; actor Mark Harmon, NBA legend Bill Walton and his ex-NFL player brother Bruce, and many others. Without the help of these guys, I would not have survived to be here today. Along with Pastor Don Seltzer and the folks at North Coast

Presbyterian Church in Encinitas, CA. They cared about my son and me, . . . while at the exact same time the NFL didn't give a damn if we died, in fact they hoped I would put a bullet in my head and solve their problem, and were busy scheming a way to deny my benefits.

The NFL decided not to listen to their own first doctor, because his opinion was in favor of a player, so the NFL selects a second doctor of their own choosing, this time a psychiatrist in Long Beach, CA. His name is very long, Dr. Branko Radisavljevic, but he says to call him Dr. Branko.

Dr. Branko enthusiastically supports my claim, and joins every other doctor to this point . Every doctor had the same opinion, it was all one voice that included my own doctors and now *TWO* NFL doctors. Unfortunately for Condon and Ells, all these reports were FAVORABLE to a disabled player . . . that's no good. . . .

The Board meets every 90 days, we know there is no way they can delay approving my claim any longer . . . but instead my case is "tabled" at their next meeting, meaning 90 more days of stress. Only the next meeting doesn't bring approval either. That means 6 extra months now of relying on charity to survive.

They DO decide at this point that I AM totally and permanently disabled and begin giving me the $1500/mo "non-football" related disability, Despite the glaring fact that every doctor had said it was concussions that caused my suffering. But remember, they don't want to admit it is concussion-related, they "don't want to open that can of worms".

So after an eight month delay to give them time to buy a doctor, and 8 more months of relying on charity to survive, I am forced to travel from San Diego to Baltimore to see Barry Gordon at Johns Hopkins. The reason given is they wanted me to take a sophisticated neuropsychological exam. I can take this test at any neuropsychologist in San Diego , as Social Security sent me to when they approved my disability claim for post-concussion . . . but they insisted I see Gordon and *ONLY* Gordon. If I refuse or hold out for another doctor, I am told, I am denied.

Gordon is not on the list of pre-approved "neutral" physicians normally used by the Board, he is hand picked by Doug ells of Groom Law. Gordon is also walking distance to NFL Benefits headquarters in Baltimore. Axelrod and I smell a rat, but we have no choice, if I don't go I am denied anyway, they will not agree to a doctor in Southern California.

So, I arrange for care for my son, they fly me coast to coast, pay for taxis, meals, hotels, even replaced clothes when my luggage was lost.

They went to ALL that expense, but they didn't go to the most important expense, HIRING A NEUROPYSCHOLOGIST to give me the test. This test takes years to understand the nuances and complexities, and, especially in cases with legal ramifications, should only be given by someone with a PhD, . . . a *neuropsychologist!*

I thought Gordon was going to be giving me the test himself, that's why all the bother to fly across country. But I wind up seeing him for only about 30 minutes. He bangs my knee with a hammer, tickles the bottom of my feet, and conducts tests I now am told by neurologists were just for show and his tests only tested the NERVE ENDINGS, not the brain.

Barry Gordon writes in his report that "the records available to me are incomplete in ways that may be relevant for my impressions." He also admits he didn't bother to look at the existing brain scans and ordered none of his own. This is like diagnosing a broken leg without seeing an x-ray—he was deciding my fate by opining on a body part he never bothered to look at!

Instead of hiring a neuropsychologist to give me this neuropsychological test they deem SO important to deciding my case, this neuropsychological test was instead given to me unsupervised by a young grad student in LINGUISTICS, with no medical background. Her name is Lara Atella.

Lara Atella keeps apologizing and laughing, she keeps telling me she had never seen this test until the day before, and she took it home to practice on her boyfriend. I spend 99% of my time in Johns Hopkins with Lara, and am sent home wondering why I didn't see much of Dr Gordon.

Atella's test result was paired with Gordon's ridiculous report stating that my symptoms of headaches, depression, dizziness, and fatigue *COULD NOT* BE CAUSED BY CONCUSSIONS!

Let me repeat in case you didn't grasp that—concussions *COULD NOT* cause headaches!

Does anyone REALLY believe that?

This process has been stretched out years when all the doctor's reports were in my favor.

Armed with a report unfavorable to a player, Within DAYS I am immediately denied my claim by a unanimous vote. Upshaw and his appointees, Tom Condon and Jeff VanNote, and Len Teeuws, my advocates in those Board meetings, never said

a word of protest . . . at this point they should have been screaming bloody murder, crying out this is a bunch of bull, and insisting this fraud stops right there. You know, advocating! Doing their appointed duty!

None of this could have been possible without the FULL knowledge, cooperation, and participation from all sides on the Board. Commisioner Taglibue, Upshaw, the NFLPA, and especially Tom Condon and Jeff VanNote. And it was all masterfully orchestrated by Doug Ell of Groom Law Firm, located at 1701 Pennsylvania Ave across the street from the White House.

What's worse, as my only advocates allowed in Board meetings, Condon and Upshaw and Upshaw's other appointees never once, including to this day, returned my phone calls, letters or emails. Or made any effort to understand my case. They simply followed orders from Doug Ell and Groom Law.

They will tell you they found the first two NFL doctor's reports 'equivocal". I have spoken with those two NFL doctors since, and they are furious I was denied and furious they were characterized as equivocal. I hope you can subpoena them. These doctors will tell you NO ONE , not even my advocates, had ever called for clarification. The NFL couldn't risk clarifying, they didn't want the truth. It was easier to wait 8 months and fly me cross country than to pick up a phone?

As they teach in law school, don't ask a question if you don't want the answer.

If you read Dr Gordon's report, you will find a gold mine of equivocalization. The fine tooth comb used by Groom Law to play semantics with doctors who approved my claim is suddenly missing when a report supports denial

Not only that, but the first two doctors filled out the required NFL questionnaire. This is where they avoid confusion and are asked to check boxes simply yes or no. Both Ford and Branko checked "yes" to the questions " am I disabled from an injury" and "was this injury a result of playing football" Both checked Yes. Period. Case closed.

Despite many demands on record from NFL Benefits Office to Gordon to attach his questionnaire to his invoice or he wouldn't get paid, he never filled that form out. And he was paid. That leaves HIS report incomplete. Gordon never answers the question "is my disability "football-related"!!!

Gordon's report gives possible alternative reasons for my symptoms, which included chronic pain and other football-related causes, so maybe he still could have checked the box "yes" when asked if my disability was football related . . . all he said was it was impossible to link headaches with concussions. We still don't know Gordon's answer to that question!

Wait, you think this is bad enough already? Here's where it gets even better. . . .

The most important and most damning proof of fraud and doctor shopping comes from *Dr. Gordon* himself. After my 9th circuit case, I found this 1990 medical journal, containing an article by our same Barry Gordon. It's titled "postconcussional syndrome". You only need read the first paragraph to see he is adamant that my symptoms, headache, depression, dizziness, and fatigue are *THE MOST COMMON SYMPTOMS* of post concussion. He even makes it easier for the reader, he creates a chart, table 1, titled "most common symptoms of post concussion" . . . right there in that list are ALL of my symptoms, the same symptoms, that when paid by the NFL he wrote were impossible to link to concussions.

His article also says he orders a brain scan "in essentially all patients". He didn't go to that bother with me.

If that's not proof of fraud and corruption, than we need to remove the words fraud and corruption from our vocabulary.

The only reason they aren't in jail is that there are some holes in Federal Laws that you in Congress need to fix to help EVERY American worker, mainly the "full discretion" allowed to the Board, and you need to return the "treating physician rule" removed from law by Grooms Law Firm's secret intervention in Supreme Court "Nord v Black and Decker" (my attorney was on the losing end of that decision).

The NFLPA fiercely tries to claim no responsibility in our claim denials. Here is a quote from Feb. 11, 2007 ESPN article on my case by John Barr and Arty Berko, that accompanied their story on me on ESPN TV's "Outside the Lines", catching Gene Upshaw in flat out lies:

"While nobody from the NFLPA would speak with ESPN about Boyd's case, NFLPA Executive Director Gene Upshaw did address Boyd's allegations at a recent news conference.

"To say that the NFLPA is 'doctor shopping,' we don't have anything to do with it, with the process," Upshaw said.

The facts say otherwise. The retirement board, the ultimate authority on disability cases, is made up of three league and three union representatives. To say the union has nothing to do with the process is simply untrue.

Upshaw went on to say, "If a doctor determines that a player is entitled to a disability and he meets the standards he gets it."

But in Boyd's case, two doctors, chosen by the retirement board, determined his disability was football-related and his claim was still rejected."

End quote

The NFLPA is quoted recently as saying they were only doing what ERISA demands them to do. In other words, "The devil made them do it!" Nonsense. ERISA demands that they look EQUALLY as hard for evidence to APPROVE a claim as they look for evidence to DENY a claim. That *clearly* is not happening in the NFL.

The real "devil that made them do it" is in reality Doug Ell and Groom Law, with their scorch and burn , leave no witnesses, win at all cost strategies.

This NFL Disability Board has blinders on and only seeks reasons to DENY.

Courts are hogtied by the "full discretion" wording, and the absence of discovery and depositions in ERISA cases. Only you in Congress, with your oversight of the NFL, and your gifting of anti-trust exemptions, and your power of subpoena under oath, can fix this scam.

ERISA gives the Board "full discretion", which is the opposite of what they are claiming now in public. Instead of LIMITING their options, "full discretion" gives the Board the widest possible range of options possible. The only restrictions on their "discretion" are what their stomachs and conscience had handle.

ERISA does not "force" the Board to ignore evidence supporting players' claims, nor to draw up elaborate doctor shopping schemes to defeat them, as Dave Duerson recently hinted. (Duerson is the newest robot member of the Board)

Congress gives the Board "full discretion" through ERISA, which gives the Board absolute power. *AND WE ALL KNOW THAT ABSOLUTE POWER CORRUPTS!* Please eliminate the "full discretion" wording in ERISA.

A 1994 OSHA study said life expectancy for NFL players is 55 years, 52 for linemen . . . that is why Condon and the Board's tactics are to "delay, deny, and hope we die . . ."

I beg this Committee to hold further hearings, subpoena Tom Condon, Gene Upshaw, Doug Ell, Paul Tagliubue, and Barry Gordon. Clean house in the NFL Disability Board, punish Groom Law and Tom Condon and Gene Upshaw for their conflicts of interests and selfish greedy actions

And most of all, someone FINALLY hold the NFL/NFLPA accountable for all the needless suffering that their blatant doctor shopping and fraudulent claims denials have caused countless NFL retired players.

I also welcome questions regarding "88 Plan".

I have emailed several attachments to my testimony and ask that they all be officially included in the record.

Thank You,

Ms. SÁNCHEZ. And I am going to ask unanimous consent that the article that was written by Dr. Gordon be included in the record as well.

[The information referred to follows:]

ARTICLE WRITTEN BY BARRY GORDON, M.D., PH.D., SUBMITTED BY THE HONORABLE LINDA T. SÁNCHEZ

"minor" head injury. The most important element in the management of these patients is the recognition that there is usually an organic, pathologic basis for their complaints, at least during the early postinjury period, and that it usually resolves over a few months. If mismanaged, however, these patients often develop an overlying neurosis that makes evaluation and management infinitely more difficult. There is nothing more frustrating to the intelligent minor head injury victim than to be told by his physician, his family, and his employer that there is "nothing wrong." Proper counseling should therefore include not only the patient, but also the family, school, or employer. Early in the course of treatment, MRI, auditory-evoked potentials, and specific neuropsychologic tests such as choice reaction time can help delineate the deficits.

The basic elements of the postconcussion syndrome are cognitive, somatic, and affective. Clinically significant neuropsychologic impairments have been documented repeatedly, even after minor "dings" without loss of consciousness. In one large recent study, the most frequent somatic complaints were headache (71 percent), decreased energy or fatigue (60 percent), and dizziness (53 percent), all of which markedly improved at 3 months. The proper management of the "fatigue" element is a major factor in recovery which may relate to orbitofrontal injury and which requires the cooperation of the school or employer. We suggest a graded return to a full work load over a period of 4 to 8 weeks.

PATIENT RESOURCE

National Head Injury Foundation, Inc.
P.O. Box 567
Framingham, MA 01701
Telephone: (617) 879-7473

POSTCONCUSSIONAL SYNDROME

BARRY GORDON, M.D., Ph.D.

DEFINITION, PATHOPHYSIOLOGY, AND CLINICAL COURSE

Postconcussional syndrome (PCS) describes the clusters of symptoms that frequently occur after minor closed head injury or other causes of head acceleration-deceleration. PCS is somewhat misleadingly named. An individual need not have had a concussion to develop PCS. No loss of consciousness or temporary lapse of cerebral function is necessary. Any sufficient blow, fall, or acceleration-deceleration movement of the head (such as whiplash) can cause PCS. Nor is PCS a single syndrome. Instead, it represents the co-occurrence of a variable mixture of symptoms caused by distinct underlying problems (Table 1). Although different combinations of these symptoms appear in different individuals, overall, headache, fatigue, and dizziness are the most common symptoms.

PCS is not usually a nonorganic "compensation neurosis" or "accident neurosis," or frank malingering. Many of the symptoms of PCS can be plausibly related to organic pathology. This has been established by animal studies, occasional human clinicopathologic correlations, and human clinical research. Although exact correlations are uncertain, it does appear that different types of injury give rise to different types of lesions, which in turn may have characteristic symptomatology (Table 2).

Table 1 Symptoms of Postconcussional Syndrome*

Headaches
Blurred vision
Double vision
Dizziness
Unsteadiness
Vertigo
Poor coordination
Neck pain, aching, stiffness
Slowed thinking
Effortful thinking
Difficulty concentrating
Difficulty sustaining concentration
Inability to divide attention
Distractibility
Sensitivity to noise
Increased sensitivity to lack of sleep, fatigue, stress
Increased sensitivity to drugs, alcohol
Poor memory (new learning)
Poor memory (recall of old information, such as names)
Lack of energy
Decreased drive or initiative
Easy fatigability
Depression
Anxiety
Poor appetite
Emotional lability
Irritability
Impatience
Loss of libido

*Symptom checklist. These include both primary and secondary symptoms of PCS.

Table 2 Clinicopathologic Consequences of Mechanical Injury

Nature of Force	*Type of Injury*	*Site(s)*	*Symptoms*
Acceleration-deceleration (esp. rotational)	Diffuse axonal injury (axonal shearing, tears)	Midbrain Superior cerebellar peduncles Corpus callosum Central white matter	Loss of consciousness Impaired concentration, ataxia
	Cortical contusions	Site of injury (coup) Opposite side (contrecoup) Bilateral but asymmetric Frontal lobes Polar, orbital Temporal lobes Anterior pole Lateral Inferior	 Distractibility Personality change
Acceleration-deceleration		Labyrinth Cervical mechanoreceptors Central vestibular connections	Dizziness, vertigo, unsteadiness in space
Acceleration-deceleration	Stretch, strain	Blood vessels Sympathetic vasoregulatory systems (also, 2° to structural effects)	Headache
		Cervical ligaments Cervical muscles Cervical spine	Neck aches, pain, dizziness
Impact trauma			

As expected, in minor head trauma, there is a rough proportionality between the severity of the mechanical injury and the severity of the resulting tissue injury. A sufficiently small mechanical force will be buffered enough so that the brain escapes injury. However, once a force is great enough to cause unconsciousness, the duration of unconsciousness, whether momentary or as long as 20 minutes, seems to have little relation to the incidence and severity of any subsequent PCS.

Psychic problems can result from the mechanical injury as well. Some of the psychic components of the PCS may well prove to have a primary, organic basis; irritability and decreased drive are perhaps among the most likely candidates. However, many problems are secondary, a reaction to the primary impairments and to the disruptions they have caused. Patients develop an understandable sense of anxiety, depression, frustration, hopelessness, irritability, and a tendency toward withdrawal. These may be aggravated by misinformation and inaccurate expectations. Patients may be misleadingly told their brains are irreversibly damaged or that every problem of daily living can be blamed on their injury.

After the injury, several days may pass before headaches, dizziness, and vertigo become apparent; it may take days to weeks for anxiety, depression, and irritability to appear. The frequency and time course of recovery are still debated in the literature. However, it appears that in most patients (>70 percent) and perhaps in the vast majority of those with uncomplicated head injury, problems resolve within 3 months, and often sooner. In those individuals with longer-lasting problems, improvement can still occur within months and even 1 to 2 years or more after the injury is sustained.

Some of these patients with persisting problems may represent those with more significant injury, while some may simply have greater biologic susceptibility. In others, recovery is delayed because of emotional reactions to the disruptions the injury has caused. This situation does not as a rule resolve when any legal or compensation issues are settled. Psychological stress caused by reaction to the other components of PCS is one of the major causes of the persisting disability that can occur.

Prior head injury also increases the likelihood of more severe, longer-lasting problems. Alcohol or drug abuse compounds the problems and may even aggravate them.

PREREQUISITES FOR TREATMENT

Time is generally the best healer for patients with PCS, and for some, the only effective one. The physician's task in treating PCS is threefold: (1) to make an accurate diagnosis; (2) to educate the patient about his condition so that he or she can better cope with it while it resolves (and also so that he or she can resist external influences that may magnify the problems); and (3) to treat symptoms when possible and to suggest ways in which the patient may mitigate the effects of those that cannot be treated.

History

The patient's own recollection of the injury is often suspect; corroboration is necessary from witnesses and from the early observations of the ambulance crew and emergency room team. Pertinent questions include the following: What was struck and how? Was the patient unconscious? If so, for how long? If the patient could not remember new events after the injury (post-traumatic amnesia), how long did it take for connected, day-to-day memory to return? (The latter is the usual measure of the duration of post-traumatic amnesia.) What are the patient's symptoms, and how did they evolve? What was done to diagnose the condition (e.g., skull x-ray examination, computed tomography [CT], magnetic resonance imaging [MRI], or electroencephalography [EEG])? Does the patient have any predisposing factors (prior head injury, a history of drug or alcohol abuse)?

It is also critical to understand the patient's mental state and social and emotional environment. What is the patient's understanding of his or her condition? What has the patient been told (by concerned friends as well as by health professionals)? What does he or she think is "going wrong?" Does the patient believe he or she is crazy? (Not infrequently, patients will start recounting their problems with, "I know you won't believe me, but. . . .") What are the patient's expectations regarding recovery? Has he or she set a timetable to go back to work? What does the patient's employer and/or family expect from him or her? (A professional can often delegate or defer the demands of his job; a blue-collar worker usually cannot.)

I have patients complete an extensive written history before their visit or in the waiting room. This includes a history of present illness, a symptom checklist (see Table 1), a past medical history, an education and employment history, and a mood assessment. This questionnaire gives the patients a chance to organize their thoughts and to tap other sources (such as their family) for information they may not remember. It also gives them a chance to checklist a detailed review of symptoms and expand on positive areas. During the direct interview, this information is rechecked and augmented as necessary.

An accurate history may support the diagnosis of PCS by establishing the occurrence of a significant head injury and early symptoms and signs. Conversely, some patients presenting with what at first seems like PCS may never have had a head injury or only truly trivial mechanical taps. Other etiologies should be suspected in these patients.

Physical and Laboratory Examinations

The basic rule of the physical and laboratory examinations is that the earlier they are performed, the more likely they are to confirm evidence of organic impairments. Although it may not be crucial to document physical abnormalities, it is often useful to do so. Patients will thus have reassuring confirmation that they are not imagining their symptoms. This may be equally reassuring for their physicians, since the symptoms of PCS are so subjective and subtle. Also, it is useful to perform an evaluation early to rule out other conditions, such as intracranial hematomas (for which there is a risk of approximately 3 percent). Finally, since a large percentage of cases raise legal questions regarding the nature and extent of the injury, the objective evaluation is often more persuasive evidence than the patient's subjective complaints.

The neurologic examination of these patients should include mental status testing, testing of extraocular movements and vestibulo-ocular suppression, and the Bárány maneuver. I obtain an MRI in essentially all patients. CT is less sensitive for demonstrating the direct results of injury, although it is still a good screen for other conditions. For those patients with complaints of blurring of vision, dizziness, vertigo, and unsteadiness or ataxia, I recommend vestibular function testing (including testing for visual fixation suppression of the vestibulo-ocular reflex) and brain stem auditory–evoked responses (BAERs).

For patients who complain of impaired attention and/or concentration, slowness of thinking, poor memory, or other mental complaints, I recommend a formal neuropsychologic examination. The main purpose of the neuropsychologic testing is to distinguish the deficits directly related to the injury from those caused by depression and anxiety. Less commonly, the testing helps establish malingering or a nonorganic cause for the patient's distress. Such would be the case, for example, if the patient claims near-total memory loss, yet is found to be deliberately choosing the wrong answers on memory tests. The testing is also useful in providing a baseline, should the patient's symptomatology worsen. It is worth noting that because the primary deficits expected from PCS are relatively subtle changes in attention and/or concentration, new learning ability, word retrieval, and judgment, valid problems may not register on the testing. Also, many of the complaints of PCS, such as difficulty with divided attention, are not well tested by current clinical examinations. In this case, a negative examination cannot count as evidence against there being an organic cause of the patient's symptoms.

Although regional cerebral metabolism and/or blood flow measurements may prove to have clinical utility in the study of PCS patients, at present they are still experimental tools. Because of uncertain standards for normalcy, brain electrical activity mapping (BEAM) and long latency cognitive-evoked potentials (P300's and similar measures) are

not yet clinically useful in any individual patient. Thermography may be useful in making the subjective complaint of headache more plausible.

TREATMENT OPTIONS

I use the approach to evaluation and treatment of PCS outlined in Figure 1.

Patient Education

Patients are typically bewildered by their condition. Their overt injury was mild and their bruises are disappearing, but they are plagued by headaches, a lack of energy, dizziness, and an inability to concentrate or to handle their usual schedule. It is not surprising that patients are frequently frustrated and angry with themselves and their medical care.

After I am convinced that I am dealing with

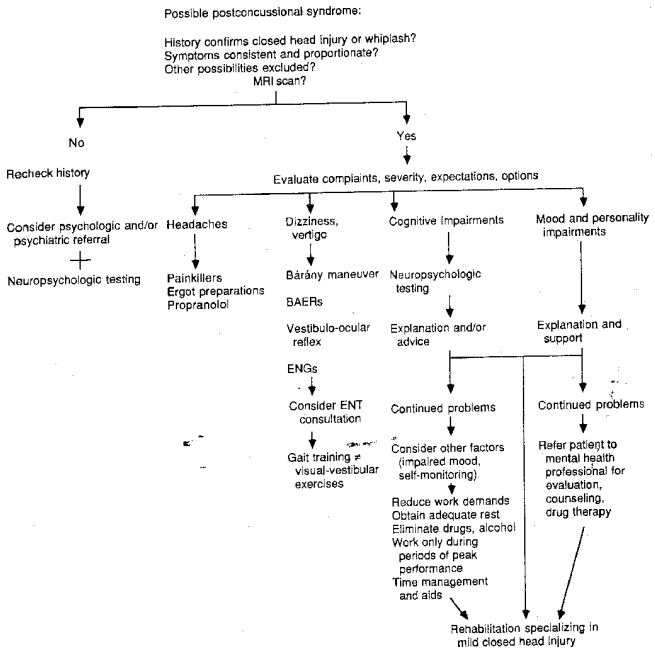


Figure 1 Evaluation and treatment of PCS.

PCS, I have found that it helps to explain to patients what has happened to them, how their apparently disparate complaints may have a single pathophysiologic explanation, and that although almost everybody recovers, the recovery usually takes longer (weeks to months) than the patient would expect.

Headache, Dizziness, and Vertigo

The headache of PCS may not have many characteristics of vascular headache, but most of these headaches are probably the result of vascular causes. Many respond to treatment with simple painkillers. Those with clearly defined onsets may be aborted by ergot preparations (ergotamine tartrate) (Ergostat, Ergomar). More frequent or more continuous headaches may respond to propranolol (Inderal) and other beta-blockers, or to antidepressants. (A more detailed strategy for treating headache is discussed elsewhere in this book.)

Dizziness and vertigo arise from several different sources in PCS. Unfortunately, the dizziness and vertigo of PCS are often highly resistant to therapy. Drugs such as meclizine 12.5 to 25 mg twice per day or three times per day can be tried, although these are usually not helpful. Gait training and visual-vestibular exercises may help promote adaptation. (A detailed treatment plan is discussed elsewhere in this book.)

Impaired Mentation

Therapy begins by cataloging what the patient must accomplish and what problem(s) he seems to be having. Typically, the patient himself is aware that he is not functioning as efficiently, that it takes him longer to do his work, and that he cannot juggle as many projects as he once could. Frequently there is also increased sensitivity to stress or fatigue. Often, these failings are subjective only; no one else has noticed them. But because they are no less real, the patient needs to be reassured that his perceptions are plausible if the physician believes they are.

Although the cognitive impairments cannot yet be directly treated, often patients have several of the following contributory problems.

Mood Impairments

Thinking is never as smooth when one is frustrated, angry, depressed, and irritable. I question patients about any similar prior mood problems. Based on their past experience, they may appreciate how much of their mental impairment is due to their mood per se. It often relieves them to understand that their current mood with its share of problems will pass, just as previous episodes did. More serious problems require professional referral (see below).

Excessive Self-Monitoring

Normally, thinking and speaking are done without much self-consciousness. If too much attention is given to monitoring what is being done, performance suffers because resources are diverted, and the normal pacing of mental operations is disrupted. (Public speaking is a good example.) Self-consciousness in thinking and speaking is common in patients with PCS, and a frequent cause of further disruption. Sometimes, patients become so wary of making errors, they set too high a standard. For example, they may remember someone's name, but since they are not *completely* sure, they will not say it.

For many patients, it is enough for the clinician to point out that their self-monitoring does not help their condition, but rather is itself a cause of the problem. Even those patients who cannot stop monitoring and doubting themselves can be reassured that the problems related to speech and thinking are not the result of direct brain malfunction; this component of their problem can be transient.

After these approaches have been considered, there are several work-around strategies for the cognitive deficits: optimizing the patient's mental capacity, increasing his or her efficiency with time management and mechanical aids, and reducing the demands on him or her during this period.

Optimizing Mental Capacity

Everyone has good and bad days, and many people know their periods of peak performance (morning, afternoon, or evening). It is no surprise that mentation is less efficient when an individual is tired or stressed, and this is frequently magnified in patients with PCS. Ideally, then, patients with PCS should try to get enough rest (both physical and mental). They should also try to engage in important or difficult work during their periods of maximal competency only. Again, professionals are generally better able to rearrange their work schedules than are blue-collar workers.

Increasing Work Efficiency

Time management techniques can be as useful for the patient with PCS as they are for others. Small pocket notebooks and appointment books can also be tried. An electronic watch with a reminder alarm is another inexpensive (approximately $15 to $50) adjunct. More complicated electronic notebooks (such as Casio's SF-4000 Digital Diary [$89] and its larger version, the Business Organizer Scheduling System [about $270]) are available. It must be realized, however, that using any of these strategies and tools demands self-discipline, which is often harder to enforce in PCS patients than it would be otherwise.

Reducing Demands

Since the patient's mental abilities are temporarily reduced, it makes sense to try to reduce his need for these abilities. Professionals in particular can often reduce their work load (if they absolutely have to), spread it out over longer periods of time (for example, work at a more leisurely pace into evenings or weekends), or delegate it.

Depression and Other Psychic Complaints

In most of my patients, depression and other psychic complaints are annoying but relatively mild. They often respond well to an explanation, and many of these patients eschew drug therapy. If drug therapy or psychotherapy is warranted, I prefer to refer this aspect of care to a psychiatrist, psychologist, or other mental health professional. In making the referral, it is important to convey an accurate impression of your assessment of what is structural and what is secondary in your patient. Since many consultants will not be able to evaluate the primary data, there is a danger that they may overemphasize the brain injury or, conversely, magnify the role of the psychic factors. Psychiatric referral is particularly warranted when complaints appear late, since those individuals in whom this occurs are the most likely to be suffering from marked depression and the real or imagined consequences of their injury.

Other Options

Drugs such as Inderal or carbamazepine (Tegretol) have been claimed to ameliorate the irritability or anxiety of patients with closed head injury. Since there is little or no statistical evidence for this, I do not prescribe these agents for this purpose.

Many centers now have specialized cognitive rehabilitation programs for patients with mild head injury. Referral to such centers is indicated for the patient with persisting problems, in large part because they provide emotional and psychiatric support. Patients should not expect these centers to alleviate primary symptoms directly (although these will often get better over time), since there is not yet any scientific proof that such programs benefit these. If such a program is available, early referral is usually warranted. If the program is *not* geared for mild cases, there is a risk that patients with mild head injury will experience demoralization and embarrassment from being around those with far more serious handicaps. Cost is also a concern.

SUGGESTED READING

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Levin HS, Eisenberg HM, Benton AL. Mild head injury. New York: Oxford University Press, 1989.

Levin HS, Grafman J, Eisenberg HM. Neurobehavioral recovery from head injury. New York: Oxford University Press, 1987.

PATIENT RESOURCES

The National Head Injury Foundation, Inc.
333 Turnpike Road
Southborough, Massachusetts 01772
Telephone: (617) 485-9950

The National Head Injury Foundation is a full-service organization dedicated to serving as an informational clearing house, support group, and advocate for those with head injury. There are many active state chapters, which may have support groups for individuals with PCS. The NHIF offers several articles of special interest for PCS patients from their catalog of more than 250 items, such as:

"Disability Caused by Minor Head Injury" (C #81-001, $1.50)
"Minor Head Injury in Children—Out of Sight But . . ." (#83-003, $1.00)
"Postconcussional Symptoms and Syndrome" (#81-003, $1.00)
"Persisting Symptoms after Mild Head Injury" (#83-007, $8.00)
"Post-Concussion Syndrome" (#82-001, $1.00)

SPINAL INJURY

DAN S. HEFFEZ, M.D., FRCS

Injuries to the spinal cord and column are tragically common causes of morbidity and mortality among young and active people. The majority of these injuries are caused by motor vehicle accidents, often as a consequence of drug or alcohol intoxication. Especially among teenagers, spinal injuries may be related to sports such as wrestling, diving, and football. As spinal injuries disable more often than kill, the cost in terms of medical expenditure and lost potential is enormous. In this chapter, I deal exclusively with the general principles of the treatment of patients with spinal injuries.

The three principle goals of therapy in all cases are:

1. Prevention of additional neurologic injury by immobilization of the spine.
2. Reduction of fracture dislocations to allow for possible recovery of existing neurologic

CURRENT THERAPY IN NEUROLOGIC DISEASE–3

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Ms. SÁNCHEZ. At this time I would like to recognize Mr. Ditka for his testimony. You may begin.

TESTIMONY OF MIKE DITKA, FORMER NFL COACH, CHICAGO, IL

Mr. DITKA. Thank you, Chairwoman Sánchez and Ranking Member of the Subcommittee.

Listen, I am Mike Ditka. I am here on behalf of one thing: the retired players that need help, in dire need. Mike Ditka Hall of Fame Assistance Trust is one part of it; the Gridiron Greats is another part of it. There is other parts of it. All we did was put together a couple groups to try to help people who need help.

It came to my attention that we had a lot of Hall of Famers who were in dire need, including John Mackey, which they finally implemented the '88 plan, and, before he passed away, Ernie Stautner. And I can go on and on with people, Joe Perry, Doug Atkins, Pete Hollis, all basically dementia.

I am not a newcomer to the game, as some would like to say. I started in this game 47 years ago as a player, an assistant coach under Coach Landry, a head coach, and then now I guess I am an expert because I am an analyst for TV. So I am not a new player in the game. And that was brought up by somebody else. I have been around for a long time. I have seen the changes. I saw the beginning. I understood why the organization called the Players Association was put in place in the first place. My roommate, Mike Powell, was one of the first presidents of that union. And we know why it was put in place. So when we talk about that, we understand that.

All we are here for is to see that the system gets fixed. The system does not work. Now, you can talk about all the terms you want to. There is a difference between perception and reality. What is perceived to be means absolutely nothing unless it is real. The reality of the situation is if you make people fill out enough forms, if you discourage them enough, if you make them jump through hoops, eventually they will say, gees, I don't need this. I can't do all this. This is ridiculous. And they are going to walk away from some of these situations.

And this basically is a lot of what has happened to these people. They are frustrated. These are proud people. They played in this game. They played this game heroically. And they have as much right to say that they are a part of this game as anybody playing in the game today, anybody who played in the 1980's, anybody who played in the 1970's.

You can go back through history. The people in the game today are not the makers of the game. They are only the keepers of the game. The game was made a long time ago, and it will be made after these people are gone. And hopefully these players today understand that the treatment former players are getting could come to them, regardless of what they may think.

So, you know, the disability system to me is broken. Fix it. Do the right thing. That is our model. Just do the right thing.

Why did this all start? I don't know why it all started. Why are we in front of Congress? I think we are in front of Congress because we feel something is wrong, and it can be fixed. And there

is a lot of people involved in this. Every party understands what the problem is. Now we got to find a solution.

We got the NFL. We heard all the kind words that were said about the NFL Management Council. Whether they are right or wrong, I don't know. We know about the owners. The owners have made a lot of money recently. We know about the Players Association. That has been documented. There has been a lot of money put in there. What we don't know about is why do retired players who have disability needs are not being taken care of? Why can't this be taken care of?

That is all we are asking. I don't care whose fault it is. We are not pointing the finger at one or the other. There is money, there is resources there. Take care of the people who need it, and that is all we are asking.

In closing, you know, I don't know that you can find fault with what we want to do. I mean, there is those who point the finger. There are those who attacked us individually. They will talk attack Brian DeMarco. This is not what it is all about. You know, God forbid any of these people who are doing the attacking would get in the position where they would need this kind of help, and we would hope that somebody would have some compassion and understanding.

Now, I hear all this stuff about all the laws. Hey, gang, you know, laws are laws, and we understand that, but it is time for some solutions. It is time for some action.

I appreciate your time. I hope some of what I said made sense. But this is not about Mike Ditka. Football owes me nothing. Nothing. I owe my whole life to football, and I want you to understand that. I am not asking on my behalf. I am asking on behalf of people who really need help. Thank you.

Ms. SÁNCHEZ. Thank you, Mr. Ditka, for your testimony.

[The prepared statement of Mr. Ditka follows:]

PREPARED STATEMENT OF MIKE DITKA

Mr. Chairman and esteemed members of the Committee, I am Mike Ditka, and I thank you for the opportunity to appear before this committee today.

Professional Football is an American institution and I am here to represent the players who built the NFL, which is now a billion dollar industry. Many of these former NFL players have late onset football related injuries and many exhibit a pattern of symptoms consistent with repeated serious brain injury over time, primarily pugilistic dementia and short term memory loss, along with other related traumatic medical injuries. They are currently suffering in silence with inadequate levels of help from the institutions that were put in place to help them. These players are not being appropriately protected or materially assisted by the NFL player's union.

I find it incomprehensible that the common man and the common fan knows that these former NFL players are being treated like dogs in a callous and uncaring manner while the NFL Player's Union endlessly debates the issue and does nothing material to help these guys. I feel that this is a real problem that has not gotten the attention or the resource allocation it deserves.

As a result of seeing multiple examples of this grave injustice firsthand, the The Mike Ditka Hall Of Fame Assistance Trust Fund was created in 2004 to help former NFL Hall of Famers and players, especially those with acute financial, medical, and other needs. The remainder of our funds are dedicated to disabled children at Misericordia.

The Mike Ditka Hall Of Fame Assistance Trust Fund and the Gridiron Greats Assistance Trust Funds share the same goals and have the same serious concerns for the well being of former NFL players, many of whom suffer from a wide range of football related ailments that we believe are directly or indirectly responsible for their current conditions. Furthermore, we believe that the institutions (NFL Play-

er's Union) that have been put in place to help them have fallen short in the past despite the fact that they have more than adequate resources to help. We feel they can do more than they currently do to help.

Many former NFL players with the most acute current needs played in the early days of league, where documentation of medical problems was less diligent than today.

Recognizing that former players are hurt should not be seen as an attempt to point fingers or blame anyone in particular. Our goal is to be part of the solution rather than accept the status quo, which is the problem. It is our goal and our mission to create public awareness which helps us raise the funds that can then be directly allocated to help these guys who need assistance. Our mission is to stand up for the guys who are no longer able to stand up for themselves in order to act in a timely manner on their behalf. Endless debate, running in circles, studies and meetings have accomplished little to help while former players suffer.

Constructive goals are frustrated by a closed Player's Union bureaucracy that seems out of touch with the real day to day needs of the oldest of former NFL players upon whose blood, sweat and pain the league has built a billion dollar industry.

The Mike Ditka Hall Of Fame Assistance Trust Fund and the Gridiron Greats Assistance Trust Fund are working for the same goal and believe that the NFL Player's Union's prior lack of attention on this matter represents a substantial step backwards and abdicates the NFL's leadership in representation, communication and concern for the well being of its current and former players.

The following summarizes our concerns with the issue at hand. We believe members of the Subcommittee should examine the following points closely in order to gain a better understanding of this issue and take the appropriate steps to rectify this unacceptable state of affairs.

1. Why and where did this all start and why are we in front of Congress?
2. The numbers of former players in need is documented and identified—there are under 300—with the collective resources of the parties involved why can't we solve this problem?
3. There are the resources and numbers—the problem has been identified and the problem can be rectified if the powers that be want to solve it—it can be done.

Please help us relieve burdensome circumstances.

In addition, to ensure that former players in need get the support and are provided with the resources they need, the Mike Ditka Hall Of Fame Assistance Trust Fund recommends that the U.S. House of Representatives:

1. Investigate the circumstances of former NFL players with specific focus on why they are experiencing such serious problems being turned down for disability/medical care when they need it.
2. Investigate delayed onset dementia, short term memory loss and the causality, correlation and relationship to repeated prior head injuries like those commonly experienced in football.
3. Investigate why this problem hasn't been solved in light of the tremendous financial resources of the NFL owners and Player's Union.
4. Investigate why there is a 12 year statute of limitations on player disability claims.
5. Investigate who made the determination that 12 years should be the limitation on claims for disabilities.
6. Investigate why so many former players are being turned down when they apply for help.

It all boils down to the difference between what is right and what is wrong. These are our people and we are asking for your support for a group of proud, dignified men who suffer greatly as a result of their injuries, many of which are directly or indirectly related to their careers in professional football.

We thank Congressmen Conyers and Smith and all members of the Committee, particularly Congresswoman Sanchez of California, for their leadership on these issues and look forward to working with members of the Subcommittee and the Full Committee to resolve the important, outstanding issues of health of former NFL players.

In summary, The Mike Ditka Hall Of Fame Assistance Trust Fund supports proactively addressing this issue. However, we have serious concerns with the NFL Player's Union's lack of action on behalf of injured former players who need help. It seems to me that we need a new approach.

Our objective is not find fault and lay blame. It is to have an open an honest discussion with all concerned parties and to create a solution that helps these guys today. In our view, the challenge is for all parties to recognize the situation and take appropriate actions to help the guys in need. Certainly between the resources all of us bring to bear we can find a solution that works for these guys.

I am proud to be part of this dialogue and my foundation and I want to continue to engage in productive dialogue with all parties interested in being part of the solution.

All that matters is seeing these guys get the help they need. The current structure has does not meet the needs of these guys and time is of the essence—now is the time to act, before it is too late.

Football does not need Mike Ditka. Mike Ditka needs football, and it has propelled me into places I never thought I would go in my life. With that, ladies and gentlemen of Congress, I submit to you that I'm not here for myself, which I have just expressed. Please take it upon yourself to help these people in need.

It's up to you.

I thank the Subcommittee again for its interest in this important issue. We look forward to working with Congress and the members of this committee on this issue.

Thank you very much.

Ms. SÁNCHEZ. Mr. Carson, you are now recognized for your testimony.

TESTIMONY OF HARRY CARSON, RETIRED NFL PLAYER, FRANKLIN LAKES, NJ

Mr. CARSON. Thank you, Madam Chairwoman. In the interests of time, you have my statement, I am going to abbreviate it so that I can fall within the 5-minute time frame. On August 5th, 2006, I joined the ranks of the greatest football players to ever play the game with my induction into the Pro Football Hall of Fame. While it was a very proud moment for my family and my friends, I viewed it as a culmination of a journey that began many years ago as a youth growing up in Florence, South Carolina. My football career was great. I enjoyed the experience. I enjoyed the relationships that I built.

Since the end of my professional football career almost 19 years ago, I tried to live the best life that I could, accepting the aches and pains that come along with what I did as an athlete. Occasionally I have to deal with back pain brought on by degenerative disks in my neck and lower back that press against my spinal column that causes me pain in my lower back and legs. But the one area that causes me the greatest concern is living with postconcussion syndrome, a condition I was diagnosed with 2 years after leaving football.

Aside from the physical wear and tear on my body, I sustained many concussions during my career that I was able to play through. I was very good at what I did as a player. Others might say I was the best inside linebacker and goal line linebacker to play the game, but there is a price that you pay for being the best. Part of the toughness of being able to play the game is to be physical with opposing linemen and running backs at the point of attack on the football field. A player risks his body and limbs to make the big tackle or to make the big play to win the game, not always understanding the cumulative effects on his body afterwards.

I knew something was wrong with me while I played, but I was so in tune with my physical body, I just couldn't put my finger on what the problem was. I, like many other players at that time, ig-

norantly laughed when we saw someone get hit so hard that they didn't know where they were on the field during the game. I was one of those players who played hard and clean, but tried to make opposing running backs know that they were in for a long, hard day when they faced the New York Giants defense.

While making big hits I was never knocked out, but I can remember seeing stars or losing my vision, with everything fading to black sometimes after hard hits given or received.

In playing the game, I would at time times reflect on my high school physical science knowledge of Newton's third law of physics, which simply states for every action there is an equal and opposite reaction. Those hard hits that I was giving as a player on the field were hits that equally affected me.

When I think of Mike Webster, I think that the demise of Mike Webster was due largely in part to linebackers like me just playing the game. In the 1970's and 1980's, when I played, when much attention was focused on the more visible sustained injuries, like knees and ankles, few focused on dings or the concussions players sustain now.

There are many studies taking place to determine whether concussions in football can lead to dementia or Alzheimer's in older former players. When you look back on the equipment that was used, especially the helmets worn, some might wonder if the inferior products could have contributed to concussions that might lead to future balance or neurological disorders in players.

It is my opinion that it is the pure nature of the game of football that causes traumatic brain injury. Concussions or dings have always been a part of the game and probably will always be a part of the game. When you have the speed of massive bodies colliding, and with the surface of the brain hitting the inner shell of the skull, causing a bruising on the brain, an athlete is going to be affected in some way that might not easily be detected.

I played the game at a very high level and was proud that I was able to leave on my own accord. In making my transition to life outside of playing, I became more aware of various neurological events that created problems for me. Areas of concern were depression, occasional headaches, blurred vision, and short-term memory loss, difficulty concentrating and staying focused, sensitivity to bright lights and loud noises, among many other issues. These problems were highlighted because I chose sports broadcasting as a vocation after my days of playing football.

I sought the help of my physician when I realized I was having some problems in my personal and professional life. I underwent 2 days of extensive testing and was diagnosed with a mild postconcussion syndrome. The condition affected my ability to perform my job effectively, with the inability to perform or process information quickly, and was partly the cause of the dissolution of my first marriage. Since my diagnosis in 1990, I have learned much about the condition. I have spoken with various groups around the country on traumatic brain injury in sports and have begun to write my memoirs on the subject as it relates to my life.

I just want to say as I was inducted into the Pro Football Hall of Fame, I chose to use the occasion to highlight the plight of retired players. Attention needed to be brought to bear on pension

and disability issues that many retirees felt were being ignored by the NFL and the Players Association. I considered myself to be very fortunate to have had the opportunity to be part of a fraternity of men who are made of the best stuff and were able to exhibit their talents at the highest level to play on the professional level. I also consider it an honor to speak today for many who do not have a voice here. I look forward to answering any questions that you might have.

Ms. SÁNCHEZ. Thank you for your testimony, Mr. Carson.

[The prepared statement of Mr. Carson follows:]

PREPARED STATEMENT OF HARRY CARSON

On August 5th, 2006 I joined the ranks of the greatest football players to ever play the game with my induction into the Pro Football Hall of Fame. While it was a very proud moment for my family and friends, I viewed it as the culmination of a journey that began many years ago as a youth growing up in Florence, South Carolina.

Before my induction I reflected back on my days playing sandlot football with my friends and then trying out for the high school team as a 9th grader. On that first day of practice I realized early that I did not have what it took to do so much running, agility drills and especially take part in live contact drills. Before the conclusion of the practice session I turned in my helmet and pads to the equipment manager. The combination of the very hot and humid August day, wearing the many pounds of equipment and the screaming of coaches barking out orders was a complete shock to my system. Up to that point I thought football was easy and anybody could play. I was wrong and I discovered that I was not quite tough enough to play.

For a year (9th grade) I lived with the humiliation of being a quitter in the eyes of some but more importantly I had to live with the bitter taste of quitting in my own gut. I came back the next year determined to rid myself of that taste of giving up. The next time I stepped on the football field I was better prepared for what I knew I was going to face and I knew I was going to have to push myself mentally and physically to stick and stay if I was going to make the team. As much as I did want to quit again I forced myself to do whatever it was going to take to survive practice. Making it through that first day of practice and then the next day and the next taught me that playing football was not a game for everyone. To play football you have a special toughness but you also have to be committed and dedicated to the team and the game. I made the team and went on to finish my high school years and then my college years at South Carolina State University.

Before my induction on August 6th I reminisced about being drafted to play for the New York Giants. Being chosen to play professional football was probably the dream of every player who plays the game. It was no different for me but I knew the likelihood of making it was not great. These men that I was going to be competing against were seasoned veterans and I was a kid out of Carolina being asked to play a position I had never played before. I took on the challenge knowing that if I didn't make it as a Giant I had a backup plan. I graduated with my college class and was qualified and prepared to teach in South Carolina and move on with my life.

I relied on those early lessons of commitment, giving my all and the will to be the best to make the transition to professional football. From the beginning I knew it was very temporary, I had no idea how long I would play but I learned very quickly that a career could be over in the blink of an eye. The speed, quickness and power of the players were things that I rarely saw in high school or college. To compete on that level you really had to be good!

As a young naive player with the Giants, it hit me early in training camp that the football that I was now playing was not just a sport but was very much a business. I had never been a part of teams that cut players; the training on teams I played on was so rough that players usually cut themselves by quitting. As a rookie I saw that if a player was injured or could not perform on the field he was waived or cut. To play on this level you had to be able to practice and you had to be able to play to your maximum on Sunday afternoons. Players would talk about it but I grew to understand that the team was a machine and all of the players were bit parts of that machine that made it function effectively. If a part was broken it was easily replaced with another to keep the machine running.

With the enormous amount of physical contact most people saw on television coupled with the amount of contact in practice drills it would be hard for most players

to remain unaffected by muscle strains and sprains, pulls, tears, etc. Many of the players I played with had some type of knee, ankle, hip, back, shoulder, elbow or neck injury they had to contend with to play football. Most were able to recuperate sufficiently enough to get back on the playing field to compete while others ended their football careers with an injury that prohibited them from playing. I watched many quality players clean out their lockers because an injury cut their playing careers short.

As a linebacker I had more than my share of injuries. Elbows, fingers, ankles, back, nerve damage in my right shoulder resulting in the atrophy of my posterior deltoid muscle and four knee operations are a part of my football resume. I firmly believe that every player who plays professional football walks away from the game with some ache or some pain. Some are able to live relatively normal pain free lives while others have to live their lives with an understanding that they may never know what feeling "normal" is all about.

Since the end of my professional football career almost 19 years ago I've tried to live the best life I could accepting the aches and pains that come along with what I did as an athlete. Occasionally I have to deal with back pain brought on by degenerative disks in my neck and lower back that press against my spinal column that causes me pain in my lower back and legs. But the one area that causes me the greatest concerns is living with Post Concussion Syndrome, a condition I was diagnosed with two years after leaving professional football. Aside from the physical wear and tear on my body, I sustained many concussions during my career that I was able to play through. I was very good at what I did as a player. Others might say I was the best inside linebacker and goal line linebacker to play the game, but there is a price that you pay for being the best. Part of the toughness of being able to play the game is to be physical with opposing lineman and running backs at the point of attack on the football field. A player risks his body and limbs to make the big tackle or to make the big play to win the game not always understanding the cumulative effects on the body afterwards. I knew something was wrong with me while I played but because I was so in tune with my physical body I just couldn't put my finger on what the problem was.

I, like many other players at that time ignorantly laughed when we saw someone get hit so hard that they didn't know where they were on the field during the game. I was one of those players who played hard and clean but tried to make opposing running backs know that they were in for a long hard day when they faced the NY Giants defense. While in making big hits I was never knocked out but I can remember seeing stars or losing my vision with everything fading to black sometimes after hard hits given or received. In playing the game I would at times reflect on my high school physical science knowledge of Newton's Third Law of Physic which simply states "For every action there is an equal and opposite reaction". Those hard hits that I was giving as a player on the field were hits that equally affected me.

In the 1970s and 80s when I played much attention was focused on the more visible injuries sustained by athletes but very few focused on the "dings' or the concussions players sustained until now. There are many studies taking place to determine whether concussions in football can lead to dementia or Alzheimer's in older former players. When you look back on the equipment that was used especially the helmets worn some might wonder if the inferior products could have contributed to concussions that might lead to future bouts of neurological disorders in players. It is my opinion that *it is the pure nature of the game of football that causes traumatic brain injuries.* Concussion or "dings" have always been a part of football and will probably always be a part of the game. When you have the speed of massive bodies colliding and with the surface of the brain hitting the inner shell of the skull causing a bruising on the brain an athlete is going to be affected in some ways that might not be easy to detect.

I played the game at a very high level and was proud that I was able to leave on my own accord. In making my transition to life outside of playing I became more aware of various neurological events that created problem for me. Areas of concern were depression, occasional headaches, blurred vision, and short term memory loss, difficulty concentrating and staying focused, sensitivity to bright light and loud noises, among many other issues. These problems were highlighted because I chose sports broadcasting as a vocation after my days of playing football. I sought help from my physician when I realized I was having some problems in my personal and professional life. I underwent 2 days of extensive testing and was diagnosed with a mild post concussion syndrome. The condition affected my ability to perform my job effectively (inability to process information quickly) and was a partial cause of the dissolution of my first marriage. Since my diagnosis in 1990 I have learned much about the condition, have spoken with various groups around the country on

traumatic brain injuries in sports and have begun to write my memoirs on the subject as it relates to my life.

Over the years since I played I have come to understand that there are many former players who have had similar problems adjusting to life after ending their careers from the NFL with many of the same symptoms I've experienced and have concluded that many of my fellow retirees are effected with Post Concussion Syndrome. I consider myself fortunate to at least know what my condition is because I was examined by an expert in that field. I feel for those who might be affected by the lingering long term effects of concussions they sustained as players but have no clue because they were never examined. As I see the many older retirees of the NFL who are now battling dementia and other mental and neurological disorders I unfortunately see what may eventually become my future. I feel that I must speak very openly and candidly about this condition from a player's perspective. In all probability the NFL and the NFL Players Association will dispute my testimony and will attempt to present evidence to the contrary to shoot down any correlation between those neurological conditions and a player's career in the National Football League.

As I was inducted into the Pro Football Hall of Fame I chose to use the occasion to highlight the plight of the retired NFL players. Attention needed to be brought to bear on pension and disability issues that many retirees felt were being ignored by the NFL and the Players Association. I considered myself to be fortunate to have had a very unique opportunity to be a part of a fraternity of men who are made of the best stuff and were able to exhibit their talents at the highest level to play on the professional level. I also consider it an honor to speak today for many who do not have a voice here.

I look forward to answering any questions your might have.

Ms. SÁNCHEZ. Mr. Marsh, you are recognized for your testimony.

TESTIMONY OF CURT MARSH, RETIRED NFL PLAYER, SNOHOMISH, WA

Mr. MARSH. Thank you, Chairwoman Sánchez and Members of the Committee. My name is Curt Marsh. I am 47 years old. I live in Snohomish, Washington. I was selected in the first round of the 1981 NFL draft by the Oakland Raiders and played offensive guard for 7 years.

I have had a total of 31 surgeries due to injuries suffered in my career. They include four low back, one neck, two open reductions, two hip replacements, seven arthroscopies, and 14 ankle surgeries, including an amputation, to list a few.

In the NFL, most injuries were just played through in the old days, and on the Raiders, because our doctor, who was in his eighties, was old school, when you got hurt, you simply got a shot of cortisone and Novocaine in the injured area and played. However, there was no warning of the damage cortisone injections did to your joints later in life, and in 1994 I found out that the injections had caused me to need both hips replaced due to joint disease.

The injury that ended my career, however, occurred at the beginning of my seventh season. It was an ankle injury misdiagnosed by our team doctor as a sprain. And I finally saw a second doctor outside the team who found I had been playing on the ankle broken, and this injury ended my playing days for good. I had 11 more surgeries over the next 6 years before I finally had no choice but to amputate.

NFL physicians are not like regular doctors, who are committed to making a person well. An NFL doctor's only job is to make a player well enough to play, and the further you go back in NFL history, the worse it was. In 1996, I found out about the new disabled player benefit for degenerative disabilities. I applied, was

told I needed to see a doctor of their choice at my own expense, to be reimbursed if I qualified. The physician would make a recommendation to a board who meets once every 6 months.

First doctor was in Everett, close to my hometown. He said that I was the worst case he had seen and recommended approval to the board. The board voted, a result 3-3 tie. I was seen by Dr. Smith in Seattle, the next one they referred me to, who said I was the worst he had seen. Again the vote was 3 to 3. Then I was referred and told I would have to see a third doctor in Los Angeles, who would be the final word. No more votes. At my own expense I went to see Dr. James DeBone, the MAP, medical advisory physician you heard about, in August 19 97. He, too, said I was the worst he had seen, and he was going to recommend I receive the disability.

The board had no choice but to approve the benefits. The whole process took about a year and a half. I believe that the procedure is much too cumbersome. I went through it and experienced it firsthand. And I find it very interesting when I hear those in the process itself say that I must be confused about my own experience. They tell me it didn't take that long; it only took a few months. And they send me pieces of paper showing I applied in 1997 and got it in 1997, which is ridiculous. I was a football player, but I am not stupid. Most people would be surprised at my IQ, and I have no problems with my memory.

To prepare for today, I read the transcript of the Mike Webster case and was extremely disappointed. It reminded me of the feelings I experienced when going through my application process. I felt as though some members of the board reviewing my case were looking for the smallest loophole to not grant disability, rather than trying to find people who truly qualified. I had no leg, no hips, no back, and the rest of my body was falling apart, and the doctors recommended that I receive the disability. And I thought to myself if I don't qualify, who does?

I appreciate that the NFL CBA introduced the degenerative disability plan at all, but more needs to be done. The suggestion I read to rely on the Social Security standard for qualification is as good a place to start as any, but the process must be open to scrutiny and streamlined. In addition, the benefit is currently a monetary benefit only, and never being able to work again means you will never qualify for health insurance either. I believe the disability plan should have a health insurance component as well.

In closing, I would like to add that the players who came before us are the foundation of all that came after us. They deserve our respect and compassion. Their medical treatment they received during their playing days was far inferior to that of today's million-dollar athletes, and they are suffering from consequences in the here and now. It is easy for those who are dealing in the world of the high-finance NFL on a day-to-day basis to get caught up in how important, who they are and what they do seem to be, so much so that it is easy to forget the suffering of those trailblazers who have no voice today.

I may be in the minority, but I believe that the union should fight for the players of the past and make the improvements that are required to serve their needs. Regardless of who is in leadership, the NFL must do more.

Thank you very much for the time.
Ms. SÁNCHEZ. Thank you, Mr. Marsh.
[The prepared statement of Mr. Marsh follows:]

PREPARED STATEMENT OF CURT MARSH

My name is Curt Marsh. I am 47 years old and live in Snohomish, Washington. I attended the University of Washington on a football scholarship and played defensive line, offensive guard and eventually ended up at offensive tackle. After my senior season I was selected in the NFL draft by the Oakland Raiders as the 23rd player picked in the first round. Oakland moved me to offensive guard were I remained for my entire 7 year career in the NFL, all with the Raiders. I played left guard behind a 15 year veteran by the name of Gene Upshaw. After 4 games in my rookie season I was promoted to the starting position and remained the starter at left guard without missing a game for that season and the next. Gene Upshaw retired after my second season. He was a good teammate and very supportive mentor.

After my rookie season the doctor found that I had a hernia and surgery was done to repair it. I had a similar surgery again after season two as a hernia was found on the other side midway through the year. The only other injuries I had were usually related to my neck. I always had a problem with what were called "stingers". They were basically pinched nerves in your neck brought on by high speed collisions with your head. I would smack into a linebacker as hard as I could and one whole side of my body would feel like it had exploded and then go numb. I was cursed with those throughout my whole career. I had 1 low back surgery in college to repair a disc injury at L5- S1 and recovered nicely. However, in training camp before my 3rd season I blew out another disc in my low back at L4-L5 and was rushed to the hospital were I was given 3 cortisone shots a day directly into my back for 2 weeks and kept in traction. When that didn't work they operated. The surgery was not as successful as the first and I did not fully regain my strength or feeling in my left leg. Parts are still numb. In addition, the cortisone shot had made me balloon up and I had these pimple like spots all over my body. It was an awful experience. I rehabbed hard and was practicing by the end of the season and ready to come back the next. Somehow, I re-injured the hernia repair on the right side and it had to be redone during the off-season between my 3rd and 4th years. All through the training camp of my 4th season my low back was very stiff and painful. The team orthopedic Physician, Dr. Rosenfeld, again used cortisone shots combined with a numbing medicine to help the pain, and I got them before each practice and games. I did not get my starting job back until the 5th game of that season. During a game against the Kansas City Chiefs I injured my left shoulder with a slight separation. I did not miss any games because of it. It was just another annoying injury.

Unhappy with my performance in my 4th year I trained extremely hard in the off-season prior to my 5th year and came into camp in the best shape of my life. On day 2 of practice during a contact drill I hit a defensive back at full speed and as we rolled to the ground I felt my upper arm snap. I had broken it completely in half. I was rushed to the hospital and taken directly to surgery were the arm was screwed back together. After the surgery I flew right back to camp and began rehab. 5 weeks later I was activated to play again. I was not put back into a starting position. I rotated into the right guard spot with another player and we would split playing time. I was also the backup center at that point. In my second game back while blocking a linebacker I heard a snap and felt extreme pain in my left hand. I looked down and saw my ring finger pointing at a very odd angle and knew my hand and/or finger was broken. It was. I was put in a cast and

continued to play. The cast however, was very cumbersome and made it difficult to pass protect so the Dr. suggested taking the cast off to play and putting it back on after each game and then doing surgery at the end of the season to repair any damage to the hand. By this time I wanted playing time so badly I would do just about anything. I wanted my starting job back and you can't get that sitting on the bench. So I agreed. Each game we would saw off the cast, shoot cortisone and novocain into my hand and then tape it up. In addition to my hand and arm hurting as well as still getting shots in my back and it getting stiffer throughout the season now my right knee was giving me problems and my left knee was clicking and grinding. My back was getting so bad that I had to get up early each morning and spend about an hour in our condominium complex hot tub stretching just to get limber enough to function and get to the practice facility. I would apply heat packs during meetings and use heat balm, as well as stretch constantly throughout the day. By the end of practice each day I was thrashed. That season ended without me winning my starting job back. So I went into the hospital to have my hand put back together and to have arthroscopic surgery on both knees to take out loose bodies and to fix cartilage injuries and to just rest my back.

I began the season 6 training camp as the starting left guard. I got up each day, did my low back routine, got the shots and off I went. During the second game of the season against the Redskins in Washington D.C. I was injured on a play where my left knee and right ankle were hurt at the same time. I was given the pain killing shots and re taped and continued to play. After returning home further tests were done and it was discovered that I had torn a ligament in my left knee. However, the x-ray done on my ankle showed no obvious breaks and it was diagnosed as ligament damage. I was put on injured reserve for the rest of that season. My knee healed without surgery but I continued to have problems with my ankle.

My ankle was well enough for me to start practices in the next training camp prior to season 7. However, once I started to play on it in practice it ballooned up and hurt tremendously again. I went to Dr. Rosenfeld and he again pulled out the same x-ray and said it was OK and he would shoot it and I should play. They drained all the fluid out before each practice and then shot it full of cortisone and Novocain to numb it and I would practice on this numb stump until the shot would wear off. Then it would balloon up again and I would be in excruciating pain. I begged the doctor to do something else and he just kept telling me if he shot it and I played it would get better. I then said I was going to go to another doctor or 2 to get other opinions. That was when he decided to send me for another x-ray only. When it came back I made sure my player union rep Mike Davis was with me in my room to meet with the doctor. The x-ray showed several loose bodies that weren't there before, but no break. Dr. Rosenfeld said he was sticking with his advice to shoot it and play. I then said I was leaving to get the other opinions. He said he knew that they were going to say that I needed to get the loose bodies removed. I said, "Well then maybe I do." He then turned to walk out the door, stopped and to our amazement said, "Well, my advice is that you get the loose bodies removed." Unbelievable. Talk about CYA. One thing you must understand in dealing with NFL medical issues is that the doctors who work for the NFL teams are not like regular doctors. Regular doctors are committed to making a person well. **An NFL doctor's**

only job is to make a player <u>well enough to play.</u> And the further back you go in NFL history the worse it was. Our team doctor Dr. Rosenfeld was in his 80's, so he was very "old school".

To make a long story shorter, I went to 3 doctors all of them said an x-ray is inadequate to diagnose this injury they would need a CAT scan. I chose Dr. Daley from Marina Del Ray, California and the CAT scan revealed that my ankle was broken. The talus bone in the center of the joint was broken all the way through and had been grinding away all this time. The x-ray angles couldn't catch it. The joint surfaces were ruined and I was never able to run again. My career was over. My body was toast. I spent the rest of that season on Injured Reserve, had my left knee scoped again and then retired. I did make one more mistake. I went to Dr. Rosenfeld to take the screw out of my ankle after it was healed because I was having some irritation. I thought it was an easy surgery no one could screw it up. I was wrong. I got a severe staff infection after the surgery that had me in the hospital for 28 days and on home IV antibiotics for another 4 weeks. I have had problems with recurring staff infections ever since.

After retiring I bought a home in Washington where I grew up and then invested in a vending business which I ran myself. I was a 1st round draft pick but my timing was not that great. I missed the really big money. As a matter of fact in my whole 7 year career I did not make a million dollars if you added every dollar I made together. I made good money, don't get me wrong, but we lived in the Bay Area and then Los Angeles where it was very expensive and most of the money I saved I put into the house and the business I bought in retirement. After a couple of years in the candy and beverage business, even though it made money it was not fulfilling. In addition I needed another surgery on my ankle and we did not have any insurance coverage. I was being asked to speak to youth groups and other organizations in my spare time and enjoyed that, so I thought I would sell my business and try to find work with young people. No one would hire me because my only other work experience was for myself or playing football. I was finally hired by the Mayor of the City of Everett Washington to run some youth programs.

I then had the first of what would turn out to be 11 more surgeries on the right ankle. I had more loose bodies taken out. Several months later some bones spurs removed, followed by some more loose bodies removed some months after that. I suffered another staff infection following the 3rd surgery and spent 11 days in the hospital including an additional surgery to clean the infected area and then 4 weeks on home IV therapy. After one more surgery to remove even more bone spurs that developed it was decided to fuse the sub-talus joint. That was done. This put more pressure on the ankle joint itself and I began having problems with that. In the mean time my low back is still in horrible shape. Somehow, in between surgeries I am still working and my bosses are very patient with me. Loose bodies were removed from my ankle joint followed by a surgery to remove bone spurs. My doctor then said he had done all he could do and referred me to the foremost authority on ankle surgery on the west coast who advised total fusion of the joint. We made 3 separate attempts to fuse the joint. After each attempt and subsequent recovery period the fusions broke down and collapsed. This was probably due the trauma

to the bone by all of the surgery and infection. The only other solutions then were to use a wheel chair or amputate.

Prior to the amputation I told the doctor that I had been experiencing extreme pain in my hips, especially my left. He examined me and found that I had avascular necrosis in both hips. It is a decease where the blood flow has been restricted to the hip bone and the bone dies and slowly crumbles away. The only solution is total hip replacement. When I asked how this could have happened to me, it was explained given my history of excessive cortisone injections that they were most probably the cause of the decease. I would need a total hip in the left within 2 years and the right sometime later. They felt that they might be able to give my right hip some more time if they did a bone graft during the amputation surgery. The amputation and hip graft were done in 1994. By this time I had missed so much work that I was amazed that they still kept me employed. They said they understood my hardships and felt that it was still the right thing to do as long as I could help them raise money for the non-profit. The Parks Department had just developed a new 501C3 to support its programs and I was assigned to help with that. They appreciated how hard I had worked when I had been capable and felt that my name recognition and personality in the community would still be helpful in working for their non profit. They became the ultimate benevolent employer.

For the next year and a half I worked as often as I could until I simply could not walk on my hip anymore and went in for the replacement in 1996. After recovering from that I had taken some youth to the Seahawk training facility to see practice. I ran into Reggie McKinzie who played several years in the NFL and was coaching with the Seattle team. He saw my artificial leg and asked me if I had applied for the new disabled player benefit. I said I only knew about the one you had to file within 12 months after playing or you were ineligible. He said there was a new one from the 93 CBA. So I called and asked for the info and was sent the information in 1996.

I applied and was told I needed to see a doctor at my own expense (to be reimbursed if I qualified) and the physician would make a recommendation to a board who meets once every 6 months. The board votes on the recommendation and you are either approved or declined. In case of a tie you are sent to another doctor and you repeat the process. In case of another tie, you are then sent to a MAP physician who has the final word on weather you are approved for the total and permanent disability or not. No more votes after the 3rd doctor will take place. In the paperwork it also said that you are totally and permanently disabled if you are not able to work for remuneration or profit. The exceptions were: if you worked for any team or the league, if you worked for a charity or if you worked for a benevolent employer. I worked for a charity and a benevolent employer. So I had the city of Everett Parks Department write a letter which I took to each doctor I went to.

My 1st doctor was a physician on Colby avenue in Everett, Washington. He looked me over thoroughly and stated that he had seen several players and not recommended many if any at all but that I was the worst he had ever seen, with my leg, hips, back, shoulder, hand, arm, neck and knees. He said he was recommending a yes for the board. After the

board met I received a letter stating that they had a vote and it resulted in a 3 to 3 tie. I needed to see another doctor at my expense if I wished to pursue this. I said yes and was sent to Dr. Smith in Seattle, Washington who stated that I was the worst he had seen. In the mean time, I was having a lot of re-occurring problems with my stump, getting sores and infections and not being able to wear my prosthesis. In addition, my low back was getting worse and I was having the signs of more disc problems with pain shooting down my leg. My right hip was getting harder and harder to get around on. After Dr. Smith sent his recommendation, I was informed again that the vote of the board was 3 to 3. I was told I would have to see the final doctor in Los Angeles, California. I paid for my round trip to see Dr. James Tibone in late August of 1997. He said the same thing I had heard from the 2 physicians before him. He stated that he did not approve many but that I was the worst case had seen and that he was going to recommend that I receive the total and permanent disability. The board met 2 months after that and I received news that my disability had been approved as of 9/1/1997 and my checks started to come. I applied for the first time in mid 1996 and about a year and a half later I was finally approved for disability.

I continued to show up at the city of Everett from time to time for about a year more until I just couldn't do it any longer. I had another hernia surgery, this time in my upper abdomen. In addition, my back, hip, leg and now neck pain were limiting me from even doing the little things on any kind of regular schedule. I had to quit and rely solely on my disability income. This meant that my wife had to find work in order for our family, which included 3 children, to have health insurance. In 2001 I went in for my 28th surgery to have the disc removed from between the C5-C6 vertebra in my neck and then have it fused together. This eliminated some of the more severe pain in my upper spine. However, I still have bad arthritis and pain in my neck and upper back from all of the high speed impact during my playing days.

In 2003 the severe pain in my low back again became too much to bear so I had surgery to remove the bulging disc at L3-L4. Following that surgery I went through what was to be the worst medical experience of my life. I again got a staff infection, but this time it was in my spinal area. I have experienced pain in my life, but never before have had I to endure the kind of pain that I lived through for several weeks with that infection. I was in the hospital for 2 months. The stay included an additional surgery to clean out the infection and add 2 steel rods on each side of my spine in the low back to stabilize the area so it could heal properly. I had to learn how to walk again when that was over. After I got home I was on home IV therapy for another 2 months. What a nightmare.

In 2004 the shoulder I had injured playing football had gotten so bad that I could not lift it more than half way to my head, so I relented and had arthroscopic surgery to clean the joint out and finally repair the damaged ligaments. By 2006 my right hip had collapsed to bone on bone and I could barely take a step. I was deathly afraid of major surgery now because of the last infection, but it had to be done. I had the total hip replacement in October and recovered fairly well. And that brings me to the here and now.

I have been required by the Plan to see a physician once a year since receiving the disability to have a thorough checkup to prove that I am still disabled. I guess they want to make sure that I haven't grown new hips or a leg, or that my back and neck are miraculously not full of metal and severely arthritic. Not to forget my knees and shoulder, or arm that I cannot fully straiten and the hand that I can now barely make into a fist.

I have been asked to comment on the disability plan and its procedures of qualification. To that I must say this. I believe that the procedure is altogether much too cumbersome. I went through it and experienced this first hand. And I find it very interesting when I hear it said that I must be confused about my own experiences. In talking with staff preparing for the hearing they called me after meeting with the NFL and NFLPA reps and asked if I was sure that I had seen a arbitration physician to decide my disability. I responded that I was sure. I was then told that the NFL reps stated that I had not and that I was probably confusing some other doctor visits I had with the disability required visits. I was a football player but I am not dumb. I have an IQ in the high 130's and have no problem with my memory. I was contacted by Gene Upshaw after I was asked to report to this committee. He said he had seen my name on a witness list and wanted to know what my interest was. I had been a teammate of Gene's and always gotten along well with him, so I told him I was going to comment on my experiences and how cumbersome the process was, taking me a year and a half, as well as how many doctors I had to see. I didn't understand how 2 doctors' recommendations saying the same thing to the same group could still come back in a deadlock twice until the 3rd doctor had to decide it for them. I said if you believed the 3rd doctor you should just send people to him in the first place. If my job was the issue that was ridiculous because of the letter my employer wrote stating that I was unemployable but that they kept me employed as a favor to me and for my name recognition to help their 501C3 to raise money. That covered 2 of the clauses in the CBA for employment. If you were employed by a benevolent employer or worked for a charity you could still qualify for the total and permanent disability. So my employment was moot. After our conversation I received an e-mail from Gene trying to tell me that he had information which said I only waited 6 months for my disability to be approved. He then faxed me a paper showing I applied June of 1997 and was approved in October of 1997. Where in the heck did they come up with these dates? This doesn't even make sense. If the board only meets once every 6 months and my case was submitted even to only 2 doctors as their paperwork says, it would take at least 6 months not 4. In addition their paperwork says that the second doctor I saw was Dr. Tibone and he was a MAP physician. Which I believe refers to their "medical arbitrating physician." You are not sent to a MAP doctor unless you have been to the board twice with a tie. That is in the instructions for the disability procedures. So they are not only trying to convince everyone else that the process is fair, quick and simple. They are so bold as to believe they can convince even me that I don't remember it correctly and I was approved within 3 to 4 months of my application coming in. It reminds me of when I was a young child and I didn't want to get caught by my parents doing something wrong, so I lied so fervently that even I began believing my own lie. Either that or they just keep horrible records.

I have absolutely no reason to lie to you today. I have nothing to gain either way. I was not even aware of the groundswell surrounding this issue until I was invited to testify and searched the internet and found many articles about Coach Ditka and Mr. Carson and others raising awareness about this issue. I even read the transcript of the case brought against the Disability Plan by the family of Mike Webster and I was extremely disappointed by what I read. It reminded me of the feelings I experienced when going through my application process. I felt as though some members on the board reviewing my case were looking for the smallest loophole to not grant disability rather than trying to find people who truly qualified. I was reminded of a movie I had seen called "Rain Maker", where a poor family was seeking insurance coverage for cancer treatment from there carrier but kept getting denied until it was found out that the denials were a result of a policy the company had to simply deny every single claim that came in regardless of the merit to try to weed out as many people as they could. Only those with the will to stick it out even had a chance at getting any further and even then they just kept denying until you went away. I am not saying that is what is happening here but I am saying that is how I felt. I had no leg, no hips, no back, and the rest of my body was falling apart. I had a job but it was with a benevolent employer and a charity which were both allowed under the plan. Even then I was hardly ever at work due to surgeries or complications. And finally the doctors that examined me recommended that I receive the disability. I thought to myself, "If I don't qualify, then who would? You must have to be paralyzed in a wheelchair to get this benefit."

I appreciate that the 1993 CBA introduced the degenerative disability plan at all, because before that a player had to file by his 12th month out of the league or he was out of luck. How many of us even know that our cumulative injuries are going to be so disabling by then? Not many. But more needs to be done. The suggestion I read about, forwarded by Gene Upshaw, to rely on the Social Security standard for qualification is as good a place to start as any. But, once the process is stream lined and fair then the benefit itself needs to be examined. The benefit is currently a monetary benefit, which is great. But that is only half of the story. There are 2 problems that I believe the next CBA should address and those are cost of living increases which can either be negotiated in each CBA or set at a percentage each year and just set continuously and the second is medical benefits. The issue with total and permanent disability is that you will never be able to work again which means you will never qualify for health insurance again either. If you are so disabled by your football related injuries that cannot work then you will most defiantly need a lot of medical care and that is extremely expensive. The amount of money I receive from the benefit helps to pay the bills and feed my family and then some, but it comes nowhere near being able to cover the staggering medical costs I have incurred over the years. I thank God my wife is willing to go to work every day and provide insurance for our family. What about those who are not married or who's wives cannot work? No amount of monthly stipend is going to cover surgeries and hospital stays or home health care. So I believe that the next addition to the disability plan should be a health insurance component which is good for the duration of time that the player qualifies for the disability.

In closing I would like to add, that the players who came before us are the foundation of all that came after us. They deserve our respect and compassion. The medical treatment they received during their playing days was far inferior to that of today's million dollar athletes and they are suffering the consequences in the here and now. It is easy for those who are dealing in the world of the high finance NFL on a day to day basis to get caught up in how important who and what they do seem to be. So much so, that it is easy to forget the suffering of those trailblazers who have no voice today. I may be in the minority but I still hold out hope that Gene Upshaw will fight for the players of the past and make the improvements that are required to serve their needs. He must be held accountable. Thank you

Curt Marsh
Surgical History

1979 L5 S1 Laminectomy
1981 Lower Hernia Left
1982 Tonsillectomy
1982 Lower Hernia Right
1983 L4 L5 Discectomy
1985 Right Upper Arm Open Reduction
1985 Left Hand Open Reduction
1985 Scope Right & Left Knees
1986 2 Surgeries on Broken Right Ankle (*Staff infection following second surgery*)
1986 Left Knee Scope
1989 11 more surgeries on right ankle including a
- subtalor fusion and 3 attempts to fuse entire
- ankle. (*One more staff infection following an*
1993 *ankle surgery in 1991*)
1994 Right Below Knee Amputation combined with a vascular and bone core replacement in right hip.
1996 Left Total Hip Replacement
1999 Stomach Hernia
2001 Discectomy and Fusion C5 C6
2003 Discectomy L3 L4 (*Followed by severe staff infection of spine)*
2003 Another L3 L4 Surgery plus Fusion to clean out infection and fix problem with first surgery.
2004 Left Shoulder Surgery to clean joint and tighten ligaments
2006 Right Total Hip Replacement

Ms. SÁNCHEZ. We are now going to take a brief recess so that we can assemble both panels for our round of questioning. Members are advised we will be in recess for a brief 5 minutes. Don't wander too far.

[Recess.]

Ms. SÁNCHEZ. Okay. At this point we would like to begin our round of questioning for the witnesses. The same rules apply to your testimony. You will see the light. It will turn green when the time has begun. At 4 minutes it will turn orange, and at 5 minutes it will turn red. If you are in the middle of answering a question, please feel free to wrap up your final thought before we move on to the next Member for questioning.

At this time I would like to recognize myself for 5 minutes of questioning, and I would like to begin with Mr. Curran. At a certain point in your testimony you said that the league was not really required to provide pensions to players who played prior to 1959, although it did. What about morally? Whose obligation or responsibility do you think it is to help former NFL players?

Mr. CURRAN. They are part of the NFL family. We all try to help as best as we can. Twenty million dollars in benefits for disability went out just last year alone from these plans.

So we all have an obligation to help, and as with the pre-1959ers, we are constantly looking to improve the manner in which we do it, either by speeding up the process, as we tried to do with the Social Security benefits, or through this new alliance with all these other funds in order to take care of players who do not qualify for total and permanent disability, but may qualify for other medical needs.

So I believe that we all have an obligation, and I think the NFL is fulfilling it.

Ms. SÁNCHEZ. Mr. Ell, I am interested, you talked about the fiduciaries of the plan. And I want to talk about the six members on the board who review these applications for disability benefits. My understanding is that three of the members who serve as fiduciaries of that plan are picked by the owners, and three are picked by the current players. Are there any retired players, or do the retired players have a say in who sits on that six-person board?

Mr. ELL. Thank you. On disability decisions, under the rules of the Department of Labor, there is a different committee that makes the initial decision. Under the plan, it is called the Disability Initial Claims Committee, and each of the sides appoints one person to that. Appeals——

Ms. SÁNCHEZ. Do retired members have a say in who sits on that?

Mr. ELL. The union appoints one person. That person is not a retired player. But there are three retired——

Ms. SÁNCHEZ. Does the union represent retired players?

Mr. ELL. I think I would have to defer to the labor lawyers, but I believe under the labor law the union is required to represent active players. The union has fought very hard for the retired players. The motto of the NFL——

Ms. SÁNCHEZ. The answer to my question would be no, there is no retired players who sit on that board then.

Mr. ELL. There are three retired players who sit on the Retirement Board.

Ms. SÁNCHEZ. The Retirement Board, but not the Disability Board.

Mr. ELL. That is correct.

Ms. SÁNCHEZ. You also mentioned that the fiduciaries of this plan, they don't get to make the rules, they just get to interpret the rules.

Mr. ELL. Yes.

Ms. SÁNCHEZ. As an attorney it makes a great deal of difference oftentimes to cases depending upon who is interpreting the rules or how the rules are being interpreted. And I wanted to ask Mr. Smith about that. You maintain that basically the languages of the plans are okay, or the proposed changes to the language where the Social Security disability standard would apply may not make any deal of difference because it is all in what? It is all in the interpretation of those rules.

I want to ask you, particularly because I know you probably have a lot of experience with this, about the review that courts have over these decisions of arbitrators. It is my understanding that 24 of 25 cases that were brought before the Federal court the retired players lost because of the difficulty in overcoming the arbitrary and capricious standards. Could you clarify that or elaborate on that for us?

Mr. SMITH. The Supreme Court has said, in a 1989 decision, that if the plan document gives that sort of discretion to the Retirement Board or the plan administrator, then a review of a decision will be for abuse of discretion. That doesn't mean that the plan administrator or the Retirement Board was right; it just means they weren't shockingly wrong. And the courts have said very often that there might be decisions they don't agree with, they would have made different decisions, they could even be against the weight of the evidence, but as long as they are not an abuse of discretion, then the fiduciary will be sustained.

So to say that the plan has won a number of these cases just tells you that the barrier for review is very high. The fact that there have been that many cases suggests that there is something broken in the system.

Ms. SÁNCHEZ. Thank you.

I want to ask the retired players about health insurance and how expensive it would be to purchase health insurance, considering the preexisting conditions that most of you suffer. Anybody want to take a stab at that?

Mr. MARSH. I quit looking. Ten or eleven years ago, when I was looking, when I left the city of Everett and I could not work anymore, it was going to cost me around $700 a month at that point to get health insurance for me and my wife and three children, and it would have been just hugely expensive for me. And I am sure it is a lot more than that. Over $1,000 a month it would probably cost me to have health insurance.

Ms. SÁNCHEZ. Anybody else?

Mr. CARSON. Well, you know, I had the opportunity to shop for insurance as well. I found it to be a bit more than I could pay, because after my football career ended, and also dealing with the

postconcussion syndrome, my life sort of took a hit. It didn't hit rock bottom, but it took a hit, and I had to make a decision as to what essentials I was going to spend my money on, whether it be my mortgage or whether it be my utilities or whatever. At that point, buying insurance was not something that I could do. If I had to go to a doctor, I basically would pay out of pocket. And God forbid if I had come down with some catastrophic illness, I would have had to mortgage my house and whatever investments I had had.

Ms. SÁNCHEZ. Mr. Marsh?

Mr. MARSH. I would just like to make one more comment, if I may.

Ms. SÁNCHEZ. Briefly.

Mr. MARSH. I just want to clean up one misconception that many people may have. When you hear that someone like me was a first-round draft pick, I was drafted in 1981. And just to make it clear, I played for 7 years. I was the 23rd player picked in 1981. In my entire career over that 7 years, I did not make $1 million if you add all the money I made together in my NFL career. So I retired with enough money to buy a house and invest in a business, and now—and then I had to find a job.

Ms. SÁNCHEZ. Okay. Thank you. My time has expired.

I will now recognize my distinguished Ranking Member Mr. Cannon for 5 minutes of questioning.

Mr. CANNON. Thank you, Madam Chair. Was my opening statement included in the record?

Ms. SÁNCHEZ. It was.

Mr. CANNON. Thank you. I appreciate that. And I apologize not having been here. I needed to be on the floor, making an amendment to the Interior appropriations bill.

I want to thank our panel for being here. This is actually a pretty interesting group of people, and surprisingly articulate. Maybe I shouldn't be surprised, but you guys have made a case that I think is very thoughtful.

This Committee is about the rules, and we were actually having a discussion about the rules on our side of the aisle here. And so without jeopardizing any future ability to object to the rules, we actually have a Member of the Committee who has a special interest in these issues, and so I would—if she is interested, I would be pleased to yield to the gentlelady from California for the period of my time.

Ms. Waters.

Ms. SÁNCHEZ. Ms. Waters.

Ms. WATERS. Well, thank you very much. I think that is very generous. I am a Member of the Judiciary Committee, but not this Subcommittee, and I thank you for yielding time to me.

I do have a very special interest. My husband was a former football player, and I have learned an awful lot about what happens to retired football players. I want to thank Mr. Bernie Parrish for having dedicated his life to trying to get some justice for former and retired football players. And I want to talk about a case that I worked on.

My husband had a friend who was a football player. His name was Jim Shorter, and he died an awful death. When he died, he

had received several amputations. He was blind. He was on dialysis. He was broke. He had nothing. And I had to work on the case.

I called the Players Association on many occasions, and I think some people down here can remember those calls. And I will never forget that I was not treated kindly. And I had been warned that that would be the case by the wife of Mr. Jim Shorter. But I was persistent, and I followed it all the way to showing up at one of the meetings of the representatives who had the fiduciary responsibility to make a decision about Mr. Jim Shorter and whether or not he would receive some kind of disability benefits.

I have learned through all of this that he had taken early retirement at that time, and he was not eligible for any disability benefits. That is something that I am told may have been worked on since that time. But I have to tell you for these players who played years ago who didn't make a lot of money and who ended up retiring and not having much in the way of money to live on, they did take early retirement in order to have some income, but they didn't know, they truly did not know, that this would eliminate their ability to get disability benefits no matter what was discovered about their medical condition and whether or not it was connected to the time that they played.

Having said that, I think it was Mr. Ell or Mr. Curran who mentioned that there are 317 players now on disability. Is that correct?

Mr. ELL. Yes, that is correct.

Ms. WATERS. What is the number of players that have played for the NFL, and what percentage is represented by this 317, out of how many players?

Mr. ELL. I think if you count terminated vested players, that is players who played at least 3 years and entitled to a pension and potential disability, and then we have about 3,000 people currently collecting a benefit, and about 2,100 active players, you can add it up in different ways, that adds up to about 10,000 people roughly.

Ms. WATERS. You are saying there are 10,000 people who have played in the NFL?

Mr. ELL. Including current players. I think——

Ms. WATERS. Total?

Mr. ELL. Without the current players it is about 8,000.

Ms. WATERS. I beg your pardon?

Mr. ELL. Without the current players it is about 8,000 terminated vested players.

Ms. WATERS. So in one of the most dangerous sports in the history of mankind, only 317 players are receiving disability from this sport. Is that correct?

Mr. ELL. Only 317 players have been found to meet the plan's eligibility benefit requirements, that is correct.

Ms. WATERS. And you mentioned that $20 million figure. Would you tell the Committee exactly what that represents?

Mr. ELL. I think that was Mr. Curran's——

Ms. WATERS. Mr. Curran, what does that 20 million represent?

Mr. CURRAN. It is the amount of money that was going out last year for people on the various disability categories that I mentioned earlier: active football, active nonfootball, football degenerative, inactive, and line of duty. There are also some death beneficiaries or surviving spouse beneficiaries.

Ms. WATERS. About how many people would that represent?

Mr. CURRAN. I think that is the same number we are talking about.

Ms. WATERS. The 317?

Mr. CURRAN. That is correct.

Ms. WATERS. Twenty million dollars.

Ms. SÁNCHEZ. The time of the gentleman has expired.

Mr. CURRAN. That is correct.

Ms. SÁNCHEZ. I am going to ask unanimous consent to give Ms. Waters an extra minute to finish up that line of questioning if she so chooses.

Ms. WATERS. Yes, thank you very much.

Mr. FEENEY. Madam Chairman, if I could.

Ms. SÁNCHEZ. Yes.

Mr. FEENEY. What I would like to do is give unanimous consent to give Mr. Cannon an additional minute, which he can yield as he pleases, so I can be faithful to the commitment that I gave to my Ranking Member.

Ms. SÁNCHEZ. A very well-thought-out plan, Mr. Feeney.

Mr. FEENEY. There is more than one way to skin a cat, Madam Chairman.

Ms. SÁNCHEZ. That is correct. And we are doing it very nicely here. I will ask unanimous consent that Mr. Cannon be given an additional minute of questioning.

Mr. CANNON. I thank the gentleman for that clarification, and appreciate the extension of the extra minute, and would be pleased to yield it to the gentlelady.

Ms. WATERS. Thank you very much, and I appreciate that.

So the $20 million comes from the fund for the NFL Players Association. How much is in that fund?

Mr. CURRAN. 1.1 billion.

Ms. WATERS. $1.1 billion, and you spent $20 million last year on 317 players total.

Mr. CURRAN. The rest of the funds are committed for future retirements. It is funded for those people that are going to retire in the future and have disabilities in the future. So that money is not discretionary. It is already committed.

Ms. WATERS. So you don't differentiate between disability and retirement. You have to have the money there for retirement. So all that money that is spent on disability takes away from the retirement money; is that correct?

Mr. CURRAN. No, that is not correct.

Ms. WATERS. How does it work?

Mr. CURRAN. Both the retirement and the disability future needs are in one fund, except for a supplemental disability fund, which even gives more. But as far as the Bert Bell fund is concerned, both disabilities and pensions are funded for what is anticipated——

Ms. WATERS. How much is in the disability fund?

Mr. CURRAN. It is one fund. It is the 1.1 billion.

Ms. WATERS. That is what I thought, and that is what I said. It is all in one fund. So to the degree that you give out money or you pay out money for disability, it reduces the amount of money for retirement; is that correct?

Mr. CURRAN. No, that is not correct. We will always have to pay the full amount of retirement to which we have committed. And if the money is insufficient to do that, we would have to put in more money. It would never revert.

Ms. SÁNCHEZ. The time of the gentleman has once again expired.

At this time I would like to recognize the gentleman from Massachusetts Mr. Delahunt.

Mr. DELAHUNT. Thank you, Madam Chair.

Mr. Curran, you indicated in your opening remarks that you were funding this willingly. I almost drew the inference that this was out of altruism and a sense of compassion. I presume this is achieved as a result of negotiations, it is a collective bargaining agreement.

Mr. CURRAN. That is correct.

Mr. DELAHUNT. The NFL didn't do this because they wanted to be kind and good. They sat down and in negotiations and they reached an agreement; is that a fair statement?

Mr. CURRAN. We reached an agreement with the union on disability, that is correct.

Mr. DELAHUNT. Thank you.

You know, 20 million out of 1.1—I mean, you say it in a way that makes it seem like it is a significant amount of money. That 1.1—presumably is professionally managed.

Mr. CURRAN. That is correct.

Mr. DELAHUNT. Right. And I presume that there is a return on investment that is somewhat equal to what we see in an index fund, for example?

Mr. CURRAN. Yes.

Mr. DELAHUNT. So if the index fund should achieve a growth of 15 percent a year, it is earning $150 million a year. Is my math pretty well?

Mr. CURRAN. Our target is 7.25 percent actually.

Mr. DELAHUNT. Yeah. I hope you do better than 7.25.

Mr. CURRAN. It depends on the markets. Three years ago we didn't.

Mr. DELAHUNT. Right. You know, if I could do better than that, I would think the NFL pension system could do better than that. But, you know, it seems to me—and I can understand the frustration of the retired players here—there is a quote that I came across by the president of the players union, and let me read it into the record. It's from a New York Times article. And this is Mr. Gene Upshaw. He told a North Carolina newspaper, the bottom line is I don't work for the retired players. They don't hire me, and they can't fire me. They can complain about me all day long, but the active players have the vote. That is who pays my salary.

I guess that clarifies your confusion, Mr. Ell, as to whether the retired players are part of the union or they are not, if we can accept that statement as being accurate.

Mr. ELL. If I may, I think that statement was clearly taken out of context. Over the——

Mr. DELAHUNT. I am not asking about that statement.

Mr. ELL. All I am saying is I don't think it is an accurate statement at all of how Gene Upshaw and the union leaders have operated over——

Mr. DELAHUNT. I am not asking how they operated. I am asking whether the retired players are part of the union.

Mr. ELL. Legally, no.

Mr. DELAHUNT. Legally, no.

Mr. ELL. Correct.

Mr. DELAHUNT. Maybe it was taken out of context. But I am sure that retired players who read that particular quote are not encouraged to believe that they are being adequately represented on the issues that directly impact them. It doesn't go to build confidence.

Mr. ELL. I understand that, but legally under the law——

Mr. DELAHUNT. I understand, but we can change the law here. That is what we are doing. And we see, at least I see, okay, a sense of disenfranchisement on the part of the retired players. Now, that might be perception, that might be accurate, I don't know, but I think it would behoove the NFL and the NFL Players Association to consider, you know, either absorbing the retired players into the Players Association so that they have a sense that they are being adequately represented. Do you have a problem with that, Mr. Ell?

Mr. ELL. Absolutely not.

Mr. DELAHUNT. Okay.

Mr. ELL. The retired players have an association, and Mr. Fugett here is the head of the Retired Players Association associated with the NFLPA. Mr. Fugett attended the——

Mr. DELAHUNT. I am sure that he does a terrific job. I am not even commenting on that. What I am saying is when it comes down to decisions and issues that impact how they live and the quality of their life, they want to be at the table represented by an association that they have confidence in.

I think it was Mr. Ditka that said let us fix the problem. How do we go about fixing the problem? There is enough money, you know, sloshing around. What does the industry generate now in terms of income, 7-, 8-, $9 billion a year?

Mr. ELL. I heard 7-. I don't know.

Mr. DELAHUNT. I don't know either, but what I am saying is I think in terms of respect and dignity, you know, there is enough there in terms of the size of the pie to address what I believe to be legitimate concerns when you have retired players who come before this Congress and say that they can't get health insurance.

Ms. SÁNCHEZ. The time of the gentleman has expired.

At this time I would like to recognize the gentleman from Florida Mr. Feeney for 5 minutes of questioning.

Mr. FEENEY. Thank you, Madam Chairman.

Mr. Smith, given your experience and your relationships with others that have represented players with disabilities, is there a bias in the selection of the physicians that do the review in terms of the eligibility for disability?

Mr. SMITH. Some of the physicians appear to be neutral; some of them do not. It depends. A much bigger problem is the phenomenon of doctor shopping, where the plan will send an applicant to multiple doctors, until they have at least one report that they can use to create a division in the medical evidence, and then rely on that same abuse of discretion that I was being asked about earlier to find that the applicant is not disabled.

Mr. FEENEY. Well, given that, Ms. Wagner, this Committee has no jurisdiction over ERISA, and you are an expert in ERISA. We do, the full Committee does, have jurisdiction, not this Subcommittee, over antitrust issues. And there are antitrust exemptions for the NFL Players Association. Mr. Smith has said he thinks that this is an attitudinal problem, that new legislation can't fix it. Do you agree with that? And is there anything that you can think of that we can do?

I mean, we just heard the president of the union Mr. Upshaw suggest that he doesn't represent, at least in his opinion, the former players. Obviously, the owners have some differing interests than former players that are asking for disability that they are going to have to in part fund. So if nobody is there representing, as they appoint these three people on the review boards, you got three appointed by Mr. Upshaw, who says he doesn't represent the former players, three appointed by the owners, is there something that we need to do legislatively, or do you agree with Mr. Smith that this is a mere attitudinal problem of the people making the decisions?

Ms. WAGNER. Well, I think a couple things. First of all, I think one of the questions you are asking is outside of my jurisdiction, which is ERISA. The joint boards are, in fact, required, as I understand it, and I am not a labor lawyer, by the Labor Management Relations Act of 1947, the Taft-Hartley Act, so I think you need to talk to somebody else about the makeup of that Board.

But I think that, although obviously I don't know about the implementation here, it strikes me that looking at the plan documents, they seem to follow exactly what they should do. They seem to say the right things. They seem to be approaching the problem the right way from an ERISA perspective. But some of the delays, and apparent by long delays, concern me without knowing, frankly, from my perspective, whether people have filed serial claims and that is the reason for the long delays; whether people have agreed to the delays, which the plan allows them to do; or whether or not there is something else happening here. It is really an implementation question, I think, rather than a structural or design question.

Mr. FEENEY. If there is nobody aggressively protecting the interests of former players who may have disabilities, either at the front end, when we are deciding how much money to put aside, or on the back end, when we are deciding who is eligible, and we have a group that should be protected that is not protected, and isn't there something legislatively you can think of we need to do to fix that?

Ms. WAGNER. No, I don't really think so. And let me tell you my experience is mostly with single-employer plans, not multiemployer plans like we are talking about here. In a single-employer plan the employer decides, period, how the plan is designed. You don't have collective bargaining, you don't even have the input of the active players. So this already takes the process a step further from the perspective of where I sit most of the time. You don't have input of retired people in single-employer plans either.

Mr. FEENEY. But this is a little different than your typical employer. It is a dangerous work environment, even for those of us that are among the most avid football fans. We don't send OSHA onto the practice field every day to make sure everybody is getting

the right amount of hydration and being treated—we don't do that. We actually give an antitrust exemption from a lot of Federal laws.

Coach Ditka, you indicate in your testimony that there are 300 players that have been documented and identified as in need of disability assistance. I assume that is in addition to the 317 that the NFL and the NFLPA collective bargaining agreement is paying?

Mr. DITKA. Yeah. Mr. Feeney, I am not sure that is 100 percent right. It is somewhere in that area. And, you know, I just think to go back and pick up these people and take care of them, it is not that big a problem. I go back to, you know, we hear the NFL talk about what they do, we hear the owners, but what do they really do? Don't they have a responsibility and an obligation as owners who have made a heck of a lot of money? Believe me, nobody is going broke. Players Association, sure they fought for what they had to get, for benefits, and I understand all that. They got a lot of money in the coffers also.

The responsibility has to go back to the league and the owners as well as anybody else to take care of these people. That is what it is all about, just right versus wrong, period. You know, do the ethical thing or do the wrong thing. So far they have chosen a path of the wrong thing.

Now they come up with this idea we are going to form another committee, but this time we are going to put Mr. Upshaw, the Commissioner of the National Football League, NFL Charities, NFL this, NFL that, and they had the audacity to say would you take the money in your trust, which is minute, and put it into our fund so we can administrate it? Come on. You got to be kidding. That is exactly what they don't do. They don't administrate anything. It is a bunch of red tape and a bureaucracy. That is all it is.

Now, listen, when people have needs, they come to us, and we say, what are your needs? You need money? You got to pay the bill? Bang, you get a check. What the hell is the matter with that? Why is that wrong? I don't understand it. Take care of them. Then go out and make them fill out the forms. And then go talk to all your other lawmakers, the ERISA, or everybody else. And I don't know all these terms. I am not that intelligent to know all this stuff. I am just saying I know what is right, and I know what is wrong. What is happening now is wrong, period.

Mr. FEENEY. Madam Chair, I don't want to quarrel with Coach Ditka.

Ms. SÁNCHEZ. I wouldn't recommend it.

Mr. FEENEY. I yield back the balance of my time.

Ms. SÁNCHEZ. Thank you, Mr. Feeney.

At this time I would like to recognize the gentleman from Georgia Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you, Madam Chairwoman.

On Sunday evenings, Sunday afternoons and evenings, you know, the American public puts on that TV, big screen TV, sometimes two or three games on at one time, and sits there and watches the games, and we see the warriors out there who are playing through injuries that any mortal man would take a few weeks out and let the recuperation process set in. But they get out there anyway because they got the finest of medical care, they have the

gentle urging of their coaches, Coach Ditka, to play through the pain. There is always somebody in the background ready to take their spot if they don't, and it is a very competitive situation.

We watch all of the ads, we go to the games, we drink the beer. It is all so many people making money. And the athletes on Monday morning go into rehab and try to get ready for the next week's game. And then after the season is over, you know, it all begins once again to get ready. And so superhuman dedication by these players.

And then once they finish their careers, after having been smacked around in the head with closed head injuries that don't start manifesting until some point later, they start knocking on doors, wanting to consider disability payments, and so they make application. Who do they make application to but a Disability Initial Claims Committee, a two-person committee, one person appointed by the NFL, the other person appointed by the NFL Players Association. And I guess these individuals who make up that Disability Initial Claims Committee are paid for their work. Is that not correct?

Mr. ELL. One of them is an employee of the NFL, one is an employee of the NFLPA. They are not paid by the plan.

Mr. JOHNSON. They do get compensation for rendering their service and adjudicating the claims, correct?

Mr. ELL. Correct.

Mr. JOHNSON. And they like to get called back so that they can adjudicate more claims, and I guess so that they can make money, too.

Mr. ELL. Actually——

Mr. JOHNSON. Hold on now. I guess the numbers that have been cited that were revealed by Congresswoman Waters show a great gaping disparity between the former players and those who are receiving disability benefits. And just looking around this room I see there is so many interested people here today that appear visibly they are injured. I can see that they are injured.

But at any rate, the claim gets denied at that process, at the Disability Initial Claims Committee, and then the poor old slob has to appeal to a six-member Retirement Board; again, three of those persons appointed by the NFL and three appointed by the NFL Players. And those people get paid, too, to decide the claims; do they not?

Mr. ELL. That is not true. They never received a penny in compensation for being fiduciaries or deciding claims.

Mr. JOHNSON. Maybe we should pay some professional folks, and those folks might even go to work, because this review board doesn't work but four times a year to handle the claims. And then there is no ability of the poor player to appeal the decision, isn't that correct, once they get denied?

Mr. ELL. Once they get a final denial from the Retirement Board——

Mr. JOHNSON. There is no appeal to an independent body.

Mr. ELL. The Retirement Board is a second body. After that——

Mr. JOHNSON. And there is no further appeal after that body.

Mr. ELL. Generally, unless sometimes the Retirement Board allows another appeal if——

Mr. JOHNSON. The door is closed.

Mr. ELL [continuing]. If there is a concern that the player hasn't had a chance to put enough evidence in.

Mr. JOHNSON. The door is then slammed shut on the player. And then as a result we have got the players who are here today who complain that as a result of all of this money that has been made on their backs, their blood, sweat and tears, that in their time of need the door is shut. And there is no one there, and they have to resort to the baseball players to help them out, to give them a hand-out. And that to me, for a proud warrior who has given their service, is quite a tragedy. My heart cries for those who are afflicted, and I know that there is something that we must do in order to correct this injustice.

Ms. SÁNCHEZ. The time of the gentleman has expired.

At this time there is enough interest in a second round of 5-minute questioning, if you would indulge us. I will recognize myself.

Mr. Ell or Mr. Curran, can either of you tell me why there is a 12-year statute of limitations on disability claims? I am interested in knowing why and who set the timeline. And particularly given the serious nature of the injuries that can be sustained over the course of a football career, why would there be a process that was structured so that there is a limited time frame when benefits can be claimed, when the immediate effects or aftereffects of some very serious injuries can last a lifetime?

Mr. ELL. Thank you. There is no 12-year statute of limitations. If you are unable to work 25 years after leaving the NFL, for whatever reason, you can get disability benefits. I think you may be referring to a provision in the plan that says you can't get the higher football degenerative disability benefits. Right now the period for that is 15 years.

Ms. SÁNCHEZ. Why is that?

Mr. ELL. I believe the problem that I believe was considered is that the longer after a player leaves the game, the harder it is to figure out whether it was football-related or not. And the collective bargaining parties decided to put their—spend the higher dollars on the people who became unable to work sooner, because they had a greater confidence that that was caused by football.

Ms. SÁNCHEZ. I am curious to ask some of the retired players whether they think that that is a good idea or not to have a 15-year statute of limitations for which a player can—is then barred from going back and getting the higher football-related injury benefits.

Mr. CARSON. Personally I think it is unfair, because I played 13 years in the National Football League, and having been out of the league almost 19 years now, I am starting to feel things that I experienced when I played, the injuries, the knees, the ankles, the hips, my back. The whole postconcussion thing has manifested itself over the years, and it hasn't really gone away. When I was diagnosed 2 years after leaving football, it was deemed to be permanent in nature. And I just can't help but think that I went—I got tested because I knew something was wrong with me. There are a whole bunch of other players who are walking around, and they don't know what is wrong with them because there is no rea-

son for them to be tested, because perhaps physically they feel fine. Neurologically they may be off somewhat. And I think this is the same problem that many of the soldiers who are coming back from Iraq are dealing with, postconcussion syndrome.

And so in my opinion, I think players should have lifetime health coverage, because the things that you put your body through on the football field, they never go away. You are going to take those things to the grave with you, whether it be knees—and there are so many of my friends now who are having knee replacement surgery. I am 53, and these guys, some of them are in their forties having knee and hip replacement surgeries right now. And so 15 years is really a joke. It should be lifetime.

Ms. SÁNCHEZ. Let me ask Mr. Ell or Mr. Curran, because of medical advances specifically, and an increased understanding of the symptoms of concussions, do you guys think that there should be a statute of limitations that precludes claims by older players who suffered concussions in the past?

Mr. CURRAN. Well, again, as Mr. Ell indicated, there is no statute of limitations. It is a question of what the level of benefits would be. And in the plan itself there is a——

Ms. SÁNCHEZ. Is there not a significant difference between the benefits received by a, quote/unquote, football-related injury versus just a regular disability?

Mr. CURRAN. Yes, there is. There is a significant difference. And as Mr. Ell indicated——

Ms. SÁNCHEZ. So why should players who maybe don't see the aftereffects for many years after their careers end be precluded from claiming the higher benefit?

Mr. CURRAN. Well, the reason it was put in, as Mr. Ell indicated earlier, was to make sure that we could connect up more closely to football people who would be 45 years old, if they retired at 30, and therefore be sure the benefit was football-related. Now, is that an arbitrary time? It is a little bit. Perhaps we could revisit that. However——

Ms. SÁNCHEZ. Perhaps you should revisit that.

Mr. Smith, do you believe that arbitration should have a more prominent role in the disability benefits process? Because some current critics of the system have suggested that allowing an arbitrator to hear all appeals and benefit denials, rather than the current system under the Retirement Board, might be a better approach. Do you agree with that?

Mr. SMITH. I think there is some merit to that, Madam Chairwoman. Right now your appeal is from this two-person Disability Initial Claims Committee to the Retirement Board. It is all inside the same box. And I don't believe that anyone on the Retirement Board has medical expertise, unless it is by coincidence. There would be room, I think, for truly neutral arbitrators, that is to say people who are not beholden to the Retirement Board or the NFL plan, that the parties have a role in selecting or maybe selecting a neutral arbitrator. That, I think, would be a big improvement on the present system. And it is certainly something that is within, as I understand it, the Subcommittee's jurisdiction. Right now there is no neutrality and not a lot of knowledge at the appeal level. The appeal is an appeal in name only.

Ms. SÁNCHEZ. Thank you.

Did you want to add something to that, Mr. Boyd?

Mr. BOYD. Yeah, I did about that, because there is no medical people involved in this disability process at all. There is three team owners, who are businessmen. There is three ex-football players, who are friends and appointees of Gene Upshaw. There is no doctors in the room when they have these board meetings. Doug Ell and Groom Law, they take all the medical information, and it is all filtered through Doug Ell, and it is presented to the six voting members of the Disability Board, and they vote on Doug's recommendation. There is not a doctor in the room, there is not a medical person in the whole process from start to finish.

Ms. SÁNCHEZ. Thank you. My time has expired.

I would now like to recognize our generous and sportsmanlike Ranking Member Mr. Cannon for 5 minutes of questioning.

Mr. CANNON. The sports goes back a long, long time, almost as much as some of you guys, and not nearly so distinguished.

Thank you, Madam Chairman.

Now, the jurisdiction of this Committee relates to the arbitration provisions of these disability issues. The full Committee has antitrust jurisdiction, which is often delegated to this Committee, but which this year or this Congress has been put in a task force. But many of the Members of this Committee serve on this task force and are involved, as I am, in these issues of antitrust.

And it seems to me that—I mention that to put some teeth into what I am about to say, which is that there is some serious concern. I think it is fairly clear that there is some dissatisfaction and a lack of a clear response, except the legalistic response to the fact that the interests of retired players are not considered in the process maybe as much as they should be, and that I suspect is because of a failure or because the National Labor Relations Act precludes the representation of retirees. But the sports situation, because it is unique, has antitrust provisions. But also because it is unique, you may want to consider some other kind of adjustment perhaps beyond the scope of this Committee. But that would be that most employers have people that are young who have just started the workforce at 20 or 30 and others at 40 or 50 and others at 60 or even beyond 60 who are getting ready to retire, and their judgment matures as they stay in the profession and therefore as they look at the retirees, they have a slightly different perspective than I think may be the case in sports.

So Mr. Ell, Mr. Curran, should we be looking at an adjustment to the NLRB that would allow for a difference for players who tend to be very young and therefore not all the perspective that they might have as they get older so that we can create some justice out of what appears a fairly unjust system or at least a system which is hard to make just because of the lack of representation by the retired players through the union? Should we get a special exemption that allows a change in the way the union is able to represent retirees?

Mr. ELL. That is quite a question. The money for all these benefits comes out of the active players, and I think that is what the law currently recognizes. I am not an NLRB expert. I do think it is unfair to say that the Players Association and Gene Upshaw is

not concerned about the retirees. Hundreds of millions of dollars——

Mr. CANNON. That is not what I said. The point is that the retirees are not represented in the process in large part because the union can't represent the retirees, not that any person is bad or wrong or evil but rather the process produces results that I think are pretty clearly incongruous.

Mr. CURRAN. Well, I don't personally believe that a law change is necessary. I think that the former players that have been appointed by the union are well able to exercise their fiduciary responsibilities on behalf of all former players. The trustees have changed over time since 1982, many times, and they have all stepped up to the plate and done their fiduciary duties. So I don't accept that the process is broken.

I believe that what Gene Upshaw has done for former players is well beyond what he had to do legally, as I said earlier, and the League is happy to make those retired players raise their benefits and retirement and raise the disability benefits. I don't believe a law change is necessary.

Mr. CANNON. I actually thought I was working from a fairly common presumption here. But I think I heard you say that the players are adequately representing the interests of the retirees.

Mr. CURRAN. I believe that the trustees appointed by the Players Association, former players themselves, are adequate to represent them in the retirement process. If you are talking about collective bargaining, then that is the union which is made up of the current members.

Mr. CANNON. But the trustees are elected by the members of the union.

Mr. CURRAN. They are appointed by the union. That is correct.

Mr. CANNON. The union is made up of people—unlike any other industry—it is made up of people who are very young and who lack a certain perspective on the future. In fact, I don't think you can get anybody but young people to do the kind of self-destructive things that happen in football.

Mr. CURRAN. It is a young workforce. That is correct. The trustees are not appointed by the workforce but by the union itself, which has a very historical view.

Mr. CANNON. But the union itself represents the people who are active.

Mr. CURRAN. That is correct.

Mr. CANNON. And that union is elected by the people who are active who are very young.

Mr. CURRAN. That is correct.

Mr. CANNON. I see my time has expired but think the point is fairly clear, that there is an inequity here, Madam Chairman, and perhaps there ought to be a legal solution. I yield back.

Ms. SÁNCHEZ. That is what we are here today to determine. Thank you, Mr. Cannon.

I am going to ask unanimous consent to be entered into the record a number of articles that we have received and the staff has received with respect to the subject matter of today's hearing, as well as letters and e-mails that we have received regarding the

NFLPA. And without objection, so ordered. Those will be entered into the record.

[The information referred to follows:]

SUBMISSION LIST ON FILE WITH THE COMMITTEE ON THE JUDICIARY, SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW, FROM FORMER NATIONAL FOOTBALL LEAGUE PLAYERS

The Subcommittee on Commercial and Administrative Law has on file letters from the following retired NFL players.

Player	Team	Years Played
Bob Allen	St. Louis Cardinals Miami Dolphins	1985-1993
John Arnett	Los Angeles Rams Chicago Bears	1957-1966
Warren Bankston	Pittsburgh Steelers Oakland Raiders	1969-1972
Carl Barzilauskas	New York Jets Green Bay Packers	1974-1979
Walter Beach, III	Cleveland Browns	1963-1966
Dick Bielski	Philadelphia Eagles Dallas Cowboys Baltimore Colts	1955-1963
Brent Boyd	Minnesota Vikings	1980-1986
Brant Boyer	Miami Dolphins Jacksonville Jaguars Cleveland Browns	1994-2003
Eddie Brown	Cleveland Browns Washington Redskins Los Angeles Rams	1974-1979
Roger Brown	Detroit Lions Los Angles Rams	1960-1969
Chris Burford	Dallas Texans Kansas City Chiefs	1960-1967
Woody Campbell	Houston Oilers	1967-1972
Preston Carpenter	Cleveland Browns Pittsburgh Steelers Washington Redskins Minnesota Vikings Miami Dolphins	1956-1967

Howard Carson	Los Angeles Rams	1980-1983
David Casper	Oakland Raiders Houston Oilers Minnesota Vikings Los Angeles Raiders	1974-1984
Wally Chambers	Chicago Bears Tampa Bay Buccaneers	1973-1980
Tony Cline	Oakland Raiders San Francisco 49ers	1970-1977
Eric L. Crabtree	Denver Broncos Cincinnati Bengals New England Patriots	1966-1974
Lou Creekmur	Detroit Lions	1950-1959
Joe Cribbs	Buffalo Bills San Francisco 49ers Indianapolis Colts Miami Dolphins	1980-1989
Cleveland Crosby	Baltimore Colts	1982
Joe DeLamielleure	Buffalo Bills Cleveland Browns	1973-1985
Bob DeMarco	St. Louis Cardinals Miami Dolphins Cleveland Browns Los Angeles Rams	1961-1975
Bob Dillon	Green Bay Packers	1952-1959
Conrad Dobler	St. Louis Cardinals New Orleans Saints Buffalo Bills	1972-1981
Reggie Dupard	New England Patriots Washington Redskins	1986-1990
Mike Eischeid	Oakland Raiders Minnesota Vikings	1966-1974

Earl Edwards	San Francisco 49ers Buffalo Bills Cleveland Browns Green Bay Packers	1969-1979
Bobby Franklin	Cleveland Browns	1960-1966
Manny Fernandez	Miami Dolphins	1968-1977
Bobby Franklin	Cleveland Browns	1960-1966
Jim Garcia	Cleveland Browns New York Giants New Orleans Saints Atlanta Falcons	1965-1968
Jack F. Gehrke	Kansas City Chiefs Cincinnati Bengals Denver Broncos	1968-1972
Walker Gillette	San Diego Chargers St. Louis Chargers New York Giants	1970-1976
John Grant	Denver Broncos	1972-1979
Don Green	Buffalo Bills Philadelphia Eagles Detroit Lions	1971-1978
Dan Hampton	Chicago Bears	1979-1990
Chet Hanulak	Cleveland Browns	1954-1957
Wayne Hawkins	Oakland Raiders	1960-1969
Ted Hendricks	Baltimore Colts Green Bay Packers Oakland Raiders Los Angeles Raiders	1968-1983
Don Horn	Green Bay Packers Denver Broncos Cleveland Browns San Diego Chargers	1967-1975
Jim Houston	Cleveland Browns	1960-1972

Sam Huff	New York Giants Washington Redskins	1956-1969
Harry Jacobs	Buffalo Bills New England Patriots New Orleans Saints	1960-1972
Jim Jensen	Dallas Cowboys Denver Broncos Green Bay Packers	1976-1982
Cody C. Jones	Los Angeles Rams	1973-1983
Stan Jones	Chicago Bears Washington Redskins	1954-1966
Sonny Jurgensen	Philadelphia Eagles Washington Redskins	1957-1974
Carlton Kammerer	San Francisco 49ers Washington Redskins	1961-1969
Leroy Kelly	Cleveland Browns	1964-1973
Jim Kiick	Miami Dolphins Denver Broncos Washington Redskins	1968-1977
Steve King	New England Patriots	1973-1982
Bob Kuechenberg	Miami Dolphins	1970-1984
Bruce Laird	Baltimore Colts San Diego Chargers	1972-1983
Jim Langer	Miami Dolphins Minnesota Vikings	1970-1981
Roger Leclerc	Chicago Bears Denver Broncos	1960-1967
Ear Leggett	Chicago Bears Los Angeles Rams New Orleans Saints	1957-1968

Ronnie Lott	San Francisco 49ers Los Angeles Raiders New York Jets Kansas City Chiefs	1981-1995
Tommy Mason	Minnesota Vikings Los Angeles Rams Washington Redskins	1961-72
Mike McCoy	Green Bay Packers Oakland Raiders New York Giants Detroit Lions	1970-1980
Karl Mecklenburg	Denver Broncos	1983-1994
Robert Meeks	Denver Bronco	1992-1996
Eugene "Mercury" Morris	Miami Dolphins San Diego Chargers	1969-1976
J. Michael Montgomery	San Diego Chargers Dallas Cowboys Houston Oilers	1971-1974
Chip Myrtle	Denver Broncos San Diego Chargers	1967-1974
Gern Nagler	Chicago Cardinals Pittsburgh Steelers Cleveland Browns	1953-1961
Jeff Nixon	Buffalo Bills	1979-1984
Terry L. Nelson	Los Angeles Rams	1973-1980
William Oshodin	Denver Broncos	1992-1995
Bernard Parrish	Cleveland Browns Houston Oilers	1959-1966
Chris Pane	Denver Broncos	1976-1979
Dave Pear	Baltimore Colts Tampa Bay Buccaneers Oakland Raiders	1975-1980

David J. Pivec	Los Angeles Rams Denver Broncos	1966-69
Ron Porter	Baltimore Colts Philadelphia Eagles Minnesota Vikings	1967-1974
Matt Robinson	New York Jets Denver Broncos Buffalo Bills	1977-1982
Bob Rowe	St. Louis Cardinals	1967-1976
Council Rudolph	Houston Oilers St. Louis Cardinals Tampa Bay Buccaneers	1972-1977
Kamal Ali Salaam-El (Reggie Harrison)	St. Louis Cardinals Pittsburgh Steelers	1974-1977
Mike Sandusky	Pittsburgh Steelers	1957-1965
Terry Schmidt	New Orleans Saints Chicago Bears	1974-84
Dick Shiner	Washington Redskins Cleveland Browns Pittsburgh Steelers New York Giants Atlanta Falcons New England Patriots	1964-1974
Bart Starr	Green Bay Packers	1956-1971
Bob Stein	Kansas City Chiefs Los Angeles Rams Minnesota Vikings San Diego Chargers	1969-1976
John C. Stofa	Miami Dolphins Cincinnati Bengals	1966-1972
Stewart "Smokey" Stover	Dallas Texans Kansas City Chiefs	1960-1966
Pat Studstill	Detroit Lions Los Angeles Rams New England Patriots	1961-1972

Dan Sullivan	Baltimore Colts	1962-1972
James Summers	Denver Broncos	1967
Jay Taylor	Phoenix Cardinals Kansas City Chiefs	1989-1994
Arland B. Thompson	Denver Broncos Green Bay Packers Baltimore Colts Kansas City Chiefs	1980-1982, 1987
David Treadwell	Denver Broncos New York Giants	1989-1994
Wally Triplett	Detroit Lions Chicago Cardinals	1949-1953
William F. Truax, III	Los Angeles Rams Dallas Cowboys	1964-1973
Joe Wendryhoski	Los Angeles Rams New Orleans Saints	1964-1968
Delvin Williams	San Francisco 49ers Miami Dolphins Green Bay Packers	1974-1982
Jeff Winans	Buffalo Bills Tampa Bay Buccaneers Oakland Raiders	1973-1980
John Wooten	Cleveland Browns Washington Redskins	1959-1968
Keith Wortman	Green Bay Packers St. Louis Cardinals	1972-1981
Ron Yary	Minnesota Vikings Los Angeles Rams	1969-1982

Ms. SÁNCHEZ. I also want to recognize again Congresswoman Waters for participating with us today and we were also joined by Congresswoman Sheila Jackson Lee from Texas as well. I do want to thank again all the witnesses for their testimony today. It has been very helpful.

Without objection, Members will have 5 legislative days to submit any additional written questions, which we will forward to the witnesses and ask that you answer as promptly as you can to also be made a part of the record. Without objection, the record will remain open for 5 legislative days for the submission of any other additional materials.

Again, I thank everybody for their time and their patience, and this hearing of the Subcommittee on Commercial and Administrative Law is adjourned.

[Whereupon, at 3:15 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

ANSWERS TO POST-HEARING QUESTIONS FROM DENNIS CURRAN, NATIONAL FOOTBALL LEAGUE

NATIONAL FOOTBALL LEAGUE
MANAGEMENT COUNCIL

Dennis Curran
Senior Vice President &
General Counsel

September 5, 2007

Hon. Linda Sanchez
Chairwoman, Subcommittee on Commercial
and Administrative Law
Committee on Judiciary
2138 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Sanchez:

I appreciate the opportunity to respond to your additional questions arising from the June 26, 2007 hearing before the Subcommittee on Commercial and Administrative Law. For ease of review, I have incorporated your questions in italics below. It is my hope that this response will provide you with the information you need.

1. *According to the testimony of Mr. Douglas Ell, 317 players of the nearly 10,000 eligible retirees have qualified for long-term disability benefits. Given that the NFL is known as the most brutal major American professional sports league in which half of the players retire because of injury, how do you explain these statistics?*

   Players retire for many reasons, among them injury, competition for roster positions, a new career and other personal reasons not known to us. We do not have statistics, nor do most employers, on the reasons our players retire. It is important to keep in mind, however, the distinction between an "injury" and a "disability" because I believe that distinction goes to the thrust of the question you have asked. Professional football is a physically demanding sport and an athlete who sustains an injury may choose to retire from the League. That does not necessarily mean he is disabled in the sense that he is unable to engage in any other employment and thereby entitled to total and permanent disability compensation from the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("NFL Plan") or for that matter, the Social Security Administration. In fact, the majority of our retired players go on to other careers.

   I would like to clarify what the "number of eligible retirees" means. According to the administrative office of the NFL Plan, the total number of living vested former players is 7,352. Of these, 2,398 are receiving a pension benefit and

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therefore are not eligible for a disability benefit. Thus, the current number of eligible players is 4,954. This number represents only the former players who would be *eligible to apply* for disability benefits. It does not take into account whether or not a player suffered any form of disabling injury and therefore is not a reflection of the number of former players who are *eligible for benefits*.

Mr. Ell's written testimony set forth a table describing the disability decisions of the NFL Plan since 1993. It is important to remember that the NFL does not decide disability claims; rather, it is the fiduciary responsibility of the six trustees who comprise the Board. Since 1993, 1,052 applications have been received from participants. (Some of the 1,052 applications are multiple applications from the same player.) Of the 1,004 which have been adjudicated, 428 were determined to be eligible for disability benefits. While I do not have data specific to the 576 cases that were not approved, it is our general experience that approximately 20% of the applications for total and permanent disability are denied on administrative grounds (e.g., players who apply without being vested), or are otherwise ineligible for benefits (e.g., players who are currently employed). It is important to note that during this time period $138 million in disability benefits was paid to former players.

2. *The NFL and the NFLPA recently announced an agreement to grant benefits to players already receiving social security disability benefits. Do you think this will streamline or improve the process? Please explain?*

Yes. The new agreement will expedite the process for those applicants who first qualify for social security disability payments before they apply for NFL Plan benefits. If a player has been determined to be eligible for disability benefits by the Social Security Administration, that determination will govern for purposes of medical eligibility with respect to benefits under the NFL Plan and thus will streamline the review of the player's request under the NFL Plan.

However, for new applicants, the process under the NFL Plan usually will provide a benefit determination significantly more quickly than does the Social Security Administration. Accordingly, the new agreement would have little impact on those situations. In either case, however, a player would be approved for retroactive payments based on the onset of the qualifying disability – not the date of the determination.

3. *Retired players have complained about the red tape in the disability benefits process. In addition to the social security disability benefit change referred to in question two, are there ways to improve the process without eliminating procedures required by law?*

Yes. The NFL is committed to working with the National Football League Players Association to improve the management of the NFL Plan. We are

currently exploring with the NFLPA ways to improve the NFL Plan's administration, including ways to make determinations in between formal meetings of the Plan's trustees. We also believe that adopting more objective criteria for determining benefit eligibility – such as those used by the American Medical Association - would improve the process and help provide significantly faster assistance to those in need.

Ultimately, however, the NFL Plan's flexibility may be limited by certain legal obligations. Governed by the Taft-Hartley Act, the NFL Plan is the result of collective bargaining between the NFL and the NFLPA, and the trustees have a fiduciary responsibility to administer the NFL Plan prudently and consistent with its terms. Additionally, the NFL Plan must follow requirements imposed by the Employee Retirement Income Security Act ("ERISA") and by Department of Labor processing regulations that are designed to protect the player and preserve the integrity of the NFL Plan's administration.

I hope this provides some additional clarity for you and the Committee. Please let me know if there is any more information we can provide.

Sincerely,

DENNIS CURRAN

ANSWERS TO POST-HEARING QUESTIONS FROM DOUGLAS W. ELL, PLAN COUNSEL TO THE BERT BELL/PETE ROZELLE NFL PLAYERS RETIREMENT PLAN

ANSWERS TO QUESTIONS FROM SUBCOMMITTEE CHAIR LINDA SANCHEZ FOR DOUGLAS ELL

Q1. According to the testimony of Mr. Douglas Ell, 317 players of the nearly 10,000 eligible retirees have qualified for long-term disability benefits. Given that the NFL is known as the most brutal major American sports league in which half of the players retire because of injury, how do you explain these statistics?

A1. I appreciate the opportunity to clarify this subject because there appears to be a misunderstanding. First, at the time of the Subcommittee hearing, 317 former players were receiving either partial or total disability benefits. This number does not include, however, the 78 players who were receiving total and permanent disability benefits when they reached age 55 and continue to receive those benefits in the form of a pension, with no reduction in the value of their benefits. This brings the total number of former players receiving disability benefits to 395. Second, there are not 10,000 eligible retirees; in fact, the number of eligible former players is only 4900. The 10,000 number includes all current players and vested[1] former players. There are roughly 2100 Active Players, who are not eligible for disability benefits because they are able to work. There are close to 3000 former players who are receiving their pensions, making them ineligible for disability benefits. Since pension and disability are both "income replacement" benefits, once a player begins to receive his pension he no longer qualifies for disability benefits. (This is not unique to NFL players; it is standard among all employers.) So, of the 10,000, only 4900 former players are eligible for disability benefits under our system.

Statistics about why NFL players retire can be misleading. Most careers are not affected by a muscle or bone problem that causes a person to be one-half of a second slower in the 40-yard dash. In the NFL, that half-second could cost a player his job. The vast majority of players who leave the NFL, including those who leave because of injury, are in most respects quite healthy and capable of other employment.

The table in my written testimony showed that, of all players who have applied for disability benefits since July 1, 1993 (when the new structure was put in place), in 43% of the decided cases the player was awarded a disability benefit. If you take out those instances where a player is clearly ineligible, such as where a former player who is not vested seeks T&P benefits, the percentage would be higher. Since these disability benefits are extremely generous – up to $224,000 a year in some cases – it is not surprising that many former players who apply do not qualify.

It is also important to keep in mind that long-term disability benefits are only one part of a generous, multifaceted package for injured players. That package begins with five years of totally free medical and dental insurance, for every vested player and his family, after his NFL career ends. Next is Workers Compensation for all players under state law. The NFLPA strongly advises each player to preserve his rights under Workers Compensation for life-time medical care for his football injuries.

[1] A player becomes vested when he has earned credit for three or more seasons. A player generally earns a season when he is paid for three or more games during that season.

Other benefits include the new 88 Plan for former players with dementia, and a recently announced agreement with select major hospitals to provide, either free or at very low cost, needed surgery for injured players.

Q2. The NFL and the NFLPA recently announced an agreement to grant benefits to players already receiving social security disability benefits. Do you think this will streamline or improve the process? Please explain?

A2. This recent decision will certainly help some players get benefits faster. For most players, disability claims will continue to be processed according to the procedures and time frames prescribed by the Department of Labor. However, if an applicant is already receiving Social Security disability benefits, he will now immediately receive disability benefits from NFL football, and will not have to see a Plan doctor.

I would like to clarify the exchange with Chairwoman Sanchez at pages 67 and 68 of the transcript of the June 26, 2007 Subcommittee hearing. At page 68, Chairwoman Sanchez asked whether the Disability Board contains retired players. In the context of the exchange, I understood her reference to be to the Disability Initial Claims Committee, which does not contain a retired player. The Disability Board of the NFL Player Supplemental Disability Plan, however, is a separate entity. Like the Retirement Board, it contains three retired players.

Q3. Retired players have complained about the red tape in the disability benefits process. In addition to the social security disability benefit change referred to in question two, are there ways to improve the process without eliminating procedures required by law?

A3. Yes, there are other ways to speed up the process. For example, if the collective bargaining parties can agree on simpler eligibility rules for disability benefits, the Disability Initial Claims Committee and the Retirement Board may be able to process claims faster. Such a change would have to be made through collective bargaining, because the Retirement Board and the Disability Initial Claims Committee do not have the authority to change eligibility rules. I know that expediting the disability system is a priority for the NFLPA, and Executive Director Gene Upshaw has reached out to NFL Commissioner Roger Goodell to discuss possible improvements as quickly as possible.

However, it is important to keep in mind that some of the "red tape" is imposed by law, and the intent behind this "red tape" is a good one. As described in the testimony of Martha Jo Wagner, the claims procedure of the Plan conforms to the detailed requirements of the Department of Labor regulations. The claims procedure and the regulations are intended to ensure a "full and fair review" of all claims on a timely basis. This "red tape" ensures that all claimants have ample due process and every opportunity to correct deficiencies in their claims. Unfortunately, a side-effect of "full and fair review" is to extend the duration of the process.

ANSWERS TO POST-HEARING QUESTIONS FROM MARTHA JO WAGNER, ESQUIRE, VENABLE LLP

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August 6, 2007

Mr. Adam Russell
Commercial and Administrative Law Subcommittee
H2-362 Ford House Office Building
Washington, D.C. 20515

Dear Mr. Russell:

Enclosed is a marked-up version of my testimony at the hearing on "The National Football League's System for Compensating Retired Players: An Uneven Playing Field?" on June 26, 2007. I believe the changes on pages 31, 32, 34, 35 and the third change on page 83 relate to transcription errors. The first and second changes on page 83 and the changes on page 84 are intended to clarify my earlier statements.

In addition, the Subcommittee Chair Linda Sanchez sent me two questions. Those questions and my responses follow.

1. The NFL and NFLPA recently announced an agreement to grant benefits to players already receiving Social Security disability benefits. Do you think this will streamline or improve the process?

Automatically providing disability benefits under the Bert Bell/Pete Rozelle NFL Player Retirement Plan (Retirement Plan) and the NFL Player Supplemental Disability Plan (Supplemental Plan; together the Disability Plans) to former National Football League players who are determined to be disabled by the Social Security Administration has the potential to streamline and improve the claims review process for at least four reasons.

- First, a single determination of disability could enable a former player to secure benefits from several sources, i.e., from the Social Security Administration and the Disability Plans, without the need for multiple disability determinations.

- Second, it was clear from the testimony of some of the former players at the hearing that they believe that at least some of the decision makers for the Retirement Plan are biased against them. Whether or not this belief is founded in fact, using disability determinations made as part of the Social Security claims review process should increase the chanees that former players believe that such determinations are being made by neutral decision makers.

- Third, deference is given to the views of the treating physician regarding the physical and mental condition of the former player in the Social Security claims review process.

- Fourth, the basic definition of disability under Social Security is apt to be broader than the definition of disability in the Retirement Plan, at least in some circumstances.

However, as was pointed out at the hearing, the actual effect of this change will depend upon the details. At least four critical questions need to be answered to begin to assess whether the proposed change will improve and streamline the current claims review process.

- First, how many former players are receiving Social Security disability benefits but are not receiving disability benefits from the Disability Plans?

- Second, on the average, how long does it take to get a Social Security determination of disability?

- Third, how are the two claims review processes to be coordinated? For example, because of the limits on retroactive benefits in the Retirement Plan, a former player may well want to apply for Retirement Plan benefits before receiving a disability determination from the Social Security Administration. If the two claims review processes go forward at the same time, not much streamlining will occur. Moreover, if the Retirement Plan claims review process is suspended while the Social Security claims review process goes forward and the Social Security process takes a long time, it actually may take longer to get a disability determination than it does under the Retirement Plan's current claims review process.

- Fourth, what happens if the Social Security disability claim is denied? Will this denial make it more difficult for the former player to prove he is disabled under the Disability Plans?

2. Retired players have complained about the red tape in the disability benefits process. Are there ways to improve the process without eliminating procedures required by law?

As I noted at the hearing, it is not clear to me why the Retirement Plan's claim review process currently takes as long as some of the players' testimony would indicate, compared with the timeframes set out in the Retirement Plan. In my experience, the claims procedures required

VENABLE LLP

by the Department of Labor under the Employee Retirement Income Security Act of 1974, as amended (ERISA) are unlikely to be the cause of the delay. However, it is not possible to suggest specific changes without first-hand experience with the Retirement Plan.

I hope this information is helpful to the Subcommittee.

Sincerely,

Martha Jo Wagner

Cc: The Honorable Linda Sanchez (w/o enclosure)

DC2: 882471.1

Answers to Post-Hearing Questions from Cyril V. (Cy) Smith, Zuckerman Spaeder LLP

1. The NFL and the NFLPA recently announced an agreement to grant benefits to players already receiving social security disability benefits. Do you think this will streamline or improve the process? Please explain.

The answer will depend on the actual language used in changing the Plan Document (the legal language of the Bert Bell/Pete Rozelle Plan itself). I have not seen any actual changes -- proposed or enacted -- to the plan document. There are lots of open questions, such as: what level of benefits will be provided by the Plan if a player already gets SSDI? There are several levels of benefits under the Plan, ranging from very low to very generous.

Also, I have little familiarity with the Social Security disability process. Those lawyers who do, tell me about long delays and arbitrary procedures. It's far from clear that using the Social Security standard will change matters for the better.

2. Retired players have complained about the red tape in the disability benefits process. Are there ways to improve the process without eliminating procedures required by law?

If by "red tape" you mean delay in the process, there are several changes which would improve matters. One would be to require a decision by the initial claims committee (or the Retirement Board in the case of an appeal) within 45 days of a completed application or an appeal. ERISA sets a ceiling for timeliness of plan decision, not a floor. In my experience, the Bert Bell/Pete Rozelle Plan typically takes far longer than necessary to decide claims, and goes right up to (and sometimes past) the legal limit. There is no good reason the Plan couldn't set its own rules to decide more quickly. (The fact that the Plan meets in person once a quarter is irrelevant; today's technology makes it simple for the Plan to meet by telephone or video conference as frequently as necessary.)

ANSWERS TO POST-HEARING QUESTIONS FROM MIKE DITKA, FORMER NFL COACH

RESPONSES OF MIKE DITKA TO QUESTIONS
FROM CHAIRWOMAN LINDA SANCHEZ
SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON THE JUDICIARY
"HEARING ON THE NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?"
HELD ON JUNE 26TH 2007

Question 1--Having gone through the NFL's retirement process and seeing how other players have been treated by the system, how can the NFL's retirement process be improved?

Thank you, Chairwoman Sanchez, for inviting me to add my comments to your questions for the record of the hearing your Subcommittee held on the NFL's Retirement Plan (the "Plan") and, particularly, the disability provisions in that Plan and their implementation by the Retirement Board, held this past June. Since I have subsequently testified on the same subjects before the Senate Committee on Commerce in September, I have attached my testimony detailing the problems with the implementation of that Plan and the need for Congressional oversight in this area at **Tab 1**. Because I am speaking in this response for many others who have done significant work on behalf of retired players, I will attach several other documents from such sources in an effort to provide the Committee with as much useful information as possible.

Some of the major problems specifically associated with the current NFL retirement process are: (1) the conflict of interests of the management representatives on the Retirement Board who can save money for the team owners by rejecting claims; (2) the failure of the Retirement Board to establish and publish fair and objective standards for qualifying for disability pension benefits; (3) the failure of the NFL teams and the NFLPA having to provide information to active players and retired players on what they will need to file a proper claim for benefits in the future (including obtaining complete medical reports when they are released from or they retire from a team) – only the Retirement Board is required to provide such information but is not accountable if it does not provide that information; (4) the lack of accountability of the Retirement Board and its staff and legal counsel when it fails to provide information and documents on a timely basis to retired players claiming benefits; and (5) the lack of transparency and accountability for the actions of the Retirement Board and its staff and legal counsel when then deny benefits and conduct investigations of retired players. I've attached a more expanded outline detailing these problems and others at **Tab 2**.

To address these problems, as a start, the NFL's retirement process can be improved by instituting the following procedures:

- Teams should be required to provide complete information on the requirements to qualify for disability benefits in the future and must provide final medical reports that will aid the players in the future if claim a disability benefit in the future.

- The Retirement Board should be required to publish and adhere to fair objectives standards for qualifying for disability pension benefits. All that the players are looking for is a level playing field.

- To avoid the conflicts of the management representatives on the Retirement Board, retired players should be allowed to appeal the denial of the benefits to an objective committee or arbitrator that is not tied either to management or the union.

- The Retirement Board and its staff and its legal should be required to provide more transparency for their actions and have consequences for not complying with ERISA (such requiring the plan to provide benefits if they Retirement Board violates its duties under ERISA).

- Requiring the Retirement Board to publish annually the number of reviews, denials and approvals of the Retirement Board, and the voting of Retirement Board members.

In addition to these problems, which are peculiar to the NFL's retirement system, the Plan contains a particularly egregious discretionary clause. The simplest amendment to the Plan that would significantly increase the protection of the players is to amend the language of this clause at Section 8.2 regarding the "Authority of the Retirement Board" in which the current Plan states, "The Retirement Board will have full and absolute

discretion, authority and power to interpret, control, implement and manage the Plan and the Trust."

As you and other Members of the Judiciary Committee well know, that language triggers a standard of court review known alternatively as "arbitrary and capricious" or "abuse of discretion." What it means is that the claimant needs to show more than that the decision was wrong; the decision must be proven unreasonable; i.e., irrational.

That sentence should be removed, in its entirety, from the Plan. It will not interfere with the power of the Board to manage the Plan or the Trust; it will merely mean that if a dispute arises that cannot be resolved without resort to litigation, the players will have the opportunity to present their claim in a court of law on an equal playing field where the court is not required to defer either to the player or to the Plan.

This issue invokes issues of ERISA law more generally and, since your question invites potential legislative responses to this problem, I have I have consulted with legal counsel who specialize in that area for the purposes of answering your inquiry and I have attached, at **Tabs 3-8**, several documents that seem useful: 1) two articles in a journal put out by the National Association of Insurance Commissioners that lay out the problems the ERISA law has created for benefit claimants; 2) a copy of testimony by the author of those articles to the NAIC as to why discretionary clauses should be prohibited; 3) a further article by the author published on the Brent Boyd case in the Chicago Daily Law Bulletin titled "Standard of review in ERISA cases 'too deferential'" (August 1, 2005); 4)

a short piece summarizing these issues; 5) a copy of the NAIC model act prohibiting discretionary clauses. If the Congress were to undertake a general legislative solution of this ERISA issue, on advice of the counsel I've consulted, here is what I would propose to add to ERISA on a federal legislative level:

> No employee benefit plan, insurance policy, contract, certificate or agreement offered or issued by an employer or insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or to provide disability income or insurance against disability may contain a provision purporting to reserve discretion to the plan sponsor, plan administrator, claims administrator, or insurer to interpret the terms of the plan or contract, or to provide standards of interpretation or review that are inconsistent with this Title.

I suggest this provision be added to ERISA Sec. 410 (29 U.S.C. Sec. 1110), which prohibits plans from containing exculpatory clauses. Professor John Langbein from Yale Law School has flagged this provision as one that should prohibit discretionary clauses since they have the same effect as an exculpatory clause. I am attaching his latest article on that point from the Northwestern University Law Review at **Tab 9**. Finally, with regard to the NFLPA's use of ERISA as a sword to deny benefits and its willingness to pursue punitive litigation against a former player who asserts his rights too strongly for the union's taste, I have attached at **Tab 10** the letter of Delvin Williams to Senator Byron Dorgan, which describes Delvin's more-than-decade-long fight for disability relief.

With regard to another legislative approach discussed by the panel at your hearing, I am told the NLRB statutes could be specifically amended, or a specific exemption granted for professional football, so that the collective bargaining unit for the NFL players could include retirees. Certainly, I would be glad to see the NFLPA become a more inclusive union that reflects and affirmatively represents the interests of retired players in collective bargaining. Full inclusion of retirees in the membership of that union would, obviously, be very desirable to balance the equities, which have been out of balance for decades with regard to their interests. Moreover, I believe the unique elements of an NFL career, including a 3.7-year average playing career and an enormous disability rate, merit such special consideration. Should the Congress decide to embark upon this legislative approach, I assure you that NFL retirees will be with you in support.

Another area in which the typical NFL career and its intersection with the disability Plan has highlighted the Plan's inadequacies in design and implementation stems from the high rate of traumatic brain injury among NFL players. Football, it has been said, is a "collision" sport, not merely a "contact" sport. Artificial surfaces often worsen this effect because, while they save teams lots of grounds-keeping money, they are often no more than concrete covered with indoor-outdoor carpeting. Such injuries are frequent, their effects are cumulative and they may not produce symptoms until years after a player's career has ended. Obviously, these injuries, their devastating effects and their typically delayed presentation pose particular challenges to the NFL's disability system—challenges which that system has failed to address to date. To aid you in your

consideration of this crucial issue, I have solicited the opinion of one of the leading attorneys in the field of brain injury litigation, whose letter briefly addressing the nexus of traumatic brain injury and the current functioning of the NFL's Disability Plan I have attached at **Tab 11** for your consideration. I urge you to consider that no disability plan will be successful if this issue is not addressed thoroughly and correctly. With specific respect to this issue, the Committee received the testimony of Brent Boyd, who's case is a study in the NFLPA's strategy of deferral and denial with regard to a legitimate disability claim made on the basis of a traumatic head injury. I include an outline of Mr. Boyd's own suggestions for improving the disability system, which is already in the Committee's possession, at **Tab 12**, in recognition of his heroic efforts on behalf of himself and all disabled NFL retirees.

Sadly, as I and other advocates for my fellow NFL retirees seek to work constructively with you to find answers to the abuses inherent in the NFL's Retirement Plan and its administration, I must comment here on the NFLPA's disappointing response to the substantive criticisms of the disability process leveled by myself and several other retirees, both at your hearing and at a subsequent hearing held before the Senate Commerce Committee this September. Instead of engaging us on the issues, the NFLPA established a "Truth Squad" website and a "White Paper" response organized around *ad hominem* attacks upon all the witnesses who dared raise a critical voice against it on behalf of retiree interests. I find it hard to express the level of disgust I have for the continuing policy of intimidation and defamation that our own union engages in when it is criticized but I can no longer say I am surprised by such tactics. In response to the

patent misrepresentations made in the "White Paper", however, I shall offer here the response written by a fellow NFL retiree and a tireless advocate for the cause of all his fellow ex-players, Mercury Morris, whose "Black Paper" is attached at **Tab 13**. I cannot surpass the excellent job Mercury does in answering the NFLPA's attempt at justifying itself for behavior with regard to disability claims that is beyond any justification.

Finally, I would like to thank you, Madam Chairwoman, and the membership of your Subcommittee and the House Committee on the Judiciary for taking notice of this important issue and asserting your oversight in this area. Such scrutiny by the Congress, in itself, is crucially helpful to what I hope will be a successful process of reform of a Retirement Plan and a disability system that are deeply flawed to the point that they too often produce harmful outcomes. I hope, with your continued oversight, that a genuine process of reform will go forward, whether through the responsible engagement of the parties themselves or, if necessary, though the actions of the Congress. Either way, the current system cannot stand. We in the retiree community have, for a long time, engaged in financial self-help of various kinds, and we will continue to do so, but it is time for all the parties, including both the NFL ownership and the NFLPA, to come together and fix this problem for the sake of many suffering people who helped build the modern empire of NFL football at the expense of their health. I will end on those notes of hope and necessity, and by attaching the testimony of my friend and teammate from the Chicago Bears, Gale Sayers, from the Senate hearing this September at **Tab 14**. I can think of no better summary of our collective responsibilities to reform this system now, both for the sake of the retirees who are suffering and for the game of football itself.

Question 2--The NFL and NFLPA have argued that the dollar levels of benefits have increased over the years. What is your response to that argument?

While the dollar level of the benefits that the NFL and the NFLPA have made available has increased slightly over time, principally since 1993, that fact is misleading if taken in isolation. Each year there are more retired players that become eligible for benefits and the benefits that are added or increased will also go to currently active players. Moreover, increasing the benefit levels without providing objective and fair standards for qualifying for the benefits, which has been the historical practice of the NFL and NFLPA, is unconscionable.

The NFL and the NFLPA like to suggest that they are providing new or increased benefits to retired players but that statement ignores important facts I'll try to summarize here.

The National Football League is a multi-billion dollar industry built on the injuries and disabilities of its players. The game is a violent and dangerous one, with many of the retired players having life-long disabilities that prevent them from working or being able to get medical insurance. The cost of the growth of the league and the wealth of its owners has been borne by the players, their families, our society, our hospitals, and our federal and local governments:

- Many of the disabled, retired players are limited in the work and medical insurance they can get – if they can work – because of their disabilities.

- The families of the disabled, retired players share in the pain and humiliation of the retired players.

- Many of the retired, disabled players are forced to rely upon state, local and federal programs to survive and to receive medical treatment. These programs include the Medicaid, Medicare, and Social Security programs. These are costs borne by all taxpayers and should be borne by the league.

- Some retired, disabled players are forced to seek medical care from the emergency rooms of community hospitals, which is not covered by insurance or the league but which increase the general cost of health care. A single catastrophic injury can cost hundreds of thousands of dollars, which should be borne by the league's insurance programs.

Workers compensation insurance is not available to professional athletes uniformly in all states. Where workers compensation insurance is available, some injured players who are about to be cut from a team may lose their claim to it by stating that they are not injured because they want to try and make the team. That statement will be used against them when they claim workers compensation benefits. Also, many of the disabled, retired players are not given advice on their rights under the workers compensation

benefits. For example, many will elect a lump-sum settlement rather than receive monthly payments, not knowing that the lump-sum payment will cause them to lose their medical coverage under most workers compensation laws and insurance programs.

In the following, I will provide a more detailed historical outline of the development of the NFL's benefits process, which I hope provides a more adequate context for your consideration of the NFL's and NFLPA's selective emphasis upon the benefit increases in recent years. This history is compiled from facts and figures taken from Pension Trust Agreements, CBAs, and other documents. This information chronicles an extended history of the relationship between the NFL, NFLPA, and the early players who believe they have earned the right to a fair share of the increases recently won in collective bargaining. These early players' efforts and sacrifices, made during the early negotiations including strikes and lost wages, were also instrumental in making the NFL the tremendous financial success that it is for players and owners today. It is wrong to ignore their efforts, which is exactly what the NFL and the NFLPA have done historically.

On behalf of generations of retirees, I question why, due to inadequate representation by the NFLPA, proper benefit increases were ignored for over twenty years resulting in little or no increase during that period for the early vested NFL players in the benefit plan. I question why the NFLPA failed to increase benefits on a timely basis for the players who were so instrumental in helping create the financial bonanza currently enjoyed by the

active NFL players and the owners. Finally, I question the NFLPA's frequently repeated boast that the "NFL players have the best benefits in all of professional sports."

First of all, here is a numerical comparison on several key points with another other sports pension plan, that of Major League Baseball (MLB):

1.	Owner contributions (2005):	NFL $64,769,237	MLB $115,000,000
2.	Total assets in plan (2005):	NFL $841 million	MLB $1.6 billion
3.	Vested players (2005):	NFL 9,560	MLB 7,531
4.	Owner cont. vs. total salary:	NFL 2.4%	MLB 4.6%

In many public statements, the NFL and NFLPA have compared the NFL plan favorably to the MLB plan. To anyone who looks at the numbers objectively, such a conclusion is absurd on its face. If the Committee would like an existing model to use in improving the current broken NFL pension system as a whole, let it look to the MLB plan.

The most serious error in the NFL Pension Plan development was the total lack of actuarial consideration of the unusual fact that a vested player does not begin receiving his pension for about 25 years after leaving the game, on average. To understand the magnitude of this statement, the Dow Jones Index was up 11 times from 1970 to 2003 and there has never been a 25-year period that the equity markets were not higher. The CPI is almost six times higher in that period.

Responses of Mike Dikta to Questions of Chairwoman Sanchez—Page 13

The original Bert Bell Retirement Plan, which began in 1959, had a Basic Fixed Annuity, which was 40% of the owner's contribution and the other 60% went to an Equity Fund (to account for market appreciation during the many years between retirement and receiving benefits). MLB has had such a variable feature in their Pension Plan since 1963.

From 1970 to 1987, the NFLPA negotiated only increased *owner* contributions to the pension plan during the CBA negotiations, without increasing the defined benefits themselves at all. As a result, the Plan's fund became substantially over funded with respect to the benefits package as it was originally defined. By looking at the record of owners contributions over the years you will see how this lack of benefit increases provided the owners with a justification in making erratic contributions and in some years no contribution at all (*see* **Tab 15**).

The 1970 CBA included many plan improvements. The new plan was changed to a defined benefit plan, benefits were increased and normal retirement age was lowered from 65 to 55. However, the Variable Equity Fund was eliminated, which also eliminated any possible growth in response to inflation or CPI increases. Therefore benefits for the early vested players were actually *decreased.*

In 1974, collective bargaining negotiations were based almost entirely on "freedom issues" by the NFLPA's design. As a result, there was no new CBA nor were their any benefit increases.

In 1977 the new CBA should have increased benefits for all players, active and retired, based on the increases in CPI and inflation. The truth is the only increases provided were for *players playing in the year 1970 and later*. *None* of the players in the original plan, the one with the Equity Fund, realized any increases at all.

In 1987, negotiations did not lead to a collective bargaining agreement and there were no benefit increases. The 1987 negotiations were very difficult and extremely polarized, with the NFL owners represented by a well-known strikebreaking attorney named Jack Donlan who conducted an anti-union crusade on the owners' behalf. By increasing only owner contributions between 1970 and 1987, without increasing the size of the benefits themselves, the NFLPA, whether they knew it or not, had played into the owners' hands. Once a player's benefit is determined, there follows a long period of time before he actually receives any benefits. With small or no increases for the older retired players, strong equity market growth and no actuarial consideration, the fund became significantly over-funded with respect to the fixed size of CBA-negotiated benefits and the owners refused to contribute the money they had promised in the CBA. In response, Union President Gene Upshaw decertified the union and went to court where the NFLPA won several court cases from the owners, including $25 million that that was withheld by the owners on the grounds that, though it had been promised in collective bargaining, it was not actuarially needed for benefits. This amount was subsequently awarded back to the Plan but retirees have *never* been shown whether any of that benefit money was allocated to early player benefit increases.

The owners agreed to pay a settlement on the disputed amount if the NFLPA would agree to a new CBA, so the NFLPA agreed to a settlement in 1993. The early vested players in the plan, who played between 1959 and 1967, thus *received their first benefit increases in 23 years*.

In the new 1993 CBA, the Bert Bell Plan and the Pete Rozelle Plan were merged effective March 30, 1994. The new plan became a Taft Hartley Trust "Maintenance of Benefits Plan" from that date. What this means is that "Contributions will be made to the trust fund as actuarially determined to be necessary to fund fixed benefits, as required by applicable law." Benefit increases thus became the new object of CBA negotiations with the amount of money necessary to fund those benefits to be actuarially derived, eliminating the direct negotiation for owner contribution amounts.

The 1993 CBA added many new benefits. In addition to the pension, it included severance, a five-year COBRA health plan after retirement, increases in disability payments of $5 million, a 401k plan with owner contributions and a Second Career Savings Plan with owner contributions near $7 million. *But none of these new benefits was made retroactive before 1993*. Of course these new features are not practicable for the older retirees, but the NFLPA has said it always negotiate for everyone, *past*, present and future, which has certainly not been borne out by the evidence. All of these new benefits, therefore, were only useful to impending or prospective retirees.

Pensions were increased across the board in 2001, going from a doubling of benefits for the early players to smaller increases for later players. Vested players before 1967 did not receive an increase from 1970 to 1993, 23 years from the so-called beginning of the NFLPA under John Mackey. There were no increases made for any early players until 1977, which resulted in serious benefit shortfalls.

The doubling of benefits for players before 1982 was a welcome and appreciated improvement. Likewise, the NFLPA did come up with a fairly good increase in 2006, when all pension benefits for retired players before 1982 received a 25% increase, compared with a 10% increase for post-1982 players. But even these two increases combined did not come *close* to reaching levels commensurate with CPI and equity market growth. Thus all players from that era have a legitimate right to request additional benefit improvement from the NFL and the NFLPA.

Mr. Upshaw often says we are misinformed. If we have been misinformed, it would have to have been in great part due to the statements by Mr. Upshaw and his staff in Washington. He has said many times he always represents the retired players during CBA negotiations. The 2003 membership renewal letter states, "With your support we can continue…to improve pension benefits for former players." And in 2005, "…we are an active part of the union." That is certainly why 3500 former players pay dues to the NFLPA. I was surprised, therefore, when Mr. Upshaw said to former players in a letter dated Dec. 2, 2005, "You are not union members and we do not represent you," after being confronted by other players and the press on the issue of whether the NFLPA

actually did represent the retirees' interests. Since then, we have all learned to parse the NFLPA's former statements about the limited, voluntary extent of their representation of retirees' interests, but such limits were never emphasized when appeals for dues were sent around in the past. It seems to me that *someone* should affirmatively represent the vested retired players, but we were only informed that we had no such actual representation when Mr. Upshaw made this public admission in direct contradiction to those earlier statements (*see* **Tab 16**).

In conclusion, there have been only erratic contributions by the owners to the elements of the Plan relevant to retirees' interests, and only less than complete attention paid to pension increases by Mr. Upshaw and the NFLPA for many years, now. The result has been continued inadequate compensation of retirees, particularly those from the early period between 1959 and 1967, for an unconscionable length of time. This issue, as well as the broken disability system, must be addressed and I deeply appreciate the Committee's efforts to begin that process.

— Tab 1 —

Testimony of Mike Ditka
Before the Senate Committee on Commerce
Hearing on Oversight of the NFL's Retirement System
September 18, 2007

Chairman Inouye, Subcommittee Chairman Dorgan, Ranking Member Stevens, Subcommittee Ranking Member DeMint, Members of the Committee and distinguished guests, my name is Mike Ditka. I played for the Chicago Bears and the Dallas Cowboys from 1961 to 1972. I also was an assistant coach for the Cowboys and the head coach of the Bears 1985 Super Bowl championship team. Since 1992, I have been involved in broadcasting of NFL games as a color commentator and analyst, as well as other business ventures. I have been fairly successful and, at the outset, I'd like to clarify that nothing could interest me less than the size of my own NFL pension. I am here today on behalf of many other retired NFL players who have not been as fortunate as I in the years since their retirements because the injuries they received playing the game of football prevented them from making a living.

For some time, now, I have been involved in charitable efforts to aid disabled and economically challenged NFL retirees through nonprofit organizations such as the Gridiron Greats and the Mike Ditka Hall of Fame Trust. For some time, these and other organizations have picked up the slack left by an NFLPA that does not do enough for disabled retired players and an ownership that seeks to avoid doing anything at all, both of which seem to have handed the operations of the Plan to an aggressive litigation firm charged with delaying or denying every legitimate claim that players bring forth. What these charities do, all they can do, is place a band-aid upon the huge wound these other

groups are, at best, ignoring by minimizing it's gravity and keeping it's true extent secret. We will continue to do this work as long as the problem exists. But we will also continue to point out the responsibility the other parties I've mentioned have for perpetuating and worsening this problem, and their corresponding duty to shoulder the burden of fixing it *before* those who suffer under the current system conveniently die and reduce the excess financial burden upon the Plan's funds.

I'd like to address the question of disability pensions under the Bert Bell Retirement Plan. It is hard to say what is more disturbing: what we know, or what we don't know. What we know is bad enough. To start with, the Plan provides disability benefits to too few players (no more than 200 or so, although this statistic often goes up or down in statements by the Plan's lawyers). According to the Plan, there are more than 7000 retired players who are entitled to receive some kind of retirement benefit. (The actual number is probably significantly higher, but I'll use 7,000 here to describe the Plan as generously as I can.) This means that, *at most*, 3 or 4 percent of retired players are receiving any kind of disability benefit. And this is in a game that pushes most players out of the league within a few years – often due to injury (the average playing career is around 3.5 years). It is a collision sport, not merely a contact sport, which is probably the most violent public spectacle since the gladiatorial games. So the idea that only three or four out of every 100 retired players are entitled to ANY kind of disability benefit (not just the top level, but any kind at all) just clashes with common sense.

On top of that, look at the number of retired players who have received disability benefits for brain injuries caused by multiple concussions. Again, according to statements by the Plan's lawyer in Sunday's Charlotte Observer, there have only been four – ever, in *history*! One of them was Mike Webster. And the Plan's representatives claim not to know the number of players who have applied for disability due to such injuries. Anyone who has played the game, especially in the recent past when it was often played on a concrete parking lot covered with a quarter-inch layer of indoor-outdoor carpeting called "Astroturf", will tell you that NFL football often results in concussions and that players commonly receive multiple concussions over the course of their careers. Again, the idea that only four men who have ever played pro football have had disabling brain injuries just doesn't make a lot of sense.

Why don't more players receive the disability benefits they need? There are lots of answers, starting with the bargaining process between the union and the NFL. Gene Upshaw described his attitude towards the retired players last year, when he told a newspaper that retired players "don't hire me and they can't fire me. They can complain about me all day long." It's possible that the union leadership doesn't push harder for fair disability benefits because they think it might mean less for current players. But part of the job of union leadership is to explain to current players that they could be ex-players next week or next month, as a result of injuries or salary cap decisions. It's actually in the interests of current players to push hard for fair, generous disability benefits – and to get that money from both the team owners and from current players.

Look at it this way: the Plan says that retired players receive only $20 million per year in disability benefits today. The players' share of revenues under the salary cap system is about $4 billion a year. Tripling the disability payments to $60 million – an increase of $40 million – would be only 1% of the players' total share. If the players and the owners each gave an extra .5% of the player's current share for disability pensions, they could easily cover this amount.

Another big barrier to fair disability benefits is the way the Bert Bell Plan is run. We've heard the same stories from too many retired players to chalk this up to complainers, the way the Plan would like to have it. All claims are reviewed by two office staff who possess no relevant skills for reviewing disability claims. If they deadlock, the claim is denied. None of the members of the Retirement Board have any medical training, and several of them have close ties to the union president – including the agent who negotiated Mr. Upshaw's $7 million contract. The Plan will delay decisions over and over again – Mike Webster's case took four years before he had a final decision. Often these delays are so that the Plan can request multiple reports from doctors in the same specialty or closely related ones – "doctor shopping" is the right word for it. We all know that if you ask for enough medical opinions, someone will eventually find that there is no disability, or disability at a lower level. And the Plan spends extraordinary amounts on its attorneys -- $3.15 million last year. In fact, that's almost one sixth of what the Plan claims it spent on all disability payments. Once again, those numbers just don't add up.

All of this suggests that, under the Bert Bell Plan, the main emphasis is on minimizing the benefits paid out, not on making sure it's done fairly. The website for the Plan's lawyers has boasted about how many times they have defeated claims by retired players. But the number of lawsuits suggests that something is broken in the Board's procedures. According to the Plan's attorneys, it has been sued by almost one quarter of the retired players whose claims were denied. This is not the sign of a healthy process.

If you want to get an idea of how the Plan really works, take a look at the Mike Webster case. Here was a guy who started almost 250 games for the Steelers, and played every offensive down for six straight seasons. He wasn't called "Iron Mike" for nothing. He played when the head slap was legal, and probably had thousands of serious hits to his head and dozens of concussions. He couldn't work after he retired, and was hired by the Kansas City Chiefs as a favor. His friends told the pension plan's investigator that he wasn't right mentally and never held a job. But the Bert Bell Plan told Mike that his brain injuries weren't the direct result of playing football, and told him that he wasn't disabled until years after he retired. They ignored the opinion of their own doctor, and refused to look at the evidence from Mike's doctors. And it took so long to decide his claim that he died in 2002 before the Plan had made a final decision.

After he filed suit, the first judge who looked at the case said that given the overwhelming evidence, the Bert Bell Plan had probably acted in bad faith. Did the Plan pay Mike's children then? No. They appealed. And this time it was three judges in a Court of Appeals that said the Plan had ignored the unanimous medical evidence. They

said it would require a "leap of faith" to agree with the Plan. And so the Plan paid hundreds and hundreds of thousands of dollars in attorneys' fees to fight the case, and also paid for the time that Mike's attorneys spent pursuing it. That helps explain why the Bert Bell Plan ran up a $3.5 million bill for attorneys last year – money that could have gone to injured players. And even today, just a week ago, representatives of the Players Association claimed that Mike Webster was actually working after he retired from football. That's not true, and they *know* it.

I've talked about some of the things we know about the Bert Bell Plan. But it's just as important to point out what we don't know, and what I hope this Committee can help find out through the hearing and oversight process. Right now, the Plan gives out virtually no information about the number of players receiving disability benefits, how many people get each type of benefit, even the total dollars paid out each year for disability. The information that gets handed out by the Plan– only in response to Congressional and media scrutiny – is fragmentary and unreliable. What we really need is full disclosure by the Bert Bell Plan of all the key information behind the disability benefits, so that the retired players, and the union, can negotiate for better procedures, changes in the way the Plan is administered, and more money for disabled retirees. I hope that this kind of necessary disclosure is one result of this Committee's work, and I look forward to working with you so that the great men who built this league can lead lives of dignity after their retirement.

— Tab 2 —

An Outline of Some Problems with the NFL's Disability System

A. There is a clear record of the Retirement Board's and its staff's efforts to deny valid benefit rights to retired disabled players under the Bert Bell - Pete Rozelle NFL Retirement Plan ("the Plan"), with tragic results for many severely disabled retired players who helped to build the National Football League into a multi-billion dollar business. Here are a few representative stories illustrating this point:

1. Randall Beisler - who, at the mere turn of his head, often becomes temporarily paralyzed for indeterminate periods of time. The Retirement Board and staff hired a private investigator to follow him and misrepresented that he was trying to "help" Mr. Beisler to get his benefits when he was actually working with the Board to deny benefits to Mr. Beisler. The Plan's own physician found that Mr. Beisler was disabled and should be provided a disability benefit under the Plan, which the Retirement Board and its staff denied. Such aggressive attacks to circumvent or overturn disability findings by approved Plan physicians by the Plan's own lawyers is a typical, not an exceptional, response.

2. Neil Colzie -- was denied disability pension benefits because the Plan's physician speculated that Mr. Colzie should be able to find a job in a sedentary position -- e.g. that he could potentially do broadcasting work because he still had a voice--so he was not sufficiently disabled.

3. Delvin Williams -- who was found to be entitled to new disability pension benefits under the Plan and sought retroactive benefits of approximately $160,000 because the Retirement Board and its staff had violated their obligation to give timely notice of the new benefits for over one year. The Plan's own physician agreed with Mr. Williams' claim. While the Judge in the District Court case in California originally ruled in Mr. Williams' favor, because of legal technicalities related to ERISA, he lost his claim in the Ninth Circuit Court of Appeals and was required to pay $75,000 to the Plan. The Retirement Board's attorneys claimed to have spent more than $1,000,000 of the Plan's money fighting Mr. Williams' claim.

B. The League is a multi-billion dollar business (over $7 billion per year in revenues by the most recent estimate) that has grown through its anti-competitive practices with the cooperation of the NFL Players Union ("the Union"). These actions and practices have been allowed to continue because of weaknesses in the Employee Retirement Income Security Act, which is the federal employee benefits law regulating employee benefit plans, including the Plan, and the federal Labor Management Relations Act, which regulates collective bargaining. Those weaknesses, which lie beyond the jurisdiction of the Committee on Commerce, nevertheless need to be addressed in order to provide the Committee with adequate context on this issue, so they are discussed below.

C. There is a clear record of inconsistencies and arbitrary decisions in the administration of the disability retirement benefits under the Plan, with tragic consequences for many disabled retired players.

1. Many severely disabled retired players have had their valid disability benefit claims denied because there is no objective oversight over the actions of the Retirement Board and its staff and the members of the Retirement Board have inherent conflict of interests in their service to the participants in the Plan.

(a) Representatives on the Retirement Board who are appointed by the owners of the NFL teams recognize that denying benefits to the disabled retired players will minimize future contributions to the Plan by the NFL teams.

(b) Representatives on the Retirement Board that were appointed by the Union have been agents of active players who do not represent retired players. If the executives of the union are more concerned with the active players who re-elect them as executives, they lack sufficient incentive to look out for the best interests of the disabled retired players, which is their charge under ERISA. If those Union representatives are more concerned with the pay for the active players, they will also recognize that denying benefits to the disabled retired players will minimize current and future payments for their clients.

2. While the Executive Director of the Union claims that the Union has negotiated new benefits for retired players, even though he does not represent them, and that the active union employees have "subsidized" those benefits. He neglects to point out that the benefits he cites are, in fact, also used by current players and once those benefits are established, the Union has moral and legal obligations to ensure that these benefits are administered objectively and uniformly. That has not happened. If the Committee could obtain the actual distribution of these funds, this discrepancy would become clear and public.

D. The Retirement Board and its staff have breached their fiduciary duties under the ERISA law.

1. Under the ERISA law, the Retirement Board and its staff are required to act uniformly in administering the Plan, and not in an arbitrary and capricious basis. They are required by Section 404(a) of ERISA to act in the best interests of the participants in the Plan to provide them benefits or to pay reasonable administrative expenses of the Plan.

2. The Retirement Board and its staff have violated their legal obligation under ERISA to notify Plan participants on a timely basis of their rights under the Plan, and they have used that breach to deny disabled retired players their right to benefits under the Plan. The Retirement Board and its staff failed to notify participants of their rights to a new disability benefit under the Plan more than one year after the ERISA law required the Retirement Board to give notice of the benefits. Given the time deadlines to apply for the benefits, the delay denied many disabled retired players the opportunity to apply for and received the benefits to which they are entitled.

3. The Retirement Board and its staff have not published or prescribed rules or standards for the determination of who should be eligible to receive retirement benefits under the Plan, leaving participants to guess what is required to be eligible for benefits under the Plan.

4. The Retirement Board and its staff have acted arbitrarily and capriciously in establishing *ad hoc* rules for eligibility for the plan, with the effect of denying benefits to participants who are severely disabled. The Retirement

Board and its staff have not applied the conditions for benefits uniformly throughout the United States. The Retirement Board and its staff rely on the opinions of the many physicians they have selected throughout the United States without providing uniform guidance on how to apply the terms of the Plan.

5. Yet, when the Retirement Board and its staff did not want to pay benefits, they would disregard the medical opinion of their own selected physicians. Example: opinion of Kevin Harrington in Delvin Williams' case.

6. In one case, the Retirement Board and its staff hired a private investigator to follow an applicant for a disability benefit, which is unheard of in ERISA benefit cases. The investigator misrepresented that he was "helping" the retired player when he, in fact, was assisting the Plan in attempting to deny benefits to the retired player.

7. The Retirement Board has paid millions of dollars to its primary outside law firm, The Groom Law Firm, and the law firms throughout the United States selected by the Groom Law Firm, to help deny the valid benefit claims of disabled retired players. Last year, fees paid to the Groom Law Group totaled $3.1 million while the corresponding firm representing Major League Baseball collected $175,000. This comparison should be taken as an index of the "scorched earth" litigation posture taken by the Plan towards claims by retirees. Since these fees are paid out of the pension plan itself, ostensibly to protect its integrity, they amount to a massive transfer payment from what should be a source of pension and disability benefits to a private law firm -- a "bounty" system that is deemed efficient merely because it depletes pension funds at a lesser rate than the payout of legitimate clams.

E. Some Problems with the Plan, and A Suggested Path to a Solution:

1. **ERISA law gives excessive deference to the Plan's administrator, which protects actions of the Retirement Board and the staff and lawyers of the Retirement Board**. As a result of the deference, the Retirement Board has prevailed in almost all of its lawsuits on legal technicalities rather than on the medical conditions of the disabled retired players.

2. **There is no practical oversight over the actions of the Retirement Board and its staff because of the deference given under the ERISA law.**

3. **There is not sufficient representation on the Retirement Board from persons with an interest in looking out for disabled retired players or to ensure that benefits are provided uniformly and objectively and not in an arbitrary and capricious basis.** There are inherent conflicts of interests of members of Retirement Board in favor of the owners of the NFL teams and the active players.

4. **There have not been any consequences to the members of the Retirement Board and its staff for their violations of their fiduciary and administrative obligations under ERISA.** For example, the Retirement Board should have been held accountable for not notifying retired players of changes to the Plan on a timely basis.

5. **The Retirement Board and its staff have not been required to prescribe, publish or adhere to objective standards for determining the eligibility for benefits under the Plan.**

6. **There is no adequate administrative help for applicants, many of which have brain injuries and corresponding short-term memory loss due to multiple concussions, to fill out applications and proceed through the process.** Simply posting application information on a website, without the availability of objective, real-time human help, is a particularly egregious shortcoming in the context of such injuries, which are common among ex-NFL players. Moreover, since the NFL has frequently argued that players have not sent in their paperwork (a claim which also stretches credulity when referring to totally disabled people who have little else to depend upon but a successful application, but which is nevertheless conveniently impossible to disprove in the absence of better recordkeeping safeguards), these interactions should be recorded and an evidentiary chain firmly established to keep the process honest.

7. **The processing of claims is inordinately long.** Plan representatives have often quoted an "average" processing

time of 18 months, which is interminable in itself if one is disabled, but if the Committee could look behind this "average" time to a true distribution of processing times (considering that many claims are disallowed almost instantaneously), it would find that the processing of claims meriting the largest levels of compensation takes a much longer period. Those that cannot be denied are delayed. This, again, is particularly egregious because, by the NFL's own computations, the average ex-player lives to an age of only 55, with linemen averaging only 52. [It should be noted that these figures are used by the Plan to urge ex-players to take retirement at an earlier age, resulting in dramatically lower levels of compensation]. This convergence of facts has given rise to a popular characterization of the Plan's strategy as "Delay, Deny and Hope They Die."

8. **There is no adequate deference given to medical opinion in the entire process.** As noted above, Plan medical experts are routinely undermined and circumvented after they have made a disability finding in favor of a retired player. Moreover, as in the case of Brent Boyd, non-Plan experts have been specifically enlisted to overturn the decision of Plan doctors who made disability findings. Medical expertise functions as a sword to deny disability, but it is no shield against the aggressive strategies of administrative denial and, if necessary, litigation by the Plan staff and the Groom Law Group.

9. **All numerical data associated with the Plan is non-public and inaccessible, making misrepresentations by the Plan's representatives common and not immediately arguable.** How many retirees are there? The Plan's own representatives have given numbers ranging from 8,000 to 13,500, seemingly dependant upon which number was more advantageous under the circumstances. How many receive disability payments? At a hearing earlier this year before the Administrative Law Subcommittee of the House Judiciary Committee, Plan representatives said 317. Later, they amended this to 428. On information and belief, which is as good as we can get with respect to such unpublished data, the number is closer to 120. Crucially, at what *levels*? (Again, like the "average" claim processing time, what is the *distribution*?). This has never been answered. How many have applied for disability predicated upon brain injuries resulting from concussions? As recently as this Friday, Plan representatives told Senate staff that *they did not know this*

number -- this even though the NFL is supposedly seeking to implement a new, progressive policy to protect players from the effects of concussions. How many have been successful in obtaining disability based on concussions? According to a statement by Attorney Douglas Ell of the Groom Law Group to a reporter, that number is *four (4)* -- for the most violent game since the Roman Arena, often played on a surface consisting of concrete covered with a quarter-inch layer of indoor-outdoor carpeting called "Astroturf", which was incorporated in stadium construction to save on grounds-keeping bills, without regard to the havoc it visited on men's bodies. *We implore the Commerce Committee, consistent with its oversight function, which is the reason for this hearing, to seek extensive and complete data on all aspects of the Plan, its procedures and its funding. The truth, which has been artfully and thoroughly hidden to date, is in these numbers. Without the thorough examination and publication of these data by the Committee, any private negotiations held in an attempt to solve this problem cannot bear fruit.*

10. **The NFL Retirees have no bargaining power to negotiate an end to this inequitable situation without the continuing oversight of the Senate.** The collective bargaining entities, the NFL and the NFLPA, do not and cannot represent the retired players. Indeed, as noted above, the Plan representatives have not even fulfilled their fiduciary and representative duties to the retired players with respect to the distribution of pension and disability distributions. *The light of common day and, with it, the power of public and governmental scrutiny of this process is the only bargaining power available to the NFL Retirees. Nevertheless, if the Committee would continue its oversight of this issue and demand regular reports of negotiating progress by the parties represented at this hearing, the NFL Retirees would like to engage the collective bargaining entities in a true negotiation in an effort to settle this matter privately, without the need for specific legislative relief. We therefore ask the Committee to exhort the parties to come together in such a negotiation immediately after this hearing and to subject that process to your regular oversight in the form of such periodic reports, which we propose to be produced to the Committee every 30 days from the date of this hearing.*

— Tab 3 —

2 of 4 DOCUMENTS

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TITLE: Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare?

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TEXT:

Introduction

Insurance company statistics show that "one out of five 35-year-olds will experience a disability that lasts three months or more before age 65." n1 Working women are even more adversely affected and are deemed "three times more likely than men to miss work due to a disability related illness." n2 According to the Social Security Administration, which pays benefits to disabled individuals incapable of engaging in any work whatsoever, n3 more than 2.1 million individuals applied for Social Security disability insurance in 2005, a 4.39% increase over the prior year. n4 Thus, meeting one's economic needs in the event of disability is a major concern.

n1 www.massmutual.com/mmfg/service/di/whygetdi.html.

n2 www.efinoody.com/insurance/disabilitystatistics.html.

n3 For a definition of "disability" under the Social Security disability program, see 42 U.S.C. § 423(d)(1)(A).

n4 www.ssa.gov/OACT/STATS/dibStat.html.

Most individuals who are covered by disability insurance receive that coverage from their employers as a benefit of their employment. n5 As such, any dispute over the benefit payment is governed by the Employee Retirement Income Security Act (ERISA). n6 Unquestionably, the ERISA law was enacted to provide substantial protection to employees based on the statute's preamble, stating its intent to:

> protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts. n7

n5 *See, generally,* J. Wooten, *The Employee Retirement Income Security Act of 1974 -- A Political History* (U.Cal. Press 2005).

n6 29 U.S.C. § 1001 *et seq.* The ERISA law's scope extends to benefits provided for the welfare of employees, which includes disability insurance. 29 U.S.C. § 1002(1). However, it does not include situations where the employer simply makes insurance coverage available for employees to purchase. *See, Johnson v. Watts Regulator Co.,* 63 F.3d 1129 (1st Cir. 1995).

n7 29 U.S.C. § 1001(b), quoted in *Varity Corporation v. Howe,* 116 S.Ct. 1065, 1078 (1996); *Black & Decker Disability Plan v. Nord,* 538 U.S. 822,123 S.Ct. 1965, 1970 (2003). "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Quoting *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 113, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989) (internal quotation marks and citations omitted).

Assurance that disability benefits will be available in time of need is crucial because, as one judge has recognized, "decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance." n8 Social Security does not completely fill that role because it provides only a small portion of earnings replacement, society relies on private insurers. Yet, preemption of disability insurance claims by the ERISA law has, despite its salutary purpose, been fraught with peril as one court noted:

> There are also obvious drawbacks to relying on private insurers, however. Although the profit motive drives companies toward efficiency, it creates a substantial risk that they will cut costs by denying valid claims. The market is somewhat inapt to punish insurers for engaging in such practices, particularly if the denials are not too flagrant, because the complexity of the insurance market and the imperfect information available to consumers make it difficult to determine whether an insurer is keeping its costs down through legitimate or illegitimate means. An individual claimant who encounters an insurance company that is disposed to deny valid claims must struggle to vindicate his rights at a time when he is at his most vulnerable. Often a newly disabled person will simultaneously confront increased medical bills and either termination of employment or diminished pay.
>
> The judiciary provides a check on these potential abuses; under ERISA, aggrieved claimants can seek redress in the courts of justice. Congress and the courts have made two decisions, however, that limit this checking effect. The first is to place limitations on judicial review of plan administrators' and fiduciaries' decisions similar to the ones placed on judicial review of governmental agency action, even though, unlike officials in governmental agencies, administrators and fiduciaries are not answerable to the public or to elected officials. Second, and perhaps more troubling, the courts have interpreted ERISA to restrict or eliminate the role of juries in deciding disputes between claimants and insurers. n9

n8 *Radford Trust v. Unum Life Insur. Co. of America,* 321 F.Supp.2d 226, 240 (D.Mass. 2004).

n9 *Id.*

Another court expressed similar worry:

> *Caveat Emptor!* This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not

> disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits. n10

> n10 *Loucks v. Liberty Life Assur. Co. of Boston*, 337 F.Supp.2d 990 (W.D.Mich. 2004) (vacated following settlement).

Judicial commentary has led to media scrutiny. The story of how a law intended to protect employee benefits has been used to shield insurers was told in the *Los Angeles Times* by Peter G. Gosselin in his article, "The Safety Net She Believed in Was Pulled Away When She Fell." n11 The *Wall Street Journal* similarly reported that the ERISA statute "has evolved into one that covers far broader territory and can have an unanticipated effect, tilting the playing field in favor of employers and serving as a legal shield for them." n12 Unfortunately, there is much to be concerned about; a law enacted for the protection of plan participants has been construed by the courts in a manner that has caused great uncertainty, if not outright harm.

> n11 *Los Angeles Times*, August 21, 2005.

> n12 Ellen Schultz, "A Hobbled Star Battles the NFL," *Wall Street Journal*, December 3, 2005.

The Transformation Wrought by ERISA

Transforming "garden variety" insurance cases into ERISA claims has always been viewed with skepticism by the federal judiciary. The 7th U.S. Circuit Court of Appeals remarked in the health benefits context:

> All this is not to deny the strangeness, as an original matter, of transforming disputes between employees and insurance companies over the meaning of the insurance contract into suits under ERISA. But the Supreme Court crossed this Rubicon in Metropolitan Life Ins. Co. v. Taylor, supra, reversing Taylor v. General Motors Corp., 763 F.2d 216 (6th Cir. 1985), which had held that a suit under the group insurance policy was not a suit under the ERISA plan pursuant to which the policy had been issued. Although we find it difficult to understand why such cases should be litigated in federal court, we are unable to escape the pull exerted by the statute, the administrative regulation, and the precedents. n13

> n13 *Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 512 (7th Cir. 1989).

Another judge, writing in a law review commented about the ERISA law's effect:

> Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. In Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield, n14 I started my opinion with these three sentences:
>
> > A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere in it a redeeming feature. n15
>
> Since writing Florence Nightingale, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the purposes Congress claimed to have in mind. For more than ten years, I have consistently and constantly criticized ERISA, and I feel no compunction in lifting passages from my prior opinions as I write this article. I cannot plagiarize myself. n16

n14 832 F. Supp. 1456 (N.D. Ala. 1993), aff'd, 41 F.2d 1476 (11th Cir. 1995).

n15 *Id.* 1457.

n16 William Acker, Jr., "Can the Courts Rescue ERISA?" 29 Cumb.L.Rev. 285, 285-86(1999).

Perhaps the U.S. Congress imagined the paternalistic goals of the ERISA law would protect claimants. Sadly, that has not proven to be the case at all. On October 3, 2005, the California Department of Insurance accused the world's largest disability insurer, UnumProvident Corporation of unfair claims practices. California's report was the third market conduct investigation of the UnumProvident Corporation and its subsidiaries n17 that corroborated the conclusions made in numerous court rulings finding pervasive claim abuses by affiliates of the UnumProvident Corporation. n18

n17 See, report of John Oxendine, Georgia Insurance Commissioner, November 30, 2000, and a multi-state market conduct investigation report (covering 49 states and the U.S. Department of Labor) issued November 18, 2004.

n18 *See, Radford Trust, supra.,* 321 F.Supp.2d at 247-48 n.20 (cataloguing cases).

Few questions have been raised, however, about why an insurer would risk the consequences of engaging in such pervasive misconduct. The answer, perhaps, lies in the regime created by the courts' interpretation and application of the ERISA law. Insurers have become well-aware of the advantages that have been handed to them as a result of court rulings that claims brought under their policies are pre-empted n19 by the ERISA law. Although ERISA preemption ostensibly does not extend to state laws that regulate insurers, the U.S. Supreme Court has narrowly interpreted that exception to find the ERISA law insulates insurers from punitive damages and "bad faith" awards that exist in the non-ERISA context. n20 Not surprisingly, insurers have reacted to that development by seeking to expand ERISA preemption, as one insurer's internal memo shows:

> A [company] task force has recently been established to promote the identification of [disability] policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, [a company employee] identified 12 claim situations where we settled for $ 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $ 0.5 million.
>
> In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. [While] our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action. n21

n19 Section 514 of the ERISA statute, 29 U.S.C. § 1144, preempts any state law that "relates to" an employee benefit plan.

n20 *Pilot Life v. Dedeaux,* 481 U.S. 41 (1987); *Aetna Health Inc. v. Davila,* 542 U.S. 200, 124 S.Ct. 2488 (2004).

In addition to questions about insurers' fairness in administering claims, ERISA cases are litigated in a *sui generis* manner that departs dramatically from other forms of litigation. While some courts have characterized ERISA claims as "review proceedings," that interpretation lacks statutory support. Civil actions authorized by § 502 of the Employee Retirement Income Security Act n27 are not "review proceedings" of a claim record. The U.S. Congress' authorization of a "civil action. . .to recover benefits due . . . under the terms of [a] plan" n28 should entitle claimants to a plenary court proceeding rather than a claim record review under the principles enunciated in *Chandler v. Roudebush.* n29

n27 29 U.S.C. § 1132(a) (2006).

n28 *Id.*

n29 425 U.S. 840 (1976).

In *Chandler,* the identical issue arose with respect to employees bringing civil actions to redress discrimination in federal employment pursuant to § 717(c) of the Civil Rights Act n30 While some lower courts had ruled that such actions involved a review of the record made at prior administrative proceedings, the U.S. Supreme Court overruled those decisions and held that federal employees were entitled to discovery and a trial rather than a review proceeding, explaining: "Nothing in the legislative history indicates that the federal-sector "civil action" was to have this chameleon-like character, providing fragmentary de novo consideration of discrimination claims where "appropriate," ibid., and otherwise providing record review." n31 The U.S. Supreme Court added:

> In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." Ibid. e.g., 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21(c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371(f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare). n32

n30 42 U.S.C. § 2000e *et seq.*

n31 425 U.S. at 861.

n32 425 U.S. at 862 n.37.

Applying *Chandler's* analysis, it is evident that nowhere in the statute itself or in the legislative history of the ERISA law is the term "substantial evidence" used; nor is there any support for a conclusion that the U.S. Congress intended that ERISA civil actions would be review proceedings.

Many courts have cited ERISA's statutory history as a rationale for deeming ERISA claims review proceedings, deriving that conclusion from a congressional report describing ERISA as providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously," n33 However, a closer examination of that quotation shows it can be traced to Senate Report 93-383 accompanying S.1179, a predecessor to the bill that eventually became the ERISA law. The draft bill afforded pension claimants the opportunity to pursue a grievance or arbitration proceeding before the U.S. Secretary of Labor; and the report refers to such a proceeding as providing "the opportunity to resolve any controversy over [ ] retirement benefits under qualified plans in an inexpensive and expeditious manner . . . Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor." n34

n33 *Perry v. Simplicity Engineering,* 900 F.2d 963, 967 (6th Cir. 1990).

n34 S.Rep. 93-383, reprinted in 1974 U.S. Code Cong. and Admin. News 5000.

That provision was dropped from the final bill, however; n35 and nowhere in the ERISA statute are there provisions limiting the manner in which the courts are to resolve civil actions brought by plan participants. On the contrary, the conference report explained that ERISA civil actions "are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947." n36 According to *Textile Workers Union v. Lincoln Mills,* n37 Section 301 n38 requires the federal courts to "fashion from the policy of our national labor laws" a federal common law governing the interpretation of collective bargaining agreements that includes plenary proceedings that even encompass trials before juries. n39

n35 Sen. Jacob Javits, one of ERISA's main sponsors, explained that House conferees were opposed to an administrative dispute mechanism "on grounds it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence it was dropped in conference." 3 Legislative History of ERISA, n. 4 at 4769.

n36 H.R. Conf. Rep. 93-1280, 93d Cong., 2d Sess. 327 (1974).

n37 353 U.S. 448, 456 (1957).

n38 29 U.S.C. § 185.

n39 See, Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry, 494 U.S. 558 (1990).

Nor can any argument be made that pre-suit appeals authorized by ERISA § 503 n40 substitute for plenary judicial proceedings. The statutory history of that provision makes it clear that the absence of an evidentiary hearing or even an arbitral forum prior to suit mandates plenary procedures. n41 Further, the absence of an administrative hearing or discovery proceedings from the claim regulations applicable to § 503, n42 while such provisions are included in relation to adjudication of other ERISA violations, n43 underscores the need for plenary proceedings for plan participants who initiate civil actions to redress benefit claim denials.

n40 29 U.S.C. § 1133 (2006).

n41 According to the House conference report, § 1133 was included as a compromise between the original House bill, which had no such provision and the Senate bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Ad.News 5038, 5108.

n42 29 C.F.R. § 2560.503-1 (2006).

n43 29 C.F.R. §§ 2560.502i-1, 2570.7 and 2570.11 (2006).

Moreover, the U.S. Supreme Court has also signaled that ERISA suits were intended to be plenary proceedings. In *Firestone,* the court explained: "Unlike the LMRA n44 [29 U.S.C. § 186(c)(2) 2006], ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans." n45 Subsequently, the U.S. Supreme Court commented in *Rush Prudential HMO, Inc. v. Moran,* n46

> [ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories

of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations* (citation omitted) (emphasis added).

n44 Cases such as *Beam v. Intl. Org. of Masters, Mates and Pilots,* 511 F.2d 975, 980 (2d Cir. 1975) had characterized Labor Management Relations Act of 1947 (LMRA) proceedings as seeking review of trustees' determinations after pointing out that "review in this case is not the examination of a dispute between an insurance company with a boilerplate contract on one hand and a consumer on the other." In contrast, that is exactly what occurred here; and unlike benefit trusts established under the LMRA, where both management and the employees appoint trustees, the decision-maker here was an insurance company, further supporting this court's distinction between claims under the LMRA and ERISA claims.

n45 489 U.S. at 110.

n46 536 U.S. 355, 385 (2002).

Of at least equal importance is the U.S. Supreme Court's finding that the U.S. Congress created a civil action for plan participants with the intent that the law not result in "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." n47 Before ERISA, federal courts applied contract law to resolve employee benefits disputes. n48 Unquestionably, but for the ERISA law, disputes involving benefit denials issued by insurers would be resolved through plenary court proceedings. n49 Moreover, even under the common law of trusts, which underpins much of the ERISA statute according to *Firestone,* plenary proceedings were the norm prior to ERISA. n50 Thus, in the words of a commentator critical of how the ERISA law has been interpreted:

> Yet even if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with "prompt resolution of claims by the fiduciary," the rationale would still fail. For it to be plausible, one would have to add two premises: that "prompt resolution of claims" is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the participants' right to receive benefits due. Merely to state these premises is to reveal their untenability. n51

n47 489 U.S. at 114.

n48 *See, Brief of Solicitor General as Amicus Curiae* in *Firestone,* 1987 U.S. Briefs 1054, at 5 n.7xo.

n49 *See, e.g., Cox v. Washington Natl. Insw. Co.,* 520 S.W.2d 76 (Ct.App.Mo. 1974) (employer sponsored disability benefit claim accorded plenary civil procedure); *Antram v. Stuyvesant Life Insur. Co.,* 287 So.2d 837 (Ala. 1973) (same).

n50 *See, e.g., Barnett v. Ross,* 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct of alleged trustee); *Phelps Dodge Corp. v. Brown,* 112 Ariz. 179, 540 P.2d 651 (1975) (jury trial conducted); *Matthews v. Swift & Co.,* 465 F.2d 814 (5th Cir. 1972) (plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review).

n51 Jay Conison, "Suits for Benefits under ERISA," 54 U.Pitt.L.Rev. 1, 57-60 (1992).

Even if one accepts the premise of allowing a deferential standard of review to apply to claim adjudications, courts should not blur the distinction between a plenary proceeding and a *de novo* standard of court review. Even under an

arbitrary and capricious standard of review, a court must examine in the first instance whether the decision-maker "entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence." n52 Another expression of the content of a review under an arbitrary and capricious standard suggests that such an examination, while deferential:

> inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence -- no matter how obscure or untrustworthy -- to support a denial of a claim for ERISA benefits. n53

n52 *Motor Vehicle Mfr. Ass'n v. State Farm Mutual Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

n53 *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172-173 (6th Cir. 2003) (citation omitted).

Consequently, a showing of whether a plan administrator's determination is arbitrary and capricious requires that the claimant be afforded the same tools as any other litigant bringing a civil action in the district court. Rule 1 of the Federal Rules of Civil Procedure mandates applicability of the rules to all civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. Indeed, in *New Hampshire Fire Ins. Co. v. Scanlon*, n54 the U.S. Supreme Court explained the presumption against summary proceedings in any claim governed by the Federal Rules of Civil Procedure:

> Summary trial of controversies over property and property rights is the exception in our method of administering justice. Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"

n54 362 U.S. 404, 406 (1960).

By imposing a lenient regime of claim review, outside of the scope of the normal rules of procedure, claimants are denied a fair consideration of their claims by the court. As professor Langbein remarks:

> Deciding a case on the merits is indeed more time-consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA-plan denials to federal judicial review, and because ERISA's draconian preemption provision suppresses the state law causes of action that existed for many such cases before ERISA, the proper role of the federal courts is to decide these cases fairly and not slough them off onto biased decisionmakers. n55

n55 Langbein, Trust Law, *supra*, at 34-35.

Thus, the courts need to more carefully examine the regime they have created.

The Value of Discovery

The only feasible way to ensure fairness in ERISA claim disputes is if the right to take discovery is preserved. Because courts are being called upon, even under an arbitrary and capricious standard of review, to assess the quality of the evidence presented, the only means by which the courts can be assured the evidence presented is scientifically and clinically valid and free from bias is through discovery. For precisely that reason, in *Calvert v. Firstar Finance, Inc.*,

n56 the 6th U.S. Circuit Court of Appeals noted concern about consultants hired by insurers to review claims: "As the plan administrator, Liberty had a clear incentive to contract with individuals who were inclined to find in its favor that Calvert was not entitled to continued LTD benefits." n57 Consequently, the 6th Circuit made it clear that discovery would provide "a better feel for the weight to accord this conflict of interest." 409 F.3d at 293 n.2. The court was referring to the insurer's conflicting roles as plan administrator and benefit payor.

n56 409 F.3d 286 (6th Cir. 2005).

n57 409 F.3d at 292. The U.S. Supreme Court also commented in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 832 (2003) that "physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers['] money and preserve their own consulting arrangements." (citation omitted).

The majority of federal courts approve of discovery aimed at uncovering potential bias. n58 However, the 7th Circuit has remained adamant in denying claimants the opportunity to take any discovery whatsoever. Most recently, in *Semien v. Life Insurance Co. of North America,* n59 the court reiterated a general prohibition against discovery, allowing discovery only if the insured could first produce credible evidence justifying discovery. However, the court's reasoning is circular because it is usually impossible to present such evidence without first conducting discovery. Without discovery, an insured is left with no means of proving bias or establishing the insurer's decision was arbitrary and capricious. Indeed, discovery fulfills professor John Henry Wigmore's assertion that cross-examination is "beyond any doubt the greatest legal engine ever invented for the discovery of truth." n60

n58 For example, the 1st Circuit allows discovery relating to corruption in the claim review process. *Liston v. Unum Corp. Officer Severance Plan,* 330 F.3d 19 (1st Cir. 2003). Conflict of interest discovery is also permitted in the 2nd Circuit (*Zervos v. Verizon N.Y., Inc.,* 252 F.3d 163 (2d Cir. 2001)); the 3rd Circuit *(Pinto v. Reliance Standard Life Insur. Co.,* 214 F.3d 377 (3d Cir. 2000)); the 5th Circuit *(Kergosien v. Ocean Energy, Inc.,* 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.")); the 8th Circuit (*Farley v. Arkansas Blue Cross & Blue Shield,* 147 F.3d 774 (8th Cir. 1998)); the 9th Circuit *(Tremain v. Bell Industries,* 196 F.3d 970 (9th Cir. 1999)); and the 11th Circuit (*Moon v. American Home Assur.Co.,* 888 F.2d 86 (11th Cir. 1989)).

n59 436 F.3d 805 (7th Cir. 2006) -- cert. denied 166 L.Ed.2d 251 (2006).

n60 5 J. Wigmore, Evidence § 1367, p. 32 (J. Chadbourn rev. 1974).

Where discovery has been allowed in ERISA cases, the results have been enlightening. For example, in *Bedrick v. Travelers Insur. Co.,* n61 depositions of the insurer's consultants taken by the plaintiff in a claim challenging a health insurer's denial of physical, speech and occupational therapy to a child suffering from cerebral palsy showed bias and a lack of adequate expertise. *Miller v. United Welfare Funa* n62 also relied on deposition testimony of a disability benefit plan administrator to find that none of the decision-makers involved in denying a claimant's request for benefits understood the medical information in the claimant's file, thus leading to a conclusion that the benefit determination was arbitrary and capricious. Thus, as *Nagele v. Electronic Data Sys. Corp.* n63 observed:

> as the arbitrary and capricious standard requires courts to scrutinize, although deferentially, decisions by plan fiduciaries for lack of reasonableness, including the absence of substantial evidence, such deficiencies in the administrative review function can be significantly illuminated through the reasonable exercise of standard discovery devices available in federal civil practice. n64

n61 93 F.3d 149 (4th Cir. 1996).

n62 72 F.3d 1066, 1072 (2d Cir. 1995).

n63 193 F.R.D. 94 (W.D.N.Y. 2000).

n64 193 F.R.D. at 104.

Therefore, because the arbitrary and capricious standard of review is made more meaningful, rather than diminished, by allowing discovery, the disallowance of discovery appears unfounded.

The Misapplication of Administrative Law

It is hard to understand how the courts have created their unique adjudicative procedures for ERISA claims. The only possible answer is that rather than applying the framework established by the Federal Rules of Civil Procedure for the adjudication of civil actions, the courts have transformed the ERISA law into a quasi-administrative law devoid of the protections that comprise a fair administrative hearing. n65 Instead of recognizing insurers' conflicts, courts have analogized insurance companies' claim processes to the equivalent of a judge presiding over a trial. However, that model has been rejected. *Gaither v. Aetna Life Ins. Co.* n66 relied on an earlier ruling, *Gilbertson v. Allied Signal, Inc.*, n67 in rejecting a judicial model of claim administration in a disability benefit case governed by the ERISA law:

> Aetna's position seems to be that as a plan fiduciary, it plays a role like that of a judge in a purely adversarial proceeding, where the parties bear almost all of the responsibility for compiling the record, and the judge bears little or no responsibility to seek clarification when the evidence suggests the possibility of a legitimate claim. The authority just cited suggests that Aetna has the wrong model. Indeed, one purpose of ERISA was "to provide a nonadversarial method of claims settlement" (citation omitted). In *Gilbertson v. Allied Signal, Inc.*, we explained what this nonadversarial process should look like:
>
> > [ERISA and its implementing regulations require] a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied . . . the reason for the denial must be stated in reasonably clear language, . . . [and] if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.
>
> 328 F.3d 625, 635 (10th Cir. 2003) (emphasis added) (citation omitted).
>
> While a fiduciary has a duty to protect the plan's assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own. An ERISA fiduciary presented with a claim that a little more evidence may prove valid should seek to get to the truth of the matter. n68

n65 *See, generally,* DeBofsky, "The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims," 37 *John Marshall Law Review* 727 (2004).

n66 394 F.3d 792 (10th Cir. 2004).

n67 328 F.3d 625 (10th Cir. 2003).

n68 394 F.3d at 807-808 (10th Cir. 2004).

Indeed, the reason *Gaither* rejected the analogy between ERISA plan administrators and federal judges is that a self-interested insurer lacks the judiciary's independence. Surely, any judge asked to decide a dispute where the judge's

personal physician was a crucial witness would recuse. n69 Paradoxically, however, many courts find no impropriety in insurers' reliance on their employee-physicians' opinions rather than independent reviews or examinations.

n69 According to 28 U.S.C. § 455(a), "[a]ny justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." The goal of 28 U.S.C. § 455(a) is to "avoid even the appearance of partiality." *Liljeberg v. Health Servs. Acquisition Corp.*, 486 U.S. 847, 860 (1988).

Nor are disability benefit claims adjudicated under the ERISA law comparable, as some courts apparently believe, to Social Security benefit disputes. Unlike the "Social Security Administration [which] is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge," n70 insurers are private entities who are under no statutory duties to conduct hearings before neutral decision-makers. Hence, in comparing claim decisions made by insurers in disability benefit cases to Social Security benefit determinations, the courts need to question why they have given private insurers more authority and why there is less penetrating review of insurers' claim determinations than an administrative agency receives.

n70 *Herzberger v. Standard Insur. Co.*, 205 F.3d 327, 332 (7th Cir. 2000).

Further, without giving the plaintiff the opportunity to cross-examine the insurer's consultants, the Court of Appeals' conclusion in *Semien* n71 that the reviewing doctors' opinions "demonstrate a thorough consideration of the available information" n72 has no evidentiary support. Acceptance of the consultants' reports as substantial evidence without the plaintiff being given the opportunity to cross-examine the witnesses would even run afoul of administrative procedures. Based on the U.S. Supreme Court's seminal ruling on due process in *administrative law* claims, *Richardson v. Perales*, n73 a case involving Social Security disability benefits, non-examining consultants' reports are insufficient. In *Perales*, the court ruled an *examining* physician's report may constitute substantial evidence in an administrative proceeding only when nine separately enumerated assurances of trustworthiness were met. n74 None of those protections, which include the tribunal's acceptance of reports only if prepared by percipient witnesses who had personally conducted a clinical, scientifically valid medical examination, and only when the claimant retained the opportunity to cross-examine the authors of the reports, are present in ERISA cases. Nor are pre-suit appeals in ERISA claims, which are decided by the insurance company that has already denied benefits, adjudicated by a body possessing the same neutrality and objectivity as an administrative agency, or even by an arbitrator. n75

n71 *Supra*, note 59.

n72 43 6 F.3d at 812.

n73 402 U.S. 389 (1971).

n74 402 U.S. at 402-406.

n75 *See*, H. Friendly, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1279-95 (1975) in which the author identified the necessary characteristics of a fair administrative hearing: 1) an unbiased tribunal; 2) notice of the proposed action and the grounds asserted for it; 3) an opportunity to present reasons why the proposed action should not be taken; 4) the right to call witnesses, including the right to cross-examine adverse witnesses; 5) the right to know the evidence at issue; 6) the right to have a decision based on the evidentiary record; 7) the right to counsel; 8) a record; 9) articulated reasons for the decision; 10) public attendance; and 11) judicial review. Most of these factors are completely absent from ERISA claims.

Accordingly, ERISA benefit adjudications performed by insurance companies are fundamentally different from Social Security disability claims because "the agency operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary." n76 Despite such marked differences, as one federal appellate judge pointed out in a dissenting opinion, claimants in ERISA benefit disputes are "effectively precluded as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in

the entire field of administrative or quasiadministrative law." n77 Consequently, some courts have begun to recognize that the inaptness of drawing an analogy between Social Security claims and disability insurance cases and have cautioned against importing "administrative agency concepts into the review of ERISA fiduciary decisions." n78

n76 *Perales,* 402 U.S. at 403.

n77 *Perlman v. Swiss Bank Corp.,* 195 F.3d 975, 983 (7th Cir. 1999) (Wood, J., dissenting).

n78 *Brown v. Blue Cross & Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1564 n. 7 (quoting *Van Boxel*) (11th Cir. 1990).

The U.S. Supreme Court has also weighed in on evidentiary considerations in ERISA claims. In *Black & Decker Disability Plan v. Nord,* n79 the court ruled that while an ERISA plan administrator need not give special deference to the opinions of treating doctors in disability benefit disputes, plan administrators must still base their findings on "reliable evidence." n80 However, that begs the question of what constitutes reliable evidence. Courts have been crediting the opinions of non-examining medical consultants without giving claimants the opportunity to cross-examine those consultants for evidence relating to potential bias, insufficient expertise or disregard of relevant evidence. Therefore, in order to assess whether the plan administrator's evidence is "reliable," as *Nord* requires, claimants must have the opportunity to conduct appropriate discovery and be accorded a plenary hearing.

n79 538 U.S. 822 (2003).

n80 538 U.S. at 834.

In all other federal civil litigation, the Federal Rules of Civil Procedure and Federal Rules of Evidence guard against inadmissible evidence. On summary judgment proceedings, Rule 56 of the Federal Rules of Civil Procedure and Federal Rule of Evidence 802 prohibit consideration of hearsay evidence; and Federal Rule of Evidence 702 precludes consideration of expert opinions unless the scientific reliability of such opinions has been established as a threshold matter. Absent admissible evidence, it is inappropriate for courts to avoid trials and to enter a summary judgment. n81 Lacking any evidentiary proceeding, courts have no means of assessing whether the evidence on which the plan denial was based is admissible or even "reliable."

n81 Fed.R.Civ.P. 56(e).

In a context comparable to ERISA claims, in *Gehin v. Wisconsin Group Insurance Bd.,* n82 the Wisconsin Supreme Court held that hearsay medical reports may not sustain a denial of disability benefits -- even in an administrative agency setting -- because:

> The harm to claimants in having their income continuation insurance benefits terminated on the basis of controverted written hearsay medical reports, without an opportunity to cross-examine the authors of those reports exceeds the burden on the Group Insurance Board to call a witness to corroborate those hearsay medical reports. n83

n82 278 Wis.2d 111, 692 N.W.2d 572 (Wis. 2005).

n83 692 N.W. at at 590.

Gehin relied heavily on *Richardson v. Perales* in finding administrative hearings that denied the claimant the right to cross-examine the authors of adverse medical reports lacked sufficient due process guarantees. The court also cited a Mississippi Supreme Court ruling that held:

> It is quite likely that the bench and bar would be scandalized if this Court should approve the receiving in evidence of ex parte, unsworn statements of persons other than doctors, even in Workmen's Compensation cases.
>
> While doctors occupy an important role in our scheme of things, they are, after all, merely human, and may not be considered wholly free from the frailties that beset the rest of us. There is nothing, therefore, in the fact that a witness may be a member of the medical profession that reasonably may be said to justify his exemption from the requirements and restriction which would apply to others giving testimony in an adversary proceeding. The admission of the reports constitutes reversible error. n84

n84 692 N.W.2d at 589 (citing *Georgia-Pacific Corp. v. McLaurin*, 370 So.2d 1359, 1362 (Miss. 1979)).

Gehin teaches an important lesson that has yet to be learned in ERISA disputes.

Potential Solutions

Given the huge economic disparity between consumers and insurers, the law of insurance bad faith developed to force insurers to apply fair and reasonable claims practices or face lawsuits seeking punitive damages. Similar standards ostensibly exist under the ERISA law that place an obligation on insurers and other plan administrators to act exclusively in the interest of plan participants and their beneficiaries for the purpose of paying benefits. n85 However, that provision was substantially weakened by a U.S. Court of Appeals ruling that found the ERISA law imposes no obligation for the fiduciary to place its "thumb on the scale in the participant's favor." n86 Although that finding might have been appropriate in the *Wallace* case because even the claimant's treating physician refused to certify ongoing disability, without a mechanism to enforce ERISA's fiduciary obligations, as the multi-state and California regulators learned, the tendency is to deny claims that would likely have been payable had appropriate claim practices been applied. Nor is this a new phenomenon. Several years ago, a federal district judge in California observed in a disability benefit case:

> [T]he facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. UNUM's unscrupulous conduct in this action may be closer to the norm of insurance company practice than the Court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.
>
> Consequently, ERISA may need to provide a greater deterrent to bad faith conduct in the administration of ERISA plans. The Court continues to believe that providing for punitive, "bad faith," or compensatory damages beyond the amount of the claimed damages would adversely disturb the balance struck by ERISA. However, for the first time, it believes that at least in the case of insurance-funded and administered plans the public interest would be advanced if ERISA contained a statutory penalty which could be imposed by the Court in extraordinary cases. n87

n85 29 U.S.C. § 1104(a)(1) (2005).

n86 *Wallace v. Reliance Standard Life Insur. Co.*, 318 F.3d 723, 724 (7th Cir. 2003).

n87 *Dishman v. Umum Life Insur.Co. of America*, 1997 WL 906147 *11 (CD. Cal. 5/9/1997).

To be sure, no one is suggesting that insurers should pay non-meritorious claims. However, it is apparent that insurance companies have not been meeting their responsibility to compensate deserving policyholders and the courts have inadequately policed the insurers' conduct.

Ultimately, the goal for both insurers and claimants is that meritorious claims receive compensation. The impact of the ERISA law on disability benefits has made that goal much harder for claimants to reach, however. It is evident that there needs to be a reassessment by the U.S. Congress, the courts and the U.S. Department of Labor (the agency that oversees the administration of the ERISA law) as to whether the law is meeting its purpose and what can be done to remedy the situation. Disability benefits are too important to entrust to resolution by private insurers whose findings receive greater deference than that accorded to government agencies and judges. Instead of creating incentives leading to claim denials, insurers must be motivated to give more careful and fairer consideration to disability benefit claims.

— Tab 4 —

25 No. 1 NAIC J. Ins. Reg. 15

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Research Article

*15 DISCRETIONARY CLAUSES AND INSURANCE

Mark D. DeBofsky, J.D. [FNa1]

Introduction

The ERISA [FN1] law was enacted by Congress in 1974 to

> Protect ... participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts. [FN2]

Despite those salutary goals, in Firestone Tire & Rubber Co. v. Bruch, [FN3] the Supreme Court gave carte blanche to ERISA plan administrators -- including health, life and disability insurers that insure employer-sponsored benefit programs -- to include clauses in their insurance policies giving themselves discretion to interpret policy terms and to decide questions of benefit eligibility. The inclusion of such clauses in policies governed by the ERISA statute creates a dramatic change in the relationship between insurer and insured, unique in the field of insurance law. [FN4] Unquestionably, such clauses significantly weaken employees' protections. Without

discretionary clauses, claims receive a plenary review. The equation changes completely with the presence of such clauses, though. As one federal court of appeals explained, "The very existence of "rights" under [employee benefit] plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has..." [FN5] In practical terms, the presence of discretionary clauses means that a benefit claimant needs to prove the insurer's decision was "unreasonable, and not merely incorrect." [FN6] Thus, as a leading ***16** scholar of the ERISA law recently pointed out, "Plan terms lowering the standard of review undermine the effectiveness of ERISA's requirement of fairness in internal proceedings, by making it so much harder to challenge unfairness." [FN7]

A shocking illustration of how discretionary clauses operate is the First Circuit's decision in Brigham v. Sun Life of Canada. [FN8] There, the court upheld an insurer's decision to deny disability benefits to a wheelchair-bound paraplegic, finding:

> The question we face in this appeal is "not which side we believe is right, but whether [the insurer] had substantial evidentiary grounds for a reasonable decision in its favor." ... Beyond this, it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. Moreover, it seems clear that Sun Life has taken a minimalist view of the record. But it is equally true that the hurdle plaintiff had to surmount, establishing his inability to perform any occupation for which he could be trained, was a high one. As to that issue, we have to agree with the district court that the undisputed facts of record do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits. [FN9]

In addition to the standard of review, the Firestone ruling has also infected the scope of how courts review benefit determinations. According to Perlman v. Swiss Bank Corp., [FN10] "Deferential review of an administrative decision means review on the administrative record." [FN11] Consequently, no depositions or other inquiry into how the claim process was undertaken is available because that would allow for consideration of evidence outside of the record. [FN12] The primary assumption underlying Perlman was that the claim application was given a "genuine evaluation." [FN13] However, there is reason to

believe that Perlman's suppositions that claims are decided objectively by insurers were markedly flawed.

***17** Reported decisions {FN14} involving UnumProvident subsidiaries (the same insurer involved in Perlman) have proven the existence of financial incentives given to claim analysts to deny claims. Investigative reports by "Dateline NBC" [FN15] and by "60 Minutes" [FN16] contained interviews with former UnumProvident personnel who described pressures to deny claims in order to meet financial projections. [FN17] Another insurer instituted a raffle with cash prize incentives awarded to claim representatives who terminated benefit claims in order to help the company meet anticipated reductions in payouts; although, to the insurer's credit, the raffle was immediately canceled when other company officials learned of it. [FN18] Yet another insurer contracted with a so-called independent review organization that appeared so biased that it could not identify a single instance of the organization recommending payment of a claim, thus leading the court to infer there were no such recommendations. [FN19] Another company repeatedly employed a lone doctor to review the bulk of its claims whom the court identified as a "man with a mission -- to find a way to justify a denial of benefits." [FN20] These exposés of patent fraud obviously do not appear in any claim record and can only be obtained through discovery aimed at uncovering evidence of corruption in the claim review process.

The economic argument against potential bias raised by Perlman suggesting that insurers are so large they will not be influenced by cost savings from individual benefit claims is also belied by an observation made years ago. It is a striking irony that the court that issued the Perlman ruling sits in a building named for a former U.S. senator from Illinois, Everett McKinley Dirksen, whose best known aphorism was a comment he made during a budget debate: "A billion here, a billion there -- pretty soon it adds up to real money." [FN21] Sen. McKinley was right; there is real money at stake when the aggregate value of claims is considered.

***18** Conflict of Interest?

One has to wonder how the courts have allowed a paternalistic statute like the ERISA law to become so draconian in its treatment of benefit claimants, particularly because insurers operating under the ERISA law are subject to the statute's exclusive benefit rule of

fiduciary conduct. [FN22] The ERISA rule, which differs from most state court decisions holding that insurers do not owe a fiduciary duty to their insureds, [FN23] was derived from the Restatement (Second) of Trusts §170. The rule mandates that plan fiduciaries act exclusively in the interest of plan participants and their beneficiaries for the purpose of paying benefits. That assumption was the bedrock of the Supreme Court's Firestone ruling; however, the intermediate appellate court that decided Firestone had a more sanguine perspective on whether insurers could be trusted to act as fiduciaries. In Bruch v. Firestone Tire & Rubber Co., [FN24] a case involving a dispute over severance benefits, the Third Circuit traced the development of the arbitrary and capricious standard of review from the Labor Management Relations Act (LMRA) and wrote:

> In their oversight of a trust where the impartiality of the trustee had been carefully assured, the LMRA courts could easily adopt the principle of trust law applicable with respect to judicial review of an impartial trustee's execution of his duties. At least one court has done so in explicit reliance on §187 of the Restatement of Trusts. See Brune v. Morse, 475 F.2d 858, 860 n. 2 (8th Cir. 1973). Because the LMRA's precautions assure that the plan administrator will be neutral, it is easy to understand why the courts adopted this rule for judicial review of decisions made in the administration of an LMRA plan.
>
> In the unfunded pension plan at issue in Count I of the complaint in this case, however, there is no assurance of the trustee's impartiality. The plan is controlled entirely by the employer, not by a group evenly divided between employer and employees. Because the plan is unfunded, every dollar provided in benefits is a dollar spent by defendant Firestone, the employer; and every dollar saved by the administrator on behalf of his employer is a dollar in Firestone's pocket. As we have already seen, the principle articulated in §187 does not govern judicial review of such a trustee's decisions.

***19** Two rationales are most frequently advanced to justify deference even in this context to fiduciaries' decisions. The first is that they have more expertise than judges in the management of pension plans; the implication is that the fiduciary whose decision is deferred to is more likely than the judge to have answered correctly the question about the meaning of the plan's term. See

> Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985) (preferring the decision of plan administrators, "whose experience is daily and continual, [over that of] judges whose exposure is episodic and occasional;" see also Ponce v. Construction Laborers Pension Trust, 628 F.2d 537, 542 (9th Cir. 1980) ("trustees are knowledgeable of the details of a trust fund (both its purpose and its operation), and thus they are in a position to make prudent judgments concerning participant eligibility").
>
> We reject this rationale for two reasons. First, in the context of claims for benefits, the questions the courts must address do not usually turn on information or experience that expertise as a claims administrator is likely to produce. As in this case, the validity of the claim is likely to turn on a question of law or of contract interpretation. Courts have no reason to defer to private parties to obtain answers to these kinds of questions. Second, as we have explained, there is a significant danger that the plan administrator will not be impartial. The lack of impartiality offsets any remaining benefit that the administrators' expertise might be thought to produce.
>
> It has also been argued that deferring to the administrator's decision will make proceedings faster. We acknowledge that. But because the speed is attained by sacrificing the impartiality of the decision-maker, we think that it comes at too great a cost.

The U.S. Court of Appeals for the Seventh Circuit expressed similar thoughts in Van Boxel v. The Journal Co. Employees' Pension Trust, [FN25] where the court wrote:

> [Employee benefit] rights are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of "arbitrary and capricious" review, relying on the company's interest in its reputation to prevent it from acting on its bias. Nor is it clear that the contractual perspective is the correct one in which to view claims under ERISA. A Congress committed to the ***20** principles of freedom of contract would not have enacted a statute that interferes with pension arrangements voluntarily agreed on by employers and employees. ERISA is paternalistic; and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.

However, those sagacious warnings were ignored by the Supreme Court when it issued Firestone in 1989. The Supreme Court's only concession to the potential for mischief by a conflicted plan administrator was the following comment:

> Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion." [FN26]

Yet, in the nearly 20 years since the issuance of Firestone, there has been no coherent explanation of how a court is to weigh the conflict. The Ninth Circuit recently ruled in Abatie v. Alta Health & Life Insur. Co., [FN27] that the insurer's conflict of interest must always be weighed, with the conflict being given little regard without "evidence of malice, self-dealing, or "a parsimonious claims-granting history," [FN28] while the conflict is weighed more heavily in the face of inadequate investigation, or if the insurer "has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." [FN29] However, the Seventh Circuit has chosen to altogether disregard the issue of the insurer's conflict. In Rud v. Liberty Life Assur. Co., [FN30] a disability benefit claim adjudicated under the arbitrary and capricious standard of review, the court rejected an argument that Liberty, which functioned as both the plan administrator and payor of benefits, acted under a conflict. The court explained:

> The ubiquity of such a situation makes us hesitate to describe it as a conflict of interest. There is no contract the parties to which do not have a conflict of interest in the same severely attenuated sense, because each party wants to get as much out of the contract as possible. How serious the conflict is depends on circumstances. See, e.g., Leahy v. Raytheon Co., 315 F.3d 11, 15-16 (1st Cir. 2002). If Liberty Life refuses to honor meritorious claims, it will obtain windfall profits in the short run, assuming that the premium that Andersen paid it was ***21** calculated on the expectation of a normal claims experience. But Andersen will be dismayed -- it has no interest in conferring such profits on Liberty Life, thereby incurring its employees' ill will with no offsetting financial benefit to itself -- and so may refuse to renew the policy when it expires, or demand a much lower premium.

> The latter option suggests a theoretical basis for suspecting a long-run conflict of interest: the chintzier the insurance company is in responding to benefits claims, the lower (given a competitive insurance market) the premium that Andersen will have to pay, whether to Liberty Life or to a competitor of Liberty Life, to obtain insurance. [FN31]

Acknowledging that every other court outside of the Seventh Circuit has been troubled by the inherent financial conflict of interest "whenever an insurer is being asked to dip into its own pocket to pay a claim for benefits," [FN32] the court rejected the potential conflict by reasoning "that given reasonably well-informed employees, an employer cannot reap a long-run benefit from reducing welfare benefits, whether directly or by delegating administration to a hard-nosed insurance company." [FN33] The court acknowledged, though, that its analysis has been challenged by other courts. For example, Pinto v. Reliance Standard Life Insur. Co., [FN34] explained:

> While in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow. Employees typically do not have access to information about claim-denying by insurance companies, and the relationship between employees and insurance companies is quite attenuated; so long as obviously meritorious claims are well-handled, it is unlikely that an insurance company's business will suffer because of its client's employees' dissatisfaction. [FN35]

While the Seventh Circuit conceded "there is doubtless some truth in these critiques," it then noted "their acceptance would destabilize large reaches of contract law, of which ERISA is, after all, a part, since it neither requires employers to establish welfare and pension plans nor prescribes the terms of ***22** such plans." [FN36] Further, despite the paternalistic nature of the ERISA statute, the court pointed out, "it is hard to see why, if the plan unequivocally authorizes the insurance company to make the conclusive determination of eligibility, the courts should rewrite the provision." [FN37] The court also criticized other courts that have raised conflict of interest as a factor diminishing discretion because those courts have abrogated freedom of contract and because such "'conflict of interest' is found in every contract." [FN38]

The Seventh Circuit's reliance on freedom of contract is significantly at odds with the Supreme Court's adoption in Firestone of a trust law paradigm to govern ERISA law, rather than a contract law approach. Nor does the ubiquity of insured employee benefit plans diminish the threat of a conflict; on the contrary, the threat is heightened because insurers' fiduciary obligation to their shareholders is in considerable tension with the fiduciary duties owed to their insureds. Yale Law School professor John Langbein also challenges the Seventh Circuit's viewpoint: "Precisely because ERISA subjects every employee benefit plan to ERISA's duties of loyalty, prudent administration, and 'full and fair' internal review of benefit denials, we know that Congress subordinated Judge [Richard] Posner's concern about not making further 'inroads into freedom of contract' in favor of the protective values enshrined in ERISA fiduciary law." [FN39] Hence, the fact that insurers do, indeed, profit from claim denials should be enough to establish a conflict of interest sufficient to trigger a de novo contract interpretation rather than for a court to defer to the insurer's findings.

Consequently, contrary to both the protective language of the ERISA statute and a clearly expressed Congressional intent that the law benefit plan participants and secure claimants' rights and remedies (29 U.S.C. §1001(b)), the courts have created a situation aptly characterized by University of Chicago economist Steven D. Levitt as "freakonomics." Levitt and his co-author Stephen J. Dubner, in their book Freakonomics, [FN40] focus on how economic incentives often lead to perverse unintended results, some beneficial, but many of which are harmful. Clearly, when insurers know that their decisions are almost completely insulated from meaningful judicial review, the opportunity for self-dealing is present. Courts need to question whether any rational policy justification can be offered for giving discretionary authority to insurers whose profit motive is in conflict with its contractual obligation to pay claims. One suggestion is that the current regime enables employers to purchase less expensive benefits because insurers will not have to face jury trials and costly litigation proceedings. However, the Supreme Court explicitly rejected that argument in Firestone with its observation that "the threat of increased litigation *23 is not sufficient to outweigh the reasons for a de novo standard..." [FN41] Further, to offer an analogy, if a consumer had a choice of flying to a destination on two airlines, one with a 95% safe arrival record and the other with a near-perfect safety record, even if the safer airline were substantially more expensive, most consumers would opt

for the safer travel option. Employee benefits are no different. Because welfare benefits are most needed in times of serious illness, disability or even unanticipated death, a modest increase in cost is a small price to pay for a benefit plan that goes the extra step to ensure a fair and complete claim appraisal. Employee benefits are too important, because, in the case of health benefit claims, they often have life and death consequences, to entrust payment decisions to insurers that can decide in their discretion when payments are due. Our court system would not trust insurers in any other context to make decisions reviewable only for arbitrariness; likewise, no legitimate rationale supports giving such authority to insurers in the ERISA context.

The Solution

California has pointed the way to a solution by banning discretionary clauses altogether, [FN42] as has the NAIC, which recently promulgated a model law prohibiting the inclusion of discretionary clauses in health and disability insurance policies. [FN43] On the federal level, although several bills have been introduced in Congress to prevent discretionary clauses from transforming the standard of court review to a deferential standard, none have been enacted. One piece of proposed legislation was introduced by former senator and Republican presidential nominee Robert Dole (R-KS) who sought to amend the ERISA law to provide that in any civil action seeking benefits, "if the action involves a matter previously decided by a named fiduciary who has a significant interest which would be adversely affected by a decision in favor of the participant or beneficiary, the court shall review the decision of the fiduciary without according any deference to any findings or conclusions of such fiduciary." [FN44] In Illinois, the Department of Financial Responsibility, Division of Insurance, recently issued an amendment to the Illinois Administrative Code that tracks the NAIC model law in prohibiting discretionary clauses. [FN45] New York intends to ban discretionary clauses. [FN46] Other states are expected to follow. Although some ***24** insurers have suggested they might evade state regulation by inserting the discretionary clause in another plan document, the Supreme Court appears to have anticipated and rejected such a move in Unum Life Insur. Co. v. Ward, [FN47] which states:

> Under UNUM's interpretation of §1104(a)(1)(D), however, States would be powerless to alter the terms of the insurance relationship

in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually "read the saving clause out of ERISA."

Thus, the ERISA savings clause, [FN48] which prevents the ERISA law from overriding state regulation of insurance, appears to support the state efforts to ban discretionary clauses. [FN49]

The effect of abolishing discretionary clauses means that insurers' decisions will not be given deference by the courts, evidence will be weighed and discovery can be undertaken to investigate the propriety of a claim denial. For matters as important as employee benefits, the ability to present a claim before an unbiased legal tribunal without the court giving deference to one side or the other preserves the Congressional intent to protect employees in their benefit plans and helps guarantee that promises made are promises kept. A study performed by Milliman, Inc., commissioned by America's Health Insurance Plans, [FN50] analyzes the effect of a prohibition against discretionary clauses, and suggests the prohibition will lead to a 3% to 4% rise in group disability income insurance premiums due to an anticipated higher incidence of litigation, a higher cost per litigated claim and lower claim recovery rates. While cost increases are certainly not desired, the increases suggested by Milliman appear modest and seem a small price to pay for fairness in claim adjudication and the protection promised by the ERISA statute.

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FN1. Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. (2003)

FN2. 29 U.S.C. §1001(b)(2003).

FN3. 489 U.S. 101 (1989).

FN4. An effort to broaden discretionary clauses to include non-ERISA claims failed in Michigan. See Krochmal v. Paul Revere Life Insurance Company, 684 N.W.2d 375 (Ct. App. Mich. 2004); vacated 708 N.W.2d 112 (Mich. 2006).

FN5. Herzberger v. Standard Insur. Co., 205 F.2d 327, 331 (7th Cir. 2000).

FN6. 205 F.3d at 329.

FN7. Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA" at 44 (Draft June 26, 2006, available at www.law.yale.edu/faculty/2940.asp) (accepted for publication, Northwestern University Law Review).

FN8. 317 F.3d 72 (1st Cir. 2003).

FN9. 317 F.3d at 85.

FN10. 195 F.3d 975 (7th Cir. 1999).

FN11. 195 F.3d at 981-82.

FN12. 195 F.3d at 981. Perlman noted, though, that without discretionary clauses, "We have allowed parties to take discovery and present new evidence in ERISA cases subject to de novo judicial decisions, see Casey v. Uddeholm Corp., 32 F.3d 1094, 1098-99 & n.4 (7th Cir. 1994)." 195 F.3d at 981.

FN13. 195 F.3d at 982.

FN14. See, e.g., Hangarter v. Provident Life and Accident Insur. Co., 373 F.3d 998 (9th Cir. 2004), which upheld a multi-million dollar verdict assessing punitive damages based on bad faith claims conduct.

FN15. Broadcast of October 13, 2002.

FN16. Broadcast of November 17, 2002.

FN17. Also see McSharry v. UnumProvident Corp., 237 F.Supp.2d 875, 877 (E.D.Tenn. 2002); Bennett v. Unum Life Insur. Co., 321 F.Supp.2d 925, 934- 35 (E.D.Tenn. 2004) (finding that "internally generated memoranda from UnumProvident and Provident executives [appear] to support the plaintiff's claim that one of UnumProvident's corporate goals was to terminate as many ongoing claims and deny as many new claims as possible").

FN18. See Feibusch v. Integrated Device Technology, Inc. Employee Benefit Plan, 03-00265 (D.Hawaii). Plaintiff's Rule 60(b) Motion to Reopen the Case Based on Newly Discovered Evidence.

FN19. Denmark v. Liberty Life Assur.Co. of Boston, 2005 U.S.Dist.LEXIS 27180 (D.Mass. 2005).

FN20. Gunn v. Reliance Standard Life Insur. Co., 399 F. Supp. 2d 1095 (C.D.Cal. 2005).

FN21. Robert Byrne, 1,911 Best Things Anybody Ever Said (1988) (Quoting Sen. Everett Dirksen).

FN22. 29 U.S.C. §1104(a)(1).

FN23. See, e.g., Robacki v. Allstate Insurance Co., 127 Ill. App. 3d 294, 296-97, 468 N.E.2d 1251 (Ill.App. 1984).

FN24. 828 F.2d 134, 143-44 (3d Cir. 1987), rev'd in part Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).
FN25. 836 F.2d 1048, 1052 (7th Cir. 1987).

FN26. 489 U.S. at 115 (citing Restatement (Second) of Trusts §187, Comment d (1959)).

FN27. F.3d, 2006 U.S.App.LEXIS 20829 (9th Cir. 8/15/06).

FN28. 2006 U.S.App.LEXIS 20829 at *29-*30.

FN29. 2006 U.S.App.LEXIS 20829 at *30.

FN30. 438 F.3d 772 (7th Cir. 2006).

FN31. 438 F.3d at 775.

FN32. Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 387-89 (3d Cir. 2000); Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997); Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1561-62 (11th Cir. 1990).

FN33. 438 F.3d at 776.

FN34. Supra. n.20.

FN35. 438 F.3d at 776 (citing Pinto v. Reliance Standard Life Ins. Co., supra, 214 F.3d at 388).

FN36. 438 F.3d at 776.

FN37. 438 F.3d at 776.

FN38. 438 F.3d at 777.

FN39. Langbein, supra. at 27.

FN40. Steven D. Levitt and Stephen J. Dubner, Freakonomics: A Rogue Economist Explores the Hidden Side of Everything (William Morrow, 2005).

FN41. 489 U.S. at 115.

FN42. Gary M. Cohen, Letter to Insurers re: Disability Income Insurance Policy Language, California Department of Insurance, October 3, 2005. California's prohibition has survived its first court challenge: Hartford Life Insur.Co. v. State of California, No. CPF 05-505218 (Super.Ct.Cal. San Francisco, June 8, 2006).

FN43. Prohibition on the Use of Discretionary Clauses Model Act (#42), passed at plenary session, National Association of Insurance Commissioners, December 2004.

FN44. S. Bill 3267, 101st Cong., 2d Sess. (1990).

FN45. 29 Ill.Reg. 10172, amending the 50 Illinois Administrative Code to add §§2001.1 and 2001.3, and amending 2001.10 (July 15, 2005).

FN46. New York State Insurance Department, Circular Letter No. 8 (March 27, 2006). This has been replaced with Circular Letter No. 14 (June 29, 2006), advising that final regulations prohibiting discretionary clauses are forthcoming. Accessed at www.ins.state.ny.us/cl06_14.htm.

FN47. 526 U.S. 358, 375 (1999).

FN48. 29 U.S.C. §1144(b)(2)(A).

FN49. See Hartford Life v. State of California, supra. n.40 (upholding the applicability of the ERISA savings clause).

FN50. R. Beal and D. Skwire, "Impact of Disability Insurance Policy

Mandates Proposed by the California Department of Insurance," Milliman, Inc., November 14, 2005.

END OF DOCUMENT

— Tab 5 —

Why Discretionary Clauses Must Be Prohibited

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Historical Background

The ERISA[1] law was enacted in 1974 by Congress to

> protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts.[2]

Despite that lofty goal, discretionary clauses in insurance policies present the most formidable obstacles faced by claimants seeking benefits due under employee benefit plans funded by insurance.

Historically, courts have questioned the wisdom of allowing discretionary clauses, which have the legal effect of triggering an arbitrary and capricious standard of judicial review when such claims reach the court. For example, Judge Richard Posner, an influential jurist and legal scholar, wrote in *Van Boxel v. The Journal Company Employees' Pension Trust,*[3] "[benefits] are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of 'arbitrary and capricious' review, relying on the company's interest in its reputation to prevent it from acting on its bias."

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[1] Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* (2003)
[2] 29 U.S.C. §1001(b)(2003).
[3] 836 F.2d 1048 (7th Cir. 1987)

Yet another reason for not granting discretion to insurers administering benefit plans was given in *Luby v. Teamsters Health, Welfare and Pension Trust Funds*,[4] where the court explained:

> Plan administrators are not government agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their responsible position, often without any expertise in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding.[5]

Despite those warnings, when the issue reached the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*,[6] the Court gave *carte blanche* to insurers to include discretionary clauses in their insurance policies, apparently without any consideration of the resulting consequences. Recognizing the effect of the Supreme Court's ruling, Judge Posner, in *Herzberger v. Standard Insur.Co.*[7] wrote, "The very existence of "rights" under [employee benefit] plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has..."[8]

Judge Posner was right, because the practical effect of allowing discretionary clauses in insurance policies is contrary to every principle of insurance law and civil procedure developed over the past 100 years.

The Practical Effect of Discretionary Clauses

As noted above, the effect of discretionary clauses has been to transform the

[4] 944 F.2d 1176 (3d Cir. 1991).
[5] 944 F.2d at 1183
[6] 489 U.S. 101 (1989)
[7] 205 F.3d 327 (7th Cir. 2000)
[8] 205 F.3d at 331.

judicial paradigm of decisionmaking. It is not enough for a claimant to show an insurer's decision was wrong or contrary to the terms of the insurance contract. Instead, the claimant must prove the decision is "unreasonable, and not merely incorrect."[9] Illustrations of how this works can be found in representative recent court decisions. For example, in *Glista v. Unum Life Insur.Co. of America,*[10] a federal court upheld an insurer's denial of benefits claimed by an individual suffering from a fatal neurological disorder based on an application of a pre-existing condition exclusion. Although the insurer's claim manual mandated a policy interpretation favoring the claimant, the insurer argued it was within its discretion to interpret its policy differently and in a manner that excluded coverage. Agreeing with that argument, the court held, "In sum, by creating a training or a reference manual, Unum did not relinquish its discretion to interpret the terms of its own insurance policy."[11] *Graham v. L&B Realty Advisors, Inc.,*[12] is another recent decision finding that despite "clear evidence to the contrary" of the insurer's determination, the court's hands were tied by the arbitrary and capricious standard of review. The court concluded:

> The Court is concerned by this result. If the Court were finding the facts based on the administrative record, it would find Graham is disabled. Likewise, if the Court could decide the standard of review to use when a carrier's decision is based on the opinions of a captive professional, the Court might extend less deference to such decisions. However, under the statutory framework of ERISA as applied in this Circuit, the Court must hold that substantial evidence supports UNUM's decision. Accordingly, UNUM's motion for summary judgment is granted.

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[9] 205 F.3d at 329
[10] 2003 U.S.Dist.LEXIS 17457 (D.Mass. 9/30/03)
[11] 2003 U.S.Dist.LEXIS 17457 *23 - *24.
[12] 2003 U.S.Dist.LEXIS 17272 (N.D.Tex. 9/30/03)

Perhaps the most shocking case, though, is *Brigham v. Sun Life of Canada*.[13] In that ruling, an insurer's decision to deny disability benefits to a paraplegic was upheld with the court making the following pronouncement:

> The question we face in this appeal is "not which side we believe is right, but whether [the insurer] had substantial evidentiary grounds for a reasonable decision in its favor." ... Beyond this, it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. Moreover, it seems clear that Sun Life has taken a minimalist view of the record. But it is equally true that the hurdle plaintiff had to surmount, establishing his inability to perform any occupation for which he could be trained, was a high one. As to that issue, we have to agree with the district court that the undisputed facts of record do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits."

These cases illustrate the almost impossible burden faced by claimants left at the mercy of insurers who are able to utilize discretionary clauses as a shield against payment of meritorious claims. Particularly due to the Supreme Court's rejection, in *Black & Decker Disability Plan v. Nord*,[14] of a rule giving deference in disability claim adjudications to opinions from treating doctors, insurers are empowered to utilize in-house doctors, rather than independent medical examinations, as a means of denying claims,[15]a strategy that the *Graham* ruling shows is sufficient to survive judicial review.

Discretionary clauses also trigger other adverse harms to claimants. For example, in *Perlman v. Swiss Bank Corp.*,[16] the court ruled, "Deferential review of an administrative decision means review on the administrative record." [17] Thus, claimants

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[13] 317 F.3d 72 (1st Cir. 1/28/03)
[14] 123 S.Ct. 1965; 155 L. Ed. 2d 1034 (2003)
[15] A physician formerly employed by the UnumProvident Corporation characterized his company's use of physicians in this manner as a "means to an end...The end was denial." Deposition of Patrick Fergal McSharry, *Chapman v. Unum* (Cal., Marin.Cty. Super.Ct.), September 4-6, 2002 at 163-169; reported on *Dateline NBC* October 13, 2002.
[16] 195 F.3d 975 (7th Cir. 1999)
[17] 195 F.3d at 981-82.

are barred from introducing any new evidence in court proceedings. The court reviews only the claim record created by the insurer, even if relevant and material evidence could not have been secured earlier.

Finally, discretionary clauses overturn a well-accepted principle of insurance law known as *contra proferentem,* which requires courts, when faced with differing policy interpretations, to adopt the interpretation favoring coverage in order to protect consumers against ambiguities. Although some courts find the principle applicable in ERISA cases, other courts, such as *Kimber v. Thiokol Corp.,*[18] have found *contra proferentem* inconsistent with a grant of discretion to interpret policy language. The *Glista* ruling also illustrates this abrogation of *contra proferentem* in a manner that allowed an insurer to defeat a benefit claim, despite the court's concession that a different reading of the policy was plausible.

Accordingly, discretionary clauses have tremendous legal significance unavailable in any other insurance context. Such clauses are the vehicle by which ERISA is transformed from an employee's sword into a near impenetrable shield. That, plus the fact that the ERISA law precludes the recovery of damages, discourages deserving claimants from pursuing meritorious claims. State Insurance Commissioners have the authority to prohibit discretionary clauses since the ERISA law has been found to exempt state insurance regulation from federal preemption. Without discretionary clauses, claimants can receive judicial review of their cases that gives equal consideration to the evidence presented by both sides. Therefore, as a matter of consumer protection and simple justice, discretionary clauses must be prohibited.

[18] 196 F.3d 1092 (10th Cir. 1999)

— Tab 6 —

Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan, 2005 U.S.App.LEXIS 11057 (9th Cir. 6/13/2005). A former football player for the Minnesota Vikings, Brent Boyd, sought disability benefits under a plan maintained by the National Football League. His claim was denied by the plan based on a finding that Boyd's disability did not result from football-related injuries; and the district court upheld that determination. On appellate review, the Ninth Circuit affirmed.

Boyd initially claimed benefits under the plan in 1997 due to a knee injury; however, that claim was denied and Boyd failed to appeal. Then, in 2000, Boyd reapplied, alleging an organic brain disorder resulting from head trauma sustained in football-related activities. Boyd cited an incident where he was knocked unconscious during a preseason game; and he later developed persistent headaches, which team doctors told him were a side effect of Indocin, a prescription medication that had been prescribed to treat pain and inflammation of Boyd's knees. After the headaches began, Boyd began using alcohol on a "habitual basis," and he also began experiencing fatigue, forgetfulness, intermittent blurred vision, difficulty reading, concentrating, and learning, ass well as flu-like symptoms.

The Bert Bell plan is governed by the ERISA law, and the Retirement Board, which manages the plan, is vested with discretion to interpret the plan provisions and adjudicate claims for benefits. The plan offers two types of benefits – a minimum $4,000 per month benefit if disability arises out of football injuries and results in total and permanent disability prior to the player reaching the age of 45 or within 12 years after the player's last credited season. A second benefit of at least $1,500 is paid if total and permanent disability is unconnected with football activities or if it arises from football activities and occurs after the age of 45 or more than 12 years after the player's last credited season. The plan also provides for benefits if a player is permanently disabled during their active career, but that benefit was not at issue. Also, a 1998 amendment to the plan relates to psychological or psychiatric disorders caused by a head injury or the use of a prescribed substance used to treat a football injury.

Although the Retirement Board determined that Boyd was totally and permanently disabled and entitled to $1,550 per month, it deferred consideration of the larger football-related benefit. Several medical reports were reviewed. The first was a report written by plan neutral physician J. Sterling Ford, M.D., a neurologist, who concluded that Boyd appeared to have problems that may be due to head injuries which he suffered during his playing days; and Dr. Ford suggested that further testing was necessary to determine the extent of the injuries. A subsequent SPECT scan showed decreased brain activity which was interpreted as consistent with head trauma.

Subsequently, the Board referred Boyd to a psychologist who found him disabled as the result of depression due to post traumatic organic brain disorder. However, the plan sought additional evidence, and referred Boyd for two days of neuropsychological testing at Johns Hopkins Hospital. The examining psychologist determined that the 1980 head injury could not have been responsible for all or a major part of the neurologic and neuropsychological problems Boyd was experiencing. That doctor opined that Boyd's problems were attributable to depression and/or chronic pain as well as untreated hypertension and physical deconditioning. After receiving the neuropsychological report, benefits were denied.

In applying the arbitrary and capricious standard of review, the court concluded that the single report from Johns Hopkins was sufficient to sustain the determination. To overturn the Retirement Board, the court would have to conclude "that the entire record leads to a 'definite and firm conviction that a mistake has been committed' by the Board in concluding that Boyd's disability did not arise from his football career." *15. The court further explained:

> Boyd's claim is not saved by relying on what he characterizes as the medical experts who expressed the opinion that Boyd's disability does arise from his League football activities. An ERISA administrator's exercise of its discretion to adjudicate claims is not a mere exercise in expert poll-taking. We hold that a mere tally of experts is insufficient to demonstrate that an ERISA fiduciary has abused its discretion, for even a single persuasive medical opinion may constitute substantial evidence upon which a plan administrator may rely in adjudicating a claim. *15-*16.

The court added that those experts Boyd cited to in support of his claim furnished equivocal findings as to causation; thus, the Board could justifiably rely on the neuropsychological testing results. A concurring opinion added that the fact that the head injury was not contemporaneously diagnosed gave further support to a conclusion that it was not unreasonable to conclude that Boyd's disability was not the result of a football-related occurrence, however, the concurring judge felt the language in the majority opinion about the "exercise in expert poll-taking" went too far.

This ruling may have reached the right result if careful scrutiny of the opinion from the Johns Hopkins neuropsychologist was well-supported by research and test data, but the outcome of this case was reached for the wrong reasons; and there is language in the opinion that should concern plaintiffs' counsel. *Boyd* changes the standard of court review of ERISA benefit decisions to the "clearly erroneous" standard, which may lead to unfortunate consequences since it is so difficult to meet that standard. This ruling also conveys a sense of abdication of judicial responsibility. It is understandable that courts are reluctant to involve themselves in benefit decisions where complex medical questions about which judges lack expertise are at issue; however, from a philosophical standpoint, given the importance of employee benefits, the more significant issue is whether a deserving claimant has been wrongfully denied benefits. The entire history of American jurisprudence has focused on the courts' role of being the arbiter of disputed questions such as this. It should not be the role of the courts to put a stamp of approval on a decision that "seems" right just because the plan obtained a report from a psychologist who practices at a prestigious institution. In the future, if a claimant has a supportive medical opinion from a University of Chicago physician, are courts going to hold that the opinion is trumped by a Harvard doctor?

The procedure applied in *Boyd* should be compared to three other recent decisions. In *Sheehan v. Metropolitan Life Insur.Co.*, 2005 U.S.Dist.LEXIS 4087 (S.D.N.Y. 3/17/2005), the court conducted a plenary bench trial and assessed the underlying support for the competing medical opinions in adjudicating the plaintiff's entitlement to benefits. Similarly, in *Napoli v. First Unum Life Insur.Co.*, 2005 U.S.Dist.LEXIS 7310 (S.D.N.Y. 4/22/2005), the court heard testimony from the plaintiff's and insurer's physicians which enabled the judge to evaluate whether the plaintiff faced a substantial risk of a heart attack if he returned to work. The court carefully considered the competing medical opinions in determining that the underlying support for the plaintiff's medical opinions lacked the strength of the evidence on which the insurer's doctor based his opinions. In contrast, in *Leipzig v. AIG Life Insur.Co.*, 326 F.3d 406 (7th Cir. 2004), the court did the same thing

as it did in this case—it simply credited a medical opinion offered by a reviewing doctor and discredited the plaintiff's physicians in finding it was not arbitrary and capricious for the insurer to deny disability benefits, even though his claim was supported by the treating and examining cardiologists, the plaintiff's internist, a rheumatologist, and a psychologist; and Social Security and a life insurer found him disabled.

Once again, we see in *Boyd* a court ruling that shows why a deferential standard of review in ERISA benefit cases is wholly inappropriate. The mistake appears to be the result of courts mis-analogizing these cases to social security disability benefit claims or misapplying trust law which Professor John Langbein convincingly showed was a mistaken approach in his 1990 article entitled, "The Supreme Court Flunks Trusts," 1990 Supreme Court Review 207. The analogy to both areas of practice is entirely inappropriate because in both Social Security administrative law clams and in trust disputes a *de novo* hearing is held to give the court an opportunity to weigh the evidence after the parties are afforded the right to cross-examination. No one can dispute the utility of cross-examination as the means of either highlighting weaknesses in medical opinions or reinforcing the strength of those opinions, particularly when the finder of fact is able to simultaneously evaluate the credibility of witnesses. The ERISA system has completely broken down; it needs to be fixed before the public completely loses confidence in the courts.

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ERISA and Disability Benefits

Despite Congress' intent in enacting the ERISA law that participants in employee benefit plans possess rights and remedies to secure the benefits promised by their employers,[1] the promise has gone unfulfilled in many cases because of the way in which courts adjudicate benefit disputes. Since the Supreme Court's issuance in 1989 of *Firestone Tire & Rubber Co. v. Bruch*,[2] the ERISA law has been transformed from the employee's sword into a near impenetrable shield wielded by employers and their insurers. The Supreme Court sanctioned the inclusion of clauses in employee benefit plans that give discretion to insurers or other plan administrators to determine claimants' eligibility to receive benefits. From a legal standpoint, what this has meant is that the claimant must prove the claim determination is "unreasonable, and not merely incorrect."[3] To make matters even worse for claimants, courts have removed ERISA cases from normal avenues of civil procedure and have denied claimants the right to trial or even the opportunity to take discovery to investigate irregularities or bias in the claim process and have concluded that "Deferential review of an administrative decision means review on the administrative record."[4] Particularly due to the Supreme Court's rejection, in *Black & Decker Disability Plan v. Nord*,[5] of a rule giving deference in disability claim adjudications to opinions from treating doctors, insurers are empowered to utilize in-house doctors, rather than independent medical examinations, as a means of denying claims,[6] which numerous cases have deemed sufficient to survive judicial review. Since the Supreme Court has, to date, refused numerous requests to intervene and remedy the current regime, only Congress can restore claimants' rights to due process in their pursuit of civil actions[7] to redress improper benefit denials.

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[1] 29 U.S.C. § 1001(b)
[2] 489 U.S. 101 (1989)
[3] *Herzberger v. Standard Ins.Co.*, 205 F.3d 327, 329 (7th Cir. 2000)
[4] *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981-82 (7th Cir. 1999); *Semien v. Life Insurance Co. of North America*, 436 F.3d 805, 813 (7th Cir.), *cert. denied* 166 L.Ed.2d 251 (2006)
[5] 123 S.Ct. 1965; 155 L. Ed. 2d 1034 (2003)
[6] A physician formerly employed by the UnumProvident Corporation characterized his company's use of physicians in this manner as a "means to an end...The end was denial." Deposition of Patrick Fergal McSharry, *Chapman v. Unum* (Cal., Marin.Cty. Super.Ct.), September 4-6, 2002 at 163-169; reported on *Dateline NBC* October 13, 2002. *Also see, See, e.g., Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569, 579 (7th Cir.); *cert. denied* 166 L.Ed.2d 147 (2006)("It is enough, in situations such as this, for the doctors to review the file and render a professional, medical opinion.")
[7] 29 U.S.C. § 1132(a)

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MODEL LAWS TO BE CONSIDERED BY THE EXECUTIVE COMMITTEE/PLENARY FOR ADOPTION

1. **Prohibition On The Use Of Discretionary Clauses Model Act (#42) (Draft 7/8/04)**

   At the Fall National Meeting, the Health Insurance and Managed Care (B) Committee adopted revisions to the Prohibition On The Use Of Discretionary Clauses Model Act intended to prohibit use of discretionary clauses in disability income insurance contracts. The revisions specifically bar contract language that purports to reserve discretion to the insurer to interpret contract terms or to provide standards of interpretation or review that are inconsistent with state law.

PROJECT HISTORY
PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

Project Description

In 2002, the NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act (Model Act), which prohibits the use of such clauses in health insurance contracts. At the 2004 Spring National Meeting, the Consumer Protections Working Group of the Executive (EX) Committee decided that a public hearing should be held in conjunction with the Health Insurance and Managed Care (B) Committee during the 2004 Summer National Meeting. The hearing was intended to create a forum for interested parties to discuss whether the NAIC should expand the Model Act to include disability income insurance. The public hearing resulted in a request that staff draft amendments to the model act to prohibit the use of discretionary clauses in disability income insurance as well as health insurance for consideration by the Health Insurance and Managed Care (B) Committee. The draft amendments to the Model Act were adopted unanimously by the B Committee at the 2004 Fall National Meeting.

Group Responsible for Drafting Model and States Participating

The Health Insurance and Managed Care (B) Committee was responsible for drafting the Model Act, chaired by Commissioner Praeger. The following states were members of the Committee: Kansas, Montana, Arizona, Arkansas, California, Delaware, Florida, Georgia, Indiana, Maryland, Missouri, Wisconsin, and West Virginia.

Charge Authorizing Project

B Committee Charge: Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments. Report quarterly.

Description of Drafting Process

2004 Spring National Meeting – The Consumer Protections Working Group of the Executive (EX) Committee Health Insurance and the Managed Care (B) Committee decided that a joint public hearing should be held at the 2004 Summer National Meeting.

2004 Summer National Meeting – A joint public hearing of the Consumer Protections Working Group of the Executive (EX) Committee and Health Insurance and Managed Care (B) Committee was held. The following individuals testified at the hearing: Mary Ellen Signorille (AARP Foundation, Litigation); Terri Sorota (American Council of Life Insurers—ACLI); Richard E. Ramsay (America's Health Insurance Plans—AHIP); Brad Wegner (Association of California Life and Health Insurance Companies); Sonya Schwartz (Families USA); Mila Kofman (Georgetown University—Health Policy Institute); Teresa S. Renaker (Lewis & Feinberg, P.C.) and clients Joanna Baida, Mark Rosten, and Gregory Rowe; Ruth Silver Taube (Silver & Taube); Melvyn D. Silver (Silver & Taube); Lawrence Frank (Standard Insurance Company); Karrol Kitt (The University of Texas at Austin); and Cathey W. Steinberg (Women's Policy Group, Women's Policy Education Fund). Testimony and written submissions were collected and are included as part of the written record of the hearing. Following the hearing, staff was directed to draft and circulate amendments to the Prohibition on the Use Of Discretionary Clauses Model Act for consideration by the Health Insurance and Managed Care (B) Committee at the 2004 Fall National Meeting

August 2004 – Draft amendments were emailed to the B Committee and interested parties. Comments were requested. Comments were collected and emailed to B Committee and interested parties prior to the 2004 Fall National Meeting.

2004 Fall National Meeting – Draft amendments and comments were reviewed. After discussion in which regulators and interested parties participated, the B Committee unanimously voted to adopt the revisions to the model act.

Significant Issues Raised

- The current Prohibition on the Use of Discretionary Clauses Model Act prohibits the use of discretionary clauses in health insurance contracts. The inclusion of discretionary clauses in disability income insurance policies is as objectionable as their inclusion in health insurance policies.

- Insurers argued that a recent Supreme Court case, *Aetna v. Davila*, taken together with other cases, invalidated the ability of the state to prohibit the use of discretionary clauses. The *Davila* case, however, is about remedies under ERISA, not about a discretionary standard. Nothing in the *Davila* case overrules a prior Supreme Court opinion that states that discretionary clauses can be prohibited by state law.

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Draft: 07/08/04
Revisions to Model 42
Adopted by the Health Insurance and Managed Care (B) Committee Sept. 13, 2004.

PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Discretionary Clause Prohibition Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation or bulletin. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation or bulletin.

Section 2. Purpose and Intent

The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the ~~health~~ carrier responsible for providing benefits has ~~unfettered~~ discretionary authority to decide what benefits are due. Nothing in this Act shall be construed as imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

Section 3. Definitions

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Disability income protection coverage" is a policy, contract, certificate or agreement that provides for periodic payments, weekly or monthly, for a specified period during the

continuance of disability resulting from either sickness or injury or a combination of them.

~~B~~C. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

~~C~~D. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service cooperation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statute instead of, or in addition to, the insurance laws and regulations.

~~D~~E. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or combination of the foregoing.

Section 4. Discretionary Clauses Prohibited

A. No policy, contract, certificate or agreement offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

B. No policy, contract, certificate or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

Section 5. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 6. Separability

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 7. Effective Date

This Act shall be effective [insert date].

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Essay

TRUST LAW AS REGULATORY LAW: THE UNUM/PROVIDENT SCANDAL AND JUDICIAL REVIEW OF BENEFIT DENIALS UNDER ERISA

John H. Langbein[*]

INTRODUCTION

Authoritative evidence has come to light that for a period of some years, stretching from the mid-1990s into the present decade, Unum/Provident Corporation (Unum), the largest American insurer specializing in disability insurance, was engaged in a deliberate program of bad faith denial of meritorious benefit claims. Part I of this Essay reviews what is known of this episode.

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[*] Sterling Professor of Law and Legal History, Yale University. I wish to acknowledge the research assistance of Joseph Masters. I am grateful for suggestions and references from participants at law school workshops at Georgia, Texas, and Yale, and from Donald Bogan, Mark DeBofsky, Mary Ellen Signorille, Robert Sitkoff, and Edward Zelinsky.

The Unum/Provident scandal draws attention to a major failing in how the federal courts have understood their role in reviewing benefit denials under the Employee Retirement Income Security Act of 1974 ("ERISA").[1] Most disability insurance in the United States (apart from the Social Security program) is employer-provided,[2] and hence ERISA-governed.[3] Many, probably most, of the victims of the Unum/Provident scandal were participants and beneficiaries of ERISA-covered disability insurance plans. As regards Unum's ERISA-governed policies, Unum's program of bad faith benefit denials was all but invited by an ill-considered passage in an opinion of the United States Supreme Court, *Firestone Tire & Rubber Co. v. Bruch*,[4] which allows ERISA plan sponsors to impose self-serving terms that severely restrict the ability of a reviewing court to correct a wrongful benefit denial.

Part II of this Essay reviews the *Bruch* decision. Part III locates Unum's program of bad faith benefit denials in ERISA's landscape of conflicted plan decisionmaking. Most ERISA plan benefit denials are the work of conflicted decisionmakers. ERISA places the plan administrator under a fiduciary duty to act "solely in the interest of the participants and beneficiaries,"[5] yet, as the Third Circuit observed of the defendant in *Bruch*, "every dollar saved by the [plan] administrator on behalf of his employer is a dollar in Firestone's pocket."[6] This Essay directs attention to a prominent line of Seventh Circuit cases in which that court has purported to invoke law-and-economics principles to minimize or deny the significance of these conflicts of interest. I explain why the Seventh Circuit cases are mistaken, and I point to a contrasting strand of Eleventh Circuit case law that, if more

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[1] Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1461 (2000).

[2] In 2003, employers provided short-term disability insurance for 39% of the workforce, and long-term disability insurance for 30%. AMERICAN COUNCIL OF LIFE INSURERS, LIFE INSURERS FACT BOOK 101 (2005). ERISA-covered plans also provide most of the nation's health insurance. Presently, 91% of private health insurance in force in the United States is employer-provided, *see* ECONOMIC REPORT OF THE PRESIDENT 86 (2006), although some of those sponsoring employers, notably governmental employers, are exempt from ERISA. *See* ERISA § 4(b), 29 U.S.C. § 1003(b) (2000). ERISA plans also supply much of the nation's life insurance. By the end of 2004, there was $7.6 trillion of group life insurance in force, virtually all employer-provided, compared to $9.7 trillion of individually purchased coverage. AMERICAN COUNCIL OF LIFE INSURERS, *supra*, at 88, 92.

[3] ERISA covers all employee benefit plans as defined in ERISA § 3(3), 29 U.S.C. § 1002(3) (2000). *See* ERISA, § 4(a), 29 U.S.C. § 1003(a) (2000). This is true except for those excluded under ERISA § 4(b), 29 U.S.C. § 1003(b), most notably the plans of federal, state, and local government employers. *See* ERISA § 4(b)(1), 29 U.S.C. § 1003(b) (2000) (referencing ERISA § 3(32), 29 U.S.C. § 1002(32)).

[4] 489 U.S. 101, 115 (1989). In the years since it was decided, *Bruch* has been the most frequently cited ERISA case. *See* JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 657–58 (4th ed. 2006).

[5] ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (2000) (discussed *infra* text accompanying notes 66–74).

[6] Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part*, 489 U.S. 101 (1989).

widely followed, could overcome much of the mischief that results from conflict-tainted benefit denials.

Part IV develops the view that the Unum/Provident scandal, by demonstrating the extent of the danger of self-serving plan benefit denials, should cause the Supreme Court to revisit the branch of its decision in *Bruch* that allows plan drafters to require reviewing courts to defer to self-serving plan decisionmaking. The Court there rested its decision on analogy to "general principles of trust law."[7] The Court reasoned that because ERISA's law of plan administration derives from the law of trusts, and because the settlor of a private trust can require deferential review, an ERISA plan drafter must also be empowered to require deferential review. There is, however, a profound difference of purpose between ordinary trust law and ERISA fiduciary law. Because "[t]he normal private trust is essentially a gift,"[8] trust law exhibits great deference to the wishes of the transferor. In ERISA, by contrast, Congress imposed trust law concepts for regulatory purposes, to restrict rather than to promote the autonomy of the employer over its employee benefit plans. This fundamental difference of purpose should lead the Court to restrict the power of an ERISA plan sponsor to alter the standard of judicial review. I point to provisions of ERISA not considered by the Court in *Bruch* that lend strong textual support to the view that Congress did not mean to empower an ERISA plan sponsor to weaken the standards under which its benefit denial decisions (or those of a hireling) are to be reviewed.

I. THE UNUM/PROVIDENT SCANDAL[9]

Unum/Provident Corporation was assembled in the 1990s from several formerly separate companies.[10] Unum and its various subsidiaries dominate the market for disability insurance. In 2003, Unum companies issued 40% of the individual disability policies and 25% of the group disability policies sold in the United States, covering more than 17 million persons.[11]

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[7] *Bruch*, 489 U.S. at 115.

[8] Bernard Rudden, *Book Review*, 44 MOD. L. REV. 610, 610 (1981) (reviewing JOHN P. DAWSON, GIFTS AND PROMISES (1980)).

[9] Portions of this account draw upon sources collected in LANGBEIN, STABILE & WOLK, *supra* note 4, at 669–74.

[10] Unum Life Insurance Co. is the demutualized successor to the former Union Mutual Insurance Co. of Maine. Unum merged in 1999 with Provident Life & Accident Insurance Co., which in 1997 had acquired Paul Revere Life Insurance Co. *See* Steven Lipin & Leslie Scism, *Provident Reaches Accord with Textron to Buy Paul Revere Unit for $1.2 Billion*, WALL ST. J., Apr. 29, 1996, at A3; *see also* Leslie Scism and Steven Lipin, *Provident's Purchase of Paul Revere Signals Recovery*, WALL ST. J., Apr. 30, 1996, at B4. "Unum" is sometimes rendered in upper case, but not in this Essay.

[11] *See* Dean Foust, *Disability Claim Denied!*, BUSINESS WEEK, Dec. 22, 2003, at 62, 63. In 2006, Unum advertised that it was the "[c]hoice of nearly one of every four U.S. employers who offer group disability insurance coverage providing income protection disability insurance to more than 11 million American workers." UnumProvident.com, About Us—UnumProvident, http://www.unumprovident.com/aboutus (last visited Feb. 26, 2006) [hereinafter About Us—UnumProvident]. The larger figure

Although most benefit claims arising under policies of disability insurance are processed routinely,[12] a disability claim can give rise to a dispute about how impaired or how employable an insured actually is. Such cases are intrinsically factitious. The recurrent question is whether, on the facts regarding this worker's physical and occupational circumstances, he or she is unable to resume employment as defined in the policy.[13] A reviewing court will not often find close guidance on such factual determinations from the policy terms, background rules of law, or prior cases. The amount at stake in a disability claim (an income stream that can endure for decades) can be quite large, even though the policy commonly integrates, and thus offsets, the insured's Social Security disability payments. The danger that an insured may exaggerate or falsify conditions of disability is ever present.[14] Moral hazard dangers are more acute with disability insurance than with other forms of insurance, such as life insurance, in which it is more costly for the insured to qualify for the insurable event and harder to falsify it.[15]

The growth of what became Unum was engineered by one J. Harold Chandler, who became CEO of a predecessor entity in 1993 and ran the merged companies until he was dismissed in 2003. Under Chandler, Unum instituted cost-containment measures that pressured claims-processing employees to deny valid claims. Pressures peaked in the last month of each quarter, called the "scrub months," when claims managers exhorted staff to deny enough claims to meet or surpass budget goals.[16] Word of these practices began to emerge in lawsuits brought by former Unum claims-processing employees, and in investigative reports broadcast in 2002 by

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mentioned in the text includes individual and other non-employer-provided policies, reflecting the decline in Unum's business that has resulted from publicity about the investigations and proceedings against the company.

[12] Unum advertises that it processed 450,000 new disability claims in 2004 and paid $2.4 billion in disability benefits. About Us—UnumProvident, *supra* note 11.

[13] The reported case law is surveyed in STEVEN PLITT ET AL., COUCH ON INSURANCE chs. 147–48 (3d ed. 1995 & Supps.).

[14] *See, e.g.*, Shyman v. Unum Life Ins. Co., 427 F.3d 452, 456 (7th Cir. 2005) (discussing an insured who claimed to be totally disabled and bedridden on account of headaches, but who "continued to trade soybean contracts (both on the floor at the Board of Trade and electronically from his home)," and was observed coaching basketball and baseball, exercising on a treadmill, and driving his children to and from school). When insurance is provided under ERISA plans, "plan administrators have a duty to all plan participants and beneficiaries to investigate claims and make sure to avoid paying benefits to claimants who are not entitled to receive them." Davis v. Unum Life Ins. Co., 444 F.3d 569, 575 (7th Cir. 2006).

[15] Disability insurers commonly limit an insured's disability coverage to a sum well short of his or her full salary. *See* Hall v. Life Ins. Co. of N. Am., 317 F.3d 773, 775 (7th Cir. 2003) ("People who know that their full income will continue after they stop working may take more risks in their daily lives and will not try as hard to return to work after injury or illness . . . ."). Sales practices, claims processing, and underwriting issues in the disability insurance industry are discussed in CHARLES E. SOULE, DISABILITY INCOME INSURANCE: THE UNIQUE RISK (5th ed. 2002).

[16] *See* Foust, *supra* note 11, at 64.

NBC's *Dateline*[17] and CBS's *60 Minutes*[18] news programs. Employees interviewed on the *Dateline* program disclosed that the claims that were "the most vulnerable" to pressures for bad faith termination were those involving "so-called subjective illnesses, illnesses that don't show up on x-rays or MRIs, like mental illness, chronic pain, migraines, or even Parkinsons."[19] The *Dateline* story pointed to an internal company email cautioning a group of claims staff that they had one week remaining to "close," that is, deny, eighteen more claims in order to meet desired targets.[20]

Some claims-processing employees who objected to these practices later contended that they had been intimidated into acquiescing, or dismissed for not complying. Several brought wrongful dismissal suits, which Unum defended on the ground that it had dismissed the dissidents for cause. The most prominent of the suits was that of Dr. Patrick McSharry, who had worked as a staff physician in Unum's claims review operations. He alleged that Unum made him review so many claims that he could not analyze them properly; that he was instructed "to use language . . . [to] support the denial of disability insurance"; that he was not allowed "to request further information or suggest additional medical tests"; and that he was "not supposed to help a claimant perfect a claim for disability insurance benefits."[21]

Not all of Unum's bad faith benefit denial cases have arisen from policies issued under ERISA-covered plans, and the non-ERISA cases have escaped ERISA's various remedial disadvantages. Whereas ERISA has been interpreted to preclude the award of punitive damages,[22] large punitive damage awards have been made against Unum/Provident companies for bad faith claim denials in several non-ERISA cases.[23] In one such case, a federal judge sustained a $5 million award on the ground that the trial "jury heard more than enough evidence to conclude that Plaintiff was totally disabled and that Defendants in bad faith terminated her benefits and caused her damages."[24]

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[17] *Dateline: Benefit of the Doubt* (NBC television broadcast, Oct. 13, 2002) (transcript on file with author).

[18] *60 Minutes: Did Insurer Cheat Disabled Clients?* (CBS television broadcast, Nov. 17, 2002) (transcript on file with author).

[19] *Id.*

[20] *See Dateline*, *supra* note 17.

[21] McSharry v. UnumProvident Corp., 237 F. Supp. 2d 875, 877 (E.D. Tenn. 2002).

[22] *See* John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in* Russell, Mertens, *and* Great-West, 103 COLUM. L. REV. 1317, 1346–48 (2003) [hereinafter Langbein, *Trail*].

[23] *See* Foust, *supra* note 11, at 63.

[24] Hangarter v. Paul Revere Life Ins. Co., 236 F. Supp. 2d 1069, 1082 (N.D. Cal. 2002), *aff'd*, 373 F.3d 998 (9th Cir. 2004). Counsel for the plaintiff has written a book about his experiences in the case. *See* RAY BOURHIS, INSULT TO INJURY: INSURANCE, FRAUD, AND THE BIG BUSINESS OF BAD FAITH (2005).

Many federal courts have now commented on Unum's aggressive claims denial practices. Published opinions speak of "selective review of the administrative record,"[25] "lack of objectivity and an abuse of discretion by UNUM,"[26] misuse of "ambiguous test results,"[27] and claims evaluation practices that "defie[d] common sense"[28] and "bordered on outright fraud."[29] In a notable opinion in the district court in Massachusetts, Chief Judge Young collected citations to nearly twenty previous cases that he described as "reveal[ing] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."[30] He faulted Unum for behavior "entirely inconsistent with the company's public responsibilities and with its obligations under the [ERISA-covered disability] Policy" in the particular case.[31]

As complaints, litigation, and media accounts multiplied, several state insurance commission staffs began investigating Unum's claims denial practices. In the view of the Georgia commissioner, Unum had been "looking for every technical legal way to avoid paying a claim."[32] In 2003 and 2004, the Maine, Massachusetts, and Tennessee insurance regulators, acting on behalf of most other states, conducted a coordinated investigation and filed a report that accused Unum of systematic irregularities in obtaining and evaluating medical evidence of disability. Unum agreed to pay a $15 million fine, to reopen several years' worth of denied claims, and to make specified changes in its claims reviewing procedures and its corporate governance.[33] In 2005 the California Department of Insurance settled separately with Unum, imposing an $8 million civil penalty.[34] California regulators reported "violations of state law in nearly one-third of a random sample of about 1,000 claims handled by UnumProvident."[35] *Barron's*, the financial newspaper, reports that "[s]ince 2004, Unum has taken charge-offs

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[25] Moon v. UNUM Provident Corp., 405 F.3d 373, 381 (6th Cir. 2005).

[26] Lain v. UNUM Life Ins. Co., 279 F.3d 337, 347 (5th Cir. 2002).

[27] Stup v. UNUM Life Ins. Co. of Am., 390 F.3d 301, 310 (4th Cir. 2004).

[28] Dandurand v. UNUM Life Ins. Co. of Am., 284 F.3d 331, 338 (1st Cir. 2002).

[29] Watson v. UnumProvident Corp., 185 F. Supp. 2d 579, 585 (D. Md. 2002).

[30] Radford Trust v. First Unum Life Ins. Co., 321 F. Supp. 2d 226, 247 (D. Mass. 2004).

[31] *Id.*

[32] Mike Pare, *$1 Million Fine Hits Unum*, CHATTANOOGA TIMES FREE PRESS, Mar. 19, 2003, at C1.

[33] *See* Maine Bureau of Insurance, Report of the Targeted Multistate Market Conduct Examination, http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 7, 2007).

[34] *See* Diya Gullapalli, *UnumProvident Is Set to Pay $8 Million Penalty in California*, WALL ST. J., Oct. 3, 2005, at C3. Unum also agreed to pay nearly $600,000 to cover the costs of the California Department's investigation. Unum will review benefit denials as far back as 1997, under the oversight of an independent consultant assigned by the Department. *Id.* For the full text of the agreement, see "Cal. Settlement Agreement," *in re* Certificates of Authority of Unum Life Insurance Co., etc., Nos. DISP05045984–85 (Oct. 2005) [hereinafter Cal. Settlement Agreement] (copy on file with author).

[35] Peter G. Gosselin, *State Fines Insurer, Orders Reforms in Disability Cases*, L.A. TIMES, Oct. 3, 2005, at A1, A12.

of $135 million," including the multi-state and California fines, as a result of the investigations.[36]

In the course of discovery proceedings in the lawsuits against Unum, there came to light a remarkable internal memorandum written in 1995 by a Unum executive.[37] In it, he exults in the "enormous"[38] advantages that ERISA, as interpreted by the courts, bestowed upon Unum in cases in which an insured sought judicial review of a benefit denial. "[S]tate law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review."[39] The memorandum recounts that another Unum executive "identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million."[40] We see in this document Unum's keen understanding of how the deferential standard of review allowed under *Bruch* interacts with aspects of ERISA remedy law to facilitate aggressive claim denial practices.

Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly, it got caught and was sanctioned, and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III, conflicted plan decisionmaking is a structural feature of ERISA plan administration. The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under *Bruch* to line its own pockets by denying meritorious claims. Cases of abusive benefit denials involving other disability insurers abound.[41] Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.

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[36] Jonathan R. Laing, *The $675 Million Solution*, BARRON'S, May 1, 2006, at 22.

[37] Memorandum from Jeff McCall to IDC Management Group & Glenn Felton, Provident Internal Memorandum, Re: ERISA (Oct. 2, 1995) [hereinafter Unum ERISA Memorandum], *reprinted in* BOURHIS, *supra* note 24, at 225.

[38] *Id.*

[39] *Id.* In a series of 5–4 decisions, the Supreme Court has interpreted ERISA to permit recovery only of "benefits due," and to preclude both compensatory and punitive damages. Great-West Life Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Mertens v. Hewitt Assocs., 508 U.S. 248 (1993); Mass. Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (unanimous decision but with dicta regarding remedy that provoked opposing concurrence, dividing the Court 5–4). I have elsewhere explained why the Court's refusal to allow compensatory "make whole" damages misreads the statute. *See* Langbein, *Trail*, *supra* note 22.

[40] Unum ERISA Memorandum, *supra* note 37. The document continues with a wink: "While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action." *Id.*

[41] *See, e.g.*, Zanny v. Kellogg Co., No. 4:05-CV-74, 2006 WL 1851236, at *9 (W.D. Mich. 2006) ("In this case, [Metropolitan Life Insurance Co.] regularly reviewed the client's file with an open inten-

II. *BRUCH*

Because the Supreme Court's 1989 decision in *Bruch*[42] figures so centrally in the ERISA-plan cases in the Unum/Provident scandal, understanding what the Court decided in that case is essential. I have elsewhere had occasion to discuss the opinion in considerable detail.[43] For present purposes, it suffices to identify the three distinct strands of the decision. First, the Court imposed de novo review as the default standard, meaning that in the absence of contrary plan terms, a reviewing court should decide a contested benefit denial case afresh, according no presumption of correctness to the plan administrator's decision to deny the claim. Second, however, the Supreme Court allowed the ERISA plan drafter to insert a term requiring the reviewing court to defer to the plan administrator's decision, effectively defeating the de novo standard. Third, the Court cautioned that in such cases of plan-dictated deferential review, the reviewing court might need to temper its deference in circumstances in which the decisionmaker acted under a conflict of interest.

A. Setting the Default Standard: De Novo Review

Although the text of ERISA as enacted in 1974 provided for judicial review of benefit denials,[44] the statute did not address the question of what standard of judicial review to apply in such cases.[45] The core choice is between deferential review—commonly called the "arbitrary and capricious" standard—which effectively presumes the correctness of the plan's decision to deny the claimed benefit, and nondeferential or de novo review, under which the reviewing court examines the merits afresh.

The Supreme Court in *Bruch* chose nondeferential review. Although the lower courts had mostly applied a deferential standard of review, on analogy to the standard that had developed for reviewing plan decisionmaking under the Taft-Hartley Act,[46] the Supreme Court held unanimously that

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tion to deny benefits despite the profound and compelling evidence of serious and prolonged mental illness."); Loucks v. Liberty Life Assurance Co., 337 F. Supp. 2d 990, 995 (W.D. Mich. 2004) (characterizing the evaluation of disability claims as "unprincipled, bias[ed] and craven[,] . . . grossly negligent and driven by financial motives"); Wible v. Aetna Life Ins. Co., 375 F. Supp. 2d 956, 969 (C.D. Cal. 2005) ("[T]he record reflects unrebutted material, probative evidence tending to show that Aetna's self-interest caused a breach of its fiduciary obligations to" the disability claimant.).

[42] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

[43] *See* John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207 [hereinafter, Langbein, *Trusts*].

[44] *See* ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (2000) (authorizing suits "to recover benefits due").

[45] *See, e.g.*, *Bruch*, 489 U.S. at 109 (noting that ERISA neglected to "set out the appropriate standard of review" in such cases).

[46] Unlike other, so-called single-employer benefit plans, the multi-employer plans instituted under the Taft-Hartley Act are required to be governed by a board comprised of equal numbers of employer- and union-selected trustees. *See* Taft-Hartley Act § 302(c)(5), 29 U.S.C. § 186 (2000). There was, accordingly, greater justification for presuming the fairness of the internal claims review processes of multi-employer plans. Regarding the scope and application of the "arbitrary and capricious" standard in

ERISA required de novo review of ERISA plan decisionmaking. The Court rested this decision on both doctrinal and functional grounds. Doctrinally, the Court regarded the preference for de novo review as a "settled principle[] of trust law . . . ."[47] Functionally, the Court grounded its decision to prefer the more searching standard on ERISA's protective purposes. ERISA was "enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans'[48] . . . and 'to protect contractually defined benefits . . . .'"[49]

B. Subordinating De Novo Review

Having explained the logic of nondeferential review, the Court then made its disastrous misstep in *Bruch*. In a brief aside, the Court assumed, and thus effectively decided, that the employer or other plan sponsor has the authority to defeat the de novo standard. Disregarding the protective purposes of ERISA that the Court had just invoked when choosing that standard, the Court treated the standard of review as a matter of default law that the employer or other plan sponsor was free to countermand by inserting self-serving language in the plan document requiring the reviewing court to grant deferential review. De novo review pertains, said the Court, "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[50] In such a case, "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review."[51]

The Court's rationale for allowing plan terms to trump ERISA's "concern for impartial decisionmaking" appears to have been a notion of waiver or consent ("parties . . . agreeing"). There are two difficulties with that reasoning. First, ERISA benefit plans are characteristic contracts of adhesion, offered on a take-the-plan-or-leave-the-job basis. As a practical matter, the employee has no opportunity to bargain with the employer about matters

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federal administrative law, see 2 RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE § 11.4, at 805–14 (4th ed. 2002).

[47] *Bruch*, 489 U.S. at 112. I have elsewhere criticized the Court's premise that de novo review of plan administration derives from trust law. *See* Langbein, *Trusts*, *supra* note 43, at 217–19. De novo review is not the trust standard. In matters of trust administration, as opposed to the construction of trust instruments, courts routinely defer to trustee decisionmaking. *See* RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. a (1959) (stating that the exercise of a trust power is discretionary unless restricted by the trust's terms or by a supervening rule of trust law). In ERISA fiduciary law, however, on account of the regulatory purposes of ERISA, I think the Court was indeed correct to prefer de novo review. *See infra* text at notes 133–59.

[48] *Bruch*, 489 U.S. at 113 (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983)).

[49] *Bruch*, 489 U.S. at 113 (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)).

[50] *Id.*

[51] *Id.*

such as the standard of review of benefit denials.[52] Accordingly, it is a mischaracterization to depict these parties as "agreeing"[53] to preclude impartial judicial review of self-serving plan decisionmaking. Second, as further explained in Part IV of this Essay, ERISA's protective purpose, that is, its regulatory mission, is to circumscribe the contractual autonomy of the parties to a pension or benefit plan.

ERISA plans are virtually always professionally drafted instruments, the work of specialist counsel or plan administration firms. Plan drafters routinely seize upon *Bruch*'s invitation to instruct the courts to defer to plan decisionmaking.[54] In consequence, deferential review pervades the ERISA-plan world, despite the primary holding in *Bruch* that purports to establish the opposite. A program of bad faith benefit denial such as that unearthed in the Unum/Provident scandal is markedly easier to carry out under a deferential standard of review, which requires the court to sustain the denial unless the victim can adduce evidence that the denial was "whimsical, random, or unreasoned,"[55] or, in Judge Posner's revealingly dismissive formulation, "off the wall."[56]

C. The Conflict Proviso

In the very passage in which the Court authorized plan drafters to defeat de novo review, the Court nevertheless tempered that grant of authority. In cases in which the plan requires deferential review, said the Court, if the "administrator or fiduciary . . . is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'"[57]

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[52] Judge Acker has remarked, "Although, in theory, the plan document is thought of as a contract between the employer (the plan sponsor) and the employee, it never is truly the product of arms-length negotiation . . . . The employee plays no part in fashioning the coverage or the claims procedure." Burroughs v. Bellsouth Telecommunications Inc., 446 F. Supp. 2d 1294, 1298 (N.D. Ala. 2006).

[53] *Bruch*, 489 U.S. at 103.

[54] In *Oliver v. Coca-Cola Co.*, 397 F. Supp. 2d 1318 (N.D. Ala. 2005), the court reproduces a typical example of such plan terms. Entitled "Construction," the clause provides that a committee of employer personnel "will have the exclusive responsibility and complete and final discretionary authority to construe the Plan and to decide all questions arising under the Plan, . . . and all actions or determinations of the Committee shall be final, conclusive and binding." *Id.* at 1323 (emphasis deleted).

[55] Teskey v. M.P. Metal Products Inc., 795 F.2d 30, 32 (7th Cir. 1986). Regarding the lower courts' efforts to interpret and apply plan terms requiring deferential review, see LANGBEIN, STABILE & WOLK, *supra* note 4, at 665–69, 674–84; Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 OKLA. L. REV. 637, 644–72 (2006); Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1119–68 (2001).

[56] Rud v. Liberty Life Assurance Co., 438 F.3d 772, 773 (7th Cir. 2006).

[57] *Bruch*, 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)). The Court has subsequently signaled its uneasiness with the conflict-tainted decisionmaking occurring under *Bruch*. Said Justice Souter in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002): "It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest."

This concession to the danger of conflicted decisionmaking—which we may conveniently refer to as *Bruch*'s conflict proviso—has in principle the potential to abate much of the mischief that has resulted from allowing plan drafters to dictate a lenient standard of review, because, as discussed next in Part III of this Essay, most ERISA plan benefit denials are the work of decisionmakers operating under serious conflicts of interest. The lower courts have not, however, taken much advantage of their license under the conflict proviso to resist plan-dictated deferential review in these cases.

III. ERISA'S CONFLICTED DECISIONMAKERS

A. Plan Administration As Fiduciary Law

"In enacting ERISA," the Supreme Court has observed, "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds."[58] This concern was an outgrowth of congressional investigations into labor union corruption, especially in the Teamsters Union, which uncovered evidence of looting, kickbacks, cronyism, and other serious maladministration in union-sponsored pension and benefit plans.[59]

In ERISA Congress responded to these dangers[60] by imposing fiduciary standards derived from private trust law[61] for the administration of all employee benefit plans. ERISA's rule of mandatory trusteeship requires that

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[58] Massachusetts v. Morash, 490 U.S. 107, 115 (1989).

[59] See Michael S. Gordon, Overview: Why Was ERISA Enacted?, *in* U.S. SEN. SPECIAL COMM. ON AGING, 98TH CONG., THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: THE FIRST DECADE 6, at 10–11 (1984); *see also* Langbein, *Trail*, *supra* note 22, at 1324 (discussing congressional investigations conducted in the 1950s and 1960s).

[60] ERISA embodies three distinct programs of protection for plan participants and beneficiaries, responding to three distinct sorts of risk: administrative or agency risk, default risk, and forfeiture risk.

The fiduciary rules (and related disclosure requirements and remedial provisions) discussed in this Essay are addressed to administrative (agency) risk, that is, to the danger that the persons who administer a plan and invest plan funds will misappropriate or mismanage the funds, or will misapply the standards for determining entitlement to plan benefits.

Default risk is the danger that a defined benefit pension plan will renege on promised benefits. The response in ERISA has been to impose actuarially based (but still not actuarially sound) funding requirements; and to establish a program of plan termination insurance administered by a government agency, the Pension Benefit Guarantee Corporation. *See* RICHARD A. IPPOLITO, THE ECONOMICS OF PENSION INSURANCE (1989); JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974: A POLITICAL HISTORY 67–79, 94, 160–61 (2005).

Forfeiture risk arises from plan terms that cause promised benefits to be lost if the employee does not remain employed long enough or otherwise fails to fulfill plan-specified conditions. ERISA regulates forfeiture by means of vesting and related rules. *See* LANGBEIN, STABILE & WOLK, *supra* note 4, at 133–67.

[61] *See* Bruch, 489 U.S. at 115; *supra* text accompanying notes 6–7.

"all assets of an employee benefit plan shall be held in trust . . . ."[62] Moreover, ERISA treats all persons who administer a plan, in the sense of exercising material discretion over plan affairs, as ERISA fiduciaries.[63] ERISA subjects these persons to its version of the core substantive rules of trust fiduciary law: the care norm, that is, the duty of prudent administration;[64] and the loyalty rule, which requires plan fiduciaries to act "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ."[65] ERISA's fiduciary law of plan administration governs claims administration[66] as well as the administration of plan assets.

Although "ERISA abounds with the language and terminology of trust law,"[67] ERISA fiduciary law differs markedly from conventional trust law in one crucial respect. Trust law presupposes that the trustee who administers a trust will be disinterested, in the sense of having no personal stake in the trust assets, although the trust terms can make contrary provision.[68] By contrast, ERISA fiduciaries are commonly aligned with the employer (or, in most plans that supply insurance benefits, with the insurance company to which the employer delegates administrative responsibilities for the particular plan).[69]

ERISA expressly authorizes the employer to use "an officer, employee, agent or other representative" as a fiduciary,[70] thereby inviting the conflicts

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[62] ERISA § 403(a), 29 U.S.C. § 1103 (2000). A proviso to the quoted language excuses a few types of plans that are regulated in other ways, such as those funded with insurance policies.

[63] *See* ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A) (2000). Regarding the case law and regulations applying this standard to the panoply of service providers who have contact with ERISA plans, see LANGBEIN, STABILE & WOLK, *supra* note 4, at 515–27.

[64] *See* ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (2000).

[65] ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A)(i) (2000). Regarding the complexities inherent in transposing the loyalty norm from the model of the private trust to the pension plan, see John H. Langbein, *The Conundrum of Fiduciary Investing Under ERISA*, *in* PROXY VOTING OF PENSION PLAN EQUITY SECURITIES 128 (Dan M. McGill ed., 1989); Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105 (1988). ERISA fiduciary law also contains a set of prohibited transaction rules, further proscribing self-dealing and kickbacks. *See* ERISA §§ 406–408, 29 U.S.C. §§ 1106–1108 (2000).

[66] Granting or denying claimed plan benefits entails the exercise of "discretionary authority" within the meaning of ERISA § 3(21)(A). *See* 29 U.S.C. § 1002(21)(A) (2000).

[67] *Bruch*, 489 U.S. at 110.

[68] *See* RESTATEMENT (SECOND) OF TRUSTS § 170(1) cmt. t (1959) (trust terms may authorize trustee self-dealing).

[69] ERISA-covered plans must designate "one or more named fiduciaries" to manage the plan's affairs. ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1) (2000). The plan sponsor, virtually always the employer, selects these persons. *See* ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2) (2000). The statute also requires that plan assets be held in trust by trustees selected under the plan or by a named fiduciary. *See* ERISA § 403, 29 U.S.C. § 1103 (2000).

[70] ERISA § 408(c)(3), 29 U.S.C. § 1108(c)(3) (2000). This provision expressly negatives liability under the prohibited transaction rule of ERISA § 406, 29 U.S.C. § 1106. See also ERISA §§ 3(16),

of interest that so trouble the law of benefit denials. This concession to employer interests, which departs notably from the trust tradition,[71] was motivated by the concern that without it employers would be less likely to sponsor benefit plans. Because pension and welfare benefit plans entail major expenditures,[72] the sponsor commonly prefers to have its own managers administering and monitoring plan operations for cost containment, a traditional management function.

B. Denigrating the Conflict

The deferential standard of review allowed under *Bruch* heightens the dangers intrinsic to ERISA's authorization of conflicted plan decisionmakers. We recall the Third Circuit's observation in *Bruch* that "every dollar saved by the [plan] administrator on behalf of his employer is a dollar in [the employer's] pocket."[73] Not all courts have been adequately sensitive to the danger of conflicted decisionmaking in ERISA benefit denial cases. In particular, a notable string of Seventh Circuit cases has attempted to "apply[] a law-and-economics rationale to establish that no conflict exists."[74] The reasoning in these opinions is deeply flawed.

1. Contrasting Gross Revenue.—Several of the Seventh Circuit cases belittle the danger of conflicts of interest by contrasting the gross revenue of the employer or the insurer with the amount of the disputed claim—asserting, for example, that "a corporation which generates revenues of nearly $6 billion annually . . . is . . . not likely to flinch at paying out $240,000."[75] This reasoning improperly places wrongdoing beyond re-

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402(a), 29 U.S.C. §§ 1002(16), 1102(a) (2000), which make the employer the default plan administrator, and § 402(a)(1), 29 U.S.C. § 1102(a)(1) (2000), which makes plan administration a fiduciary function.

[71] For example, Bogert's formulation states that: "It is not possible for any person to act fairly in the same transaction on behalf of [him]self and in the interest of the trust beneficiary." GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 543, at 227 (rev. 2d ed. 1993). The Supreme Court has contrasted "the traditional trustee, [who] . . . 'is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries,'" with the ERISA fiduciary, who "may have financial interests adverse to beneficiaries. Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . ." Pegram v. Herdrich, 530 U.S. 211, 225 (2000) (citation omitted).

[72] Employer spending on benefits amounted to $1 trillion in the year 2002. *See* EMPLOYEE BENEFIT RESEARCH INSTITUTE (EBRI), FACTS FROM EBRI: EMPLOYER SPENDING ON BENEFITS, 2002, at 1 (2004).

[73] Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part*, 489 U.S. 101 (1989); *see supra* text accompanying note 6.

[74] Mers v. Marriott Int'l Group Accidental Death & Dismemb. Plan, 144 F.3d 1014, 1020 (7th Cir. 1998).

[75] Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995); *accord* Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999) ("When the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results."); *Mers*, 144 F.3d at 1020–21 (denying claimed $200,000 benefit as

proach so long as the benefit denied pales in comparison with the wrongdoer's gross revenue. Since virtually all plan benefit claims are "trivial"[76] when so measured, the Seventh Circuit's rationale would wholly preclude a reviewing court from considering the role of conflict of interest in plan decisionmaking.

In light of what is now known about the Unum/Provident scandal, it is beyond conjecture that Judge Easterbrook erred when he asserted as late as December 2005 that "Unum is much too large to be affected by its resolution of any one benefits claim."[77] However modest any one claim, if an insurer or other plan administrator denies enough claims, the aggregate savings can be quite significant. Unum reported paying $4.2 billion in disability benefits in 2004.[78] To paraphrase Senator Dirksen (whose name adorns the Seventh Circuit's courthouse), $240,000 here, $240,000 there, pretty soon it's real money.[79]

2. Reputation.—Another tack in the Seventh Circuit cases has been the claim that reputational incentives will adequately deter conflicted decisionmakers from abuse. Judge Easterbrook has contended: "Large businesses . . . want to maintain a reputation for fair dealing with their employees. They offer fringe benefits such as disability plans to attract good workers, which they will be unable to do if promised benefits are not paid."[80]

Reputational incentives may indeed constrain conflicted plan decisionmakers from abuse of authority,[81] but competing considerations weaken that incentive. The danger of unfair treatment in a matter as remote as the denial of a future disability or other benefit claim seldom weighs heavily in an employee's thinking when accepting employment. It is a rare prospective employee who, if he or she has a choice of employers, undertakes to investigate the relative integrity of the benefit claims processes of those employers or their insurers. Because individual benefit denials are not publicized, and because many are quite justified on the merits, an underlying pattern of bias may be hard for the isolated employee to discern.[82]

"minuscule compared to [insurer's] bottom line"); Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 815 (7th Cir. 1997) (contrasting $134,000 claim with employer's total revenue of $12.3 billion).

[76] *Perlman*, 195 F.3d at 981.

[77] Shyman v. Unum Life Ins. Co., 427 F.3d 452, 455 (7th Cir. 2005).

[78] *See* About Us—UnumProvident, *supra* note 11.

[79] The maxim, "A billion here, a billion there, and pretty soon you're talking real money," though commonly ascribed to the late Senator Everett M. Dirksen, has not been authoritatively traced to him. *See* Dirksen Congressional Center, A Billion Here, A Billion There . . . , http://www.dirksencenter.org/print_emd_billionhere.htm (last visited Feb. 26, 2006).

[80] *Perlman*, 195 F.3d at 981; *accord Mers*, 144 F.3d at 1021 ("[E]mployers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits.").

[81] I have emphasized this point elsewhere. *See* Langbein, *Trusts*, *supra* note 43, at 216; *accord* Fischel & Langbein, *supra* note 65, at 1132.

[82] *See* Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 388 (3d Cir. 2000).

Moreover, the greater the prospective gain from denying a benefit claim, the greater the inclination to subordinate the risk of reputational injury. For example, as Judge Posner remarked in a pension case in which $125 million turned on the plan fiduciaries' decision about what compensation was covered under a benefit accrual formula, "a loss of reputation might be a price worth paying to avoid $125 million in unanticipated expense."[83] Daniel Fischel and I have elsewhere pointed to the weakness of reputational incentives in severance plan cases that arise from corporate downsizings: "[T]he employer's reputational interest [is] not likely to be effective when the long term relationship [is] dissolving . . . . In these cases, the gains from self-interested action by non-neutral fiduciaries may outweigh the usual inhibiting future costs."[84] Considerations of this sort suggest that labor markets lack the capital markets' efficiency in disseminating reputational information.

In a prominent case decided in 1987, *Van Boxel v. Journal Co. Employees' Pension Trust*,[85] Judge Posner commented on the inadequacy of reputational incentives to prevent abusive plan administration. Speaking of a pension plan, he said that plan participants' rights "are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of 'arbitrary and capricious' review, relying on the company's interest in its reputation to prevent it from acting on its bias."[86]

3. Confusing Contract with Fiduciary Obligation.—Judge Posner has recently gravitated toward his colleagues' apologetics for conflicted decisionmaking. In 2006 in *Rud v. Liberty Life Assurance Co.*,[87] he rejected the "argu[ment] that a conflict of interest exists because any money [that the insurer] pays to a claimant reduces its profits. The ubiquity of such a situation makes us hesitate to describe it as a conflict of interest."[88] Seeking to explain why ubiquity should excuse an otherwise manifest conflict, Judge Posner analogized the ERISA benefit denial cases to the contractual relations of commercial parties, who "have a conflict of interest in the same severely attenuated sense, because each party wants to get as much out of the contract as possible."[89]

In resorting to the language of contract to justify the self-serving behavior of an ERISA plan administrator who decides benefit claims, Judge Posner overlooks a profoundly important difference: ERISA requires the administrator (or an insurer exercising delegated powers of plan administra-

[83] Gallo v. Amoco Corp., 102 F.3d 918, 921 (7th Cir. 1996).
[84] Fischel & Langbein, *supra* note 65, at 1132.
[85] 836 F.2d 1048 (7th Cir. 1987).
[86] *Id.* at 1052.
[87] 438 F.3d 772 (7th Cir. 2006).
[88] *Id.* at 775.
[89] *Id.*

tion) to act in a fiduciary capacity. Under ERISA's duty of loyalty, the decisionmaker must interpret and apply plan terms "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ."[90] Judge Posner is, therefore, confusing a contract counterparty, who is allowed to act selfishly, with an ERISA fiduciary, who is forbidden to.[91]

Although Judge Posner recognizes that "ERISA is a paternalistic statute in a number of respects, notably in its vesting rules,"[92] he fails to confront the reality that ERISA's fiduciary regime, which governs benefit denial cases, is also profoundly paternalistic. Precisely because ERISA subjects every employee benefit plan to ERISA's duties of loyalty, prudent administration,[93] and "full and fair" internal review of benefit denials,[94] we can be certain that Congress preferred these protective principles of ERISA fiduciary law over Judge Posner's concern about not making further "inroads into freedom of contract."[95] To refute Judge Posner's 2006 opinion in *Rud* that the employment contract implicitly authorizes self-serving decisionmaking about plan benefits, one need look no further than Judge Posner's 1987 opinion in *Van Boxel*, in which he emphasized that plan participants' rights "are too important these days for most employees to want to place them at the mercy of a biased tribunal . . . ."[96]

4. Experience Rating.—Judge Easterbrook has offered a pair of further rationalizations for deferring to conflicted decisionmaking. In a case involving denial of a benefit claim by Unum, decided before the Unum/Provident scandal became public, he pointed out that large group insurance policies are "retrospectively-rated," meaning "that the employer agrees to reimburse the insurer" for benefit payments and expenses.[97] He reasoned that in such circumstances, because the employer rather than the insurer would bear the ultimate costs of approving claims, "we have no reason to think that the actual decisionmakers at Unum approached their task

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[90] ERISA § 404(a)(1)(A), 29 U.S.C. § 1104 (2000)

[91] Indeed, Judge Posner has elsewhere emphasized this distinction. "Contract law . . . does not proceed on the philosophy that I am my brother's keeper. That philosophy may animate the law of fiduciary obligations but parties to a contract are not each other's fiduciaries." Original Great Am. Chocolate Chip Cookie Co. v. River Valley Cookies, Ltd., 970 F.2d 273, 280 (7th Cir. 1992).

[92] *Rud*, 438 F.3d at 776.

[93] ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (2000).

[94] ERISA § 503(2), 29 U.S.C. § 1133(2) (2000). I explain below that ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (2000), makes these provisions mandatory law, and hence not subject to alteration by plan terms. *See infra* text accompanying notes 138–52.

[95] *Rud*, 438 F.3d at 777.

[96] Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052 (7th Cir. 1987). The discordance between the two Posner opinions is remarked in Mark D. DeBofsky, *Benefit Payment Decisions Should Not Be Left Up to Insurers*, CHI. DAILY L. BULL., May 16, 2006, at 5.

[97] Perlman v. Swiss Bank Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999).

any differently than do the decisionmakers at the Social Security Administration,"[98] to whose decisions courts apply deferential review.

Judge Easterbrook's argument neglects a familiar commercial reality: Even when an insurance policy is experience-rated, the insurer still has a significant incentive to deny claims, because the market for insurance services is intensely competitive. Low-cost providers prevail over high-cost providers. The more effectively an insurer contains costs under an experience-rated policy, the better that insurer's chance of retaining the account and getting others. In a Third Circuit case, Judge Becker pointed to just this "active incentive to deny close claims in order to keep costs down" as "an economic consideration overlooked by the Seventh Circuit."[99]

5. Supposed Difficulties of Implementation.—Judge Easterbrook has also asserted, in a case involving Unum, that plan sponsors or their hirelings would be unable to get claims processing employees to misbehave, because getting employees to identify with the interests of their employer "is a daunting challenge for any corporation."[100] There is indeed an economic literature, on which Judge Easterbrook drew,[101] regarding the challenges of incentivizing employees. That literature does not, however, claim that employees cannot be incentivized; rather, the point is that overcoming such characteristic agency problems requires counter-incentives and more acute monitoring—just what Unum did to get its claims processing employees to engage for years in what Judge Young called a "pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."[102] The events in the Unum/Provident scandal demonstrate that the view advanced in the Seventh Circuit—that "applying a law-and-economics rationale . . . establish[es] that no conflict exists"[103] in benefit denial cases involving conflicted decisionmakers—is bad law[104] and bad economics.

C. Analogizing to Administrative Law

In contending that courts have as much reason to be deferential to the decisionmaking of Unum as to that of the Social Security Administration,

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[98] *Id.*

[99] Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 388 (3d Cir. 2000).

[100] *Perlman*, 195 F.3d at 981 ("Getting employees to act *as if* shareholder's welfare were their own is a daunting challenge for any corporation.").

[101] *Id.* (citing Candice Prendergast, *The Provision of Incentives in Firms*, 37 J. ECON. LIT. 7 (1999)).

[102] Radford Trust v. First Unum Life Ins. Co., 321 F. Supp. 2d 226, 247 (D. Mass. 2004).

[103] Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998).

[104] The Seventh Circuit's claim contradicts the Supreme Court's recognition in *Bruch* that such conflicts should be weighed as "'facto[rs] in determining whether there is an abuse of discretion.'" Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).

Judge Easterbrook was analogizing to administrative law. A prominent formulation of this analogy between ERISA plan decisionmakers and governmental agencies appeared in a pre-*Bruch* opinion by Judge Wilkinson in the Fourth Circuit. He observed that although deferential review "is perhaps more commonly associated with appellate court review of administrative findings, deference is likewise due when a district court reviews the action of a private plan trustee."[105] In both contexts, he reasoned, applying deferential review "ensure[s] that administrative responsibility rests with those whose experience is daily and continuous, not with judges whose exposure is episodic and occasional."[106]

This analogy to the expertise of administrative agencies has been strongly resisted. In the Third Circuit opinion in *Bruch*, Judge Becker pointed out that a benefit denial case does not ordinarily "turn on information or experience which expertise as a claims administrator is likely to produce."[107] In many circumstances, such a case will "turn on a question of law or contract interpretation. Courts have no reason to defer to private parties to obtain answers to these kinds of questions."[108] He concluded that the "significant danger that the plan administrator will not be impartial [offsets] any remaining benefit which the administrator[']s expertise might be thought to produce."[109]

Other courts have drawn attention to the significance of institutional and procedural differences between the two reviewing functions. The Eleventh Circuit has emphasized that "the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies."[110] This important ground of distinction, underscored so starkly in the Unum/Provident scandal,[111] cuts strongly against Judge Easterbrook's contention that "[w]e have no reason to think that Unum's benefits staff is any more 'partial' against applicants than are federal judges when deciding benefits claims."[112] The partiality of self-interested reviewers, long suspected in ERISA benefit denial practice, has now been documented in the Unum/Provident scandal.

In speaking of Social Security Administration (SSA) proceedings, which Judge Easterbrook equated with Unum's, Judge Posner has correctly observed that the SSA "is a public agency that denies benefits only after giving the applicant an opportunity for a full and fair adjudicative hearing,

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[105] Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985).

[106] *Id.*

[107] Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987).

[108] *Id.*

[109] *Id.*

[110] Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1564 n.7 (11th Cir. 1990).

[111] See *supra* text accompanying notes 16–21, for discussion of the pressures to deny meritorious claims that Unum brought to bear on its claims evaluation personnel.

[112] Perlman v. Swiss Bank Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999).

The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by [ERISA] plan administrators."[113]

D. Developing Bruch*'s Conflict Proviso*

Bruch's conflict proviso, noticed above,[114] made a potentially important concession to the hazards of conflicted decisionmaking. Even in a case in which the plan documents require deferential review, said the Supreme Court, if the "administrator or fiduciary . . . is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[115] This slender passage has produced a large case law wrestling with the question of whether a plan decisionmaker is conflicted, and if so, how much the reviewing court should temper its deference.[116]

In an early post-*Bruch* decision, *Brown v. Blue Cross & Blue Shield of Alabama*,[117] the Eleventh Circuit held that "when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest."[118] The Eleventh Circuit has adhered to this burden-shifting rule in later cases.[119] This standard, if widely followed, would materially narrow the scope of deference that courts must grant to plan-dictated standards of review.

The other circuits have not, however, agreed. Most circuits require the plaintiff to show not only that the decisionmaker was conflicted, but also that the conflict resulted in an improper decision. Thus, the Second Circuit has held (in a benefit denial case involving Unum) that conflict "is alone insufficient as a matter of law to trigger stricter review."[120] The First Circuit leaves "the burden on the claimant to show that [the] decision was improp-

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[113] Herzberger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000). This point is further developed in Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law Claims in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 738–43 (2004).

[114] *See supra* text accompanying note 57.

[115] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)). In a footnote in a subsequent ERISA preemption case, the Court reiterated the conflicts proviso, remarking that in *Bruch* "we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 384 n.15 (2002). The Court continued: "It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Id.*

[116] See LANGBEIN, STABILE & WOLK, *supra* note 4, at 665–69; Kennedy, *supra* note 55, at 1146–62.

[117] 898 F.2d 1556 (11th Cir. 1990).

[118] *Id.* at 1566.

[119] *See, e.g.*, Adams v. Thiokol Corp., 231 F.3d 837, 842 (11th Cir. 2000).

[120] Pulvers v. First UNUM Life Ins. Co., 210 F.3d 89, 92 (2d Cir. 2000).

erly motivated."[121] In the Eighth Circuit the claimant must present "probative evidence that [a] palpable conflict of interest actually caused a serious breach of the plan administrator's fiduciary [duty]."[122] In a case involving an insurance company as plan decisionmaker, the Seventh Circuit said that although the company "acts as both administrator and insurer of the plan, that factor, standing alone, does not constitute a conflict of interest."[123] The contrary view voiced in *Brown* seems more candid: An insurance company's "fiduciary role lies in perpetual conflict with its profit-making role as a business."[124]

The Supreme Court could, without confessing error in *Bruch*, materially reduce the scope of *Bruch*'s mischief by resolving this conflict among the circuits in favor of the position of the Eleventh Circuit, insisting on de novo review despite contrary plan terms in cases involving conflicted decisionmaking. That path is also open to any of the circuits that may find reason to reexamine the question. The suspicion is sometimes voiced in the ERISA plaintiffs' bar that part of what has motivated other circuits not to take advantage of their authority to resist plan-dictated deferential review clauses under *Bruch*'s conflict proviso is the fear that caseloads would increase. Deciding a case on the merits is indeed more time consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA plan benefit denials to federal judicial review,[125] and because ERISA's draconian preemption provision[126] suppresses the state-law causes of action that existed for many such cases before ERISA,[127] the proper role of the federal courts is to decide these cases fairly, and not slough them off on biased decisionmakers.

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[121] Pari-Fasano v. ITT Hartford Life & Accident Ins. Co., 230 F.3d 415, 418 (1st Cir. 2000) (citing Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 184 (1st Cir. 1998)).

[122] Schatz v. Mutual of Omaha Ins. Co., 220 F.3d 944, 948 (8th Cir. 2000).

[123] Cozzie v. Metro. Life Ins. Co., 140 F.3d 1104, 1108 (7th Cir. 1998). The Seventh Circuit "presume[s] that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998).

[124] Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1561–62 (11th Cir. 1990).

[125] ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (2000) authorizes suit "to recover benefits due." The statute also requires an ERISA plan to have internal review procedures that "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." ERISA § 503(2), 29 U.S.C. § 1133(2) (2000).

[126] ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (2000). *See* Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109, 110–12 (1985) ("The language of section 514(a) sweeps as broadly as the English language allows.").

[127] See, for example, *infra* text accompanying notes 160–65, regarding the protections in state insurance law against policy terms skewing the standard of review against the insured.

The Unum/Provident scandal, showing just how serious the danger of conflicted plan decisionmaking really is, supplies a cogent justification for the lower courts to tighten the standard of review in such cases.[128] For the Supreme Court, however, the better path would be to reconsider its misstep in *Bruch*.

IV. THE LIMITS OF TRUST LAW

Apart from the conflict proviso just discussed, the decision in *Bruch* has two main branches. The Supreme Court held (1) that the standard of judicial review for ERISA plan decisionmaking is nondeferential or de novo, but (2) that the plan sponsor may by apt drafting of the plan documents defeat that standard and insist on deferential review. In justifying the first branch of the decision, the Court found in ERISA's protective policy the basis for preferring de novo review.[129] The Court rested the second branch of its opinion on analogy to the "general principles of trust law," which permit the "parties" to the trust (the settlor and the trustee) to "agree[] upon a narrower standard of review."[130]

The "general principles of trust law" support the Court's result, in the sense that trust law is primarily a body of default law.[131] The settlor of a trust is allowed to relax the standard of judicial review of trustee decision-

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[128] Bogan and Fu argue in support of de novo review on different grounds. They would conclusively presume a breach of ERISA's duty of loyalty when a conflicted fiduciary denies a participant claim. Bogan & Fu, *supra* note 55, at 672–84. They analogize the ERISA cases to the no-further-inquiry rule of trust law, which conclusively presumes that trustee self-dealing entails breach of trust. I have criticized the no-further-inquiry rule in John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 YALE L.J. 929 (2005). Quite apart from the merits of the trust law rule, I regard the position advanced by Bogan and Fu as having been foreclosed by the statutory text of ERISA. Because ERISA expressly permits employer personnel to serve as plan administrators, *see supra* text accompanying note 70, it authorizes the very sort of conflicts of interest that the no-further-inquiry rule attempts to deter in trust administration. In trust law, when the settlor authorizes the conflict, the no-further-inquiry rule does not apply. *See* RESTATEMENT (SECOND) OF TRUSTS § 170(1), cmt. f (1959) (terms of the trust may authorize self-dealing).

[129] ERISA "was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans' . . . and 'to protect contractually defined benefits.'" Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989) (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983); Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)). The Court has subsequently observed with respect to its "lenient" practice of deferring to plan-dictated discretionary review clauses that "there is no ERISA provision directly providing a lenient standard for judicial review of benefit denials." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385 (2002).

[130] *Bruch*, 489 U.S. at 115.

[131] *See* UNIFORM TRUST CODE § 105(a) (2000) (identifying all trust law as default law except for those provisions identified in § 105(b)). I have discussed the objectives and operation of the UTC provision in John H. Langbein, *Mandatory Rules in the Law of Trusts*, 98 NW. U. L. REV. 1105, 1106, 1119–28 (2004) [hereinafter Langbein, *Mandatory Rules*].

making.[132] The question is whether that principle of settlor autonomy should be transposed to ERISA fiduciary law.

A. Default or Mandatory Law?

Congress enacted ERISA for regulatory purposes. When a legislature absorbs a private-law regime such as trust law for regulatory purposes, as did Congress in ERISA, the regulatory purposes should be understood to dominate, and, where necessary, to alter the application of the borrowed principles.[133] The reason that conventional private trust law is so strongly rooted in default law is that the primary purpose of the private trust is to implement the settlor's donative intent.[134] However, as the Court remarked when explaining *Bruch*'s preference for de novo review as the default standard, ERISA was enacted to protect plan participants and beneficiaries.[135]

What the Court neglected to consider in *Bruch* was whether ERISA's regulatory purpose would be better implemented by refusing to allow plan drafters to order reviewing courts to defer to plan decisionmaking. The extensive autonomy that the settlor of a private trust enjoys in shaping the terms of the trust to his or her wishes is not appropriate in circumstances in which Congress' purpose in imposing trust principles was to restrict, rather than facilitate, private autonomy.[136] As the Court remarked some years later in an unrelated ERISA case, "trust law does not tell the entire story. After all, ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection."[137]

B. Textual Support

Although the Court in *Bruch* did not consider whether permitting a plan drafter to impose a self-serving standard of review intrudes upon

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[132] See RESTATEMENT (THIRD) OF TRUSTS § 50(1) (2003) ("A discretionary power conferred upon the trustee to determine the benefits of a trust beneficiary is subject to judicial control only to prevent misinterpretation or abuse of the discretion by the trustee.").

[133] Speaking of ERISA's fiduciary duty of prudent administration, ERISA § 404(a)(1)(A), the Conference Committee Report said: "The conferees expect that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purposes of employee benefit plans." H.R. REP. NO. 93-1280, at 302 (1974) (Conf. Rep.), *as reprinted in* 1974 U.S.C.C.A.N. 5038, 5083.

[134] "The controlling consideration in determining the meaning of a donative document is the donor's intention." RESTATEMENT (THIRD) OF PROPERTY: WILLS AND OTHER DONATIVE TRANSFERS § 10.1 (2001); *accord* RESTATEMENT (THIRD) OF TRUSTS § 4 (2003).

[135] *See supra* text accompanying notes 48–49.

[136] ERISA is not the only field in which trust law principles have been employed for regulatory purposes. A variety of regulatory compliance trusts, found in federal and state law, are discussed in John H. Langbein, *The Secret Life of the Trust: The Trust As an Instrument of Commerce*, 107 YALE L.J. 165, 174–77 (1997).

[137] Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).

ERISA's protective purpose, the text of ERISA in fact contains provisions that strongly support the view that a plan's standard of review should be treated as a matter of mandatory rather than default law, and hence not subject to contrary plan drafting.

1. "[C]onsistent with the provisions of" ERISA.—Embedded in ERISA section 404, which imposes the core fiduciary duties of loyalty and prudence, is subsection 404(a)(1)(D), requiring plan instruments to be "consistent with the provisions of" ERISA.[138] In a case decided four years before *Bruch*, the Supreme Court interpreted this measure to mean "that trust documents cannot excuse trustees from their duties under ERISA, and that trust documents must generally be construed in light of ERISA's policies . . . ."[139] Especially because the opinion in *Bruch* invoked ERISA's protective purposes as the rationale for interpreting ERISA to require de novo review as the default standard, the question arises whether plan terms defeating de novo review are "consistent with the provisions of" ERISA.

Section 404(a)(1)(D) has been particularly significant in restraining plan drafters from overreaching in investment matters. For example, in the pension litigation arising from the collapse of Enron Corporation,[140] participants in plans funded in part with Enron stock contended that the plan fiduciaries who knew about the company's increasingly imperiled prospects had a duty to disregard plan terms requiring them to buy and retain the stock. In an amicus brief, the Department of Labor, which administers ERISA, emphasized the controlling importance of section 404(a)(1)(D). The Department argued that section 404(a)(1)(D) places plan fiduciaries under a duty "to ignore the terms of the plan document where those terms require[] them to act imprudently in violation of [the duty of prudent administration found in] ERISA § 404(a)(1)(B)."[141] Thus, "[e]ven if the plan document requires an investment, the fiduciaries must override it if it violates ERISA."[142]

This theme that ERISA's core fiduciary regime is mandatory rather than default law has found favor in the case law. The Fifth Circuit has said: "In case of a conflict [between ERISA duties and plan terms], the provisions of the ERISA policies as set forth in the statute and regulations prevail" over those of the plan.[143] In an employer stock plan case arising from

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[138] ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (2000).

[139] Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 568 (1985).

[140] *See In re* Enron Corp. Sec., Derivative & ERISA Litig., 284 F. Supp. 2d 511 (S.D. Tex. 2003).

[141] Amended Brief of the Secretary of Labor as Amicus Curiae Opposing the Motions to Dismiss at 30–31, *In re* Enron Corp. Securities, Derivative & ERISA Litigation, 284 F. Supp. 2d 511 (S.D. Tex. 2003) (No. 01-3913), 2002 WL 32913114.

[142] *Id.* at 32 (citing, among other authority, long-standing Department opinion letters, No. 90-05A, 1990 WL 172964, at *3 (Mar. 29, 1990); No. 83-6A, 1983 WL 22495, at *1–*2 (Jan. 24, 1983)).

[143] Laborers' Nat'l Pension Fund v. Northern Trust Quantitative Advisors, Inc., 173 F.3d 313, 322 (5th Cir. 1999) (holding that investment manager must disregard plan terms if investing plan assets as required by plan would violate its duty of prudence).

the insolvency of Polaroid Corporation, the district court refused to enforce a plan term that required the plan to invest in Polaroid stock. The court cited section 404(a)(1)(D) for the view that, "by force of statute, [the plan fiduciaries] had the fiduciary responsibility to disregard the Plan and eliminate Plan investments in Polaroid stock if the circumstances warranted."[144] Accordingly, "to the extent Polaroid stock was an imprudent investment, [the plan fiduciaries] possessed the authority as a matter of law to exclude Polaroid stock . . . [as an] investment alternative, regardless of the Plan's dictates."[145]

Similar issues arose in the takeover battles of the 1980s, in circumstances in which plan terms required fiduciaries to vote plan-owned shares of employer stock in a manner that appeared to contravene the duty of loyalty to plan participants. In the celebrated 1982 takeover contest involving Martin Marietta's offer for Bendix Corporation,[146] the Bendix plan contained a term prohibiting the trustee from tendering Bendix shares in a hostile tender offer. "When Martin Marietta announced its offer to purchase Bendix shares, however, [the trustee] decided that the risk of violating ERISA Section 404(a)(1)(D) by failing to tender the Bendix shares was so great that it had a duty to tender the shares in violation of the plan."[147] The courts sustained the trustee's position.[148] Department of Labor regulations now provide that when a plan investment manager (always a fiduciary under ERISA[149]) determines that complying with plan-dictated voting instructions would be "imprudent or not solely in the interest of plan participants, the investment manager would be required to ignore the voting policy that would violate ERISA § 404(a)(1)(D) in that instance."[150]

The message of these authorities is that ERISA fiduciary law as applied to investment matters is regulatory law, whose protective policy may not be defeated by self-serving plan terms. The view I am advancing is that ERISA's regime of judicial review of fiduciary decisionmaking of benefit denials ought similarly to be understood as beyond the reach of self-serving

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[144] *In re* Polaroid ERISA Litigation, 362 F. Supp. 2d 461, 474 (S.D.N.Y. 2005).

[145] *Id.* at 474–75. In another of the employer stock plan cases, concerning the Sears 401(k) plan, the district court sustained the plaintiff plan participants' claim that, under ERISA section 404(a)(1)(D), "'blindly following' the Plan provisions requiring matching contributions to be made in Sears stock would be imprudent, in violation of ERISA fiduciary duties, when the Investment Committee knew or should have known the price of the stock was fraudulently inflated." *In re* Sears Roebuck & Co. ERISA Litig., 32 E.B.C. 1699, 1704 (N.D. Ill. 2004).

[146] *See generally* PETER F. HARTZ, MERGER: THE EXCLUSIVE INSIDE STORY OF THE BENDIX–MARTIN MARIETTA TAKEOVER WAR (2000 ed.).

[147] *See* Edward A. Landry, *Fiduciary Responsibility Under ERISA in a Takeover Situation*, 12 PROB. NOTES 148, 151 (1986).

[148] *Id.*

[149] *See* ERISA § 3(38), 29 U.S.C. § 1002(38) (2000) (defining "investment manager" as fiduciary); *see also* ERISA § 3(21)(A)(i), 29 U.S.C. § 1002(21)(A)(i) (2000) (defining person who "exercises any authority or control respecting [plan] . . . assets" as fiduciary).

[150] Interpretive Bulletin 94-2, 29 C.F.R. § 2509.94–.92 (1994).

plan terms. Although the Supreme Court rightly observed that the "general principles of trust law"[151] inform much of ERISA, those principles must yield to ERISA's regulatory purpose "'to promote the interests of employees and their beneficiaries in employee benefit plans' . . . and 'to protect contractually defined benefits.'"[152] ERISA's protective policy, buttressed through section 404(a)(1)(D), should prevail over plan terms that abridge ERISA's fiduciary duties of loyalty and prudence. Plan terms cannot authorize plan fiduciaries to loot the plan or waste its assets. For the same reason, plan fiduciaries should not be allowed to abridge ERISA's de novo standard of judicial review of plan decisionmaking.

2. Forbidding Exculpation Clauses.—Beyond section 404(a)(1)(D), other provisions of ERISA support the view that Congress meant to limit the power of plan sponsors to impose self-serving terms. Whereas private trust law allows a settlor to insert an exculpation clause,[153] ERISA forbids it. Section 410(a) provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under [ERISA fiduciary law][154] shall be void as against public policy."[155] A plan term that defeats the otherwise applicable ERISA standard of nondeferential de novo review in favor of self-serving deferential review is in considerable tension with the prohibition on plan terms that relieve a fiduciary from its responsibility under ERISA. There is scant practical difference between a conventional exculpation clause and the language that Judge Posner "drafted and commend[ed] to employers" for taking advantage of their license to skew the standard of review under *Bruch*: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."[156]

3. "[F]ull and fair review."—Recall that ERISA requires a plan to have internal review procedures that "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair re-

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[151] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

[152] *Id.* at 113 (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983); Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985).

[153] RESTATEMENT (SECOND) OF TRUSTS § 222 (1959); UNIFORM TRUST CODE § 1008 (2000) (discussed in Langbein, *Mandatory Rules*, *supra* note 131, at 1123–25).

[154] The statutory term replaced in the brackets is "this part," a reference to Title I, Part 4, which contains ERISA's fiduciary provisions.

[155] ERISA § 410(a), 29 U.S.C. § 1110(a) (2000). The Solicitor General argued in an amicus brief in *Bruch* that, on account of this provision, "language in a plan document purporting to give biased administrators unbounded discretion to decide what the terms of the plan mean . . . would not be enforceable under ERISA." Brief for the United States as Amicus Curiae Supporting Respondents at *27 n.11, Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1988), 1988 U.S. S. Ct. Briefs LEXIS 1680. (I owe this reference to Donald Bogan.) The Court did not take notice of the point.

[156] Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000).

view by the appropriate named fiduciary of the decision denying the claim."[157] Plan terms lowering the standard of judicial review undermine the effectiveness of ERISA's requirement of fairness in internal proceedings, by making it so much harder to challenge unfairness. An egregious example of the tension between ERISA's requirement of "full and fair" review and contrary plan terms appears in dictum in a Fourth Circuit case in which the court remarked that it would enforce a plan whose "language provided that pain could never support a finding of disability."[158] In a Seventh Circuit case, Judge Posner, taking as his premise that *Bruch* allows a plan to "specify the degree of deference due the plan administrator's benefit determination," asked rhetorically: "Why can't [the plan] equally specify the procedures and rules of evidence, including presumptions, that the plan's administrator shall use to evaluate claims?"[159] The answer is that ERISA's requirement of "full and fair" internal review should be understood as mandatory law, preventing plan terms that impose unreasonable evidentiary standards.

C. Protective Principles from State Insurance Law

The Unum/Provident scandal has provoked a concerted movement among state insurance commissioners to forbid terms in insurance policies that alter the standard of judicial review.[160] The rationale for these interventions, in the words of the California provision, is that policy terms attempting to govern the standard of review deprive the insured of "the protections of California insurance law, including the covenant of good faith and fair dealing . . . ."[161] The influential National Association of Insurance Commissioners is encouraging the states to take this position.[162] The Hawaii Commissioner ruled in 2004 that "[a] 'discretionary clause' granting to a plan administrator discretionary authority so as to deprive the insured of a *de novo* appeal is an unfair or deceptive act or practice in the business of insur-

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[157] ERISA § 503(2), 29 U.S.C. § 1133(2) (2000).

[158] Smith v. Cont'l Cas. Co., 369 F.3d 412, 420 (4th Cir. 2004).

[159] Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 917 (7th Cir. 2003).

[160] *See* Henry Quillen, *State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans*, J. PENSION PLANNING & COMPLIANCE, Summer 2006, at 67. Bad-faith claims denial is a longstanding subject of state insurance regulatory concern. The field has its own treatise: STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES (2d ed. 1997 & Supp.).

[161] Gary M. Cohen, General Counsel, California Department of Insurance, to Teresa S. Renaker, Esq., "Letter Opinion per [California Insurance Code] § 12921.9: Discretionary Clauses" (Feb. 26, 2004), *noted in* 11 ERISA Litigation Rptr. 10.

[162] Quillen recounts NAIC's deliberations and recommendations in Quillen, *supra* note 160, at 71–73. He reprints the 2004 version of the NAIC's model act prohibiting discretionary clauses, together with a 2003 NAIC staff memorandum arguing that the act would escape ERISA preemption. *Id.* at 83–88. The NAIC's intervention is further discussed in Donald T. Bogan, *ERISA: State Regulation of Insured Plans after* Davila, 38 J. MARSHALL L. REV. 693, 740 (2005); Peter A. Meyers, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925, 936 (2005).

ance and may not be used in health insurance contracts or plans in Hawaii."[163] At that time such clauses were "prohibited by statute in Maine and Minnesota, and by Insurance Commissions in California, Illinois, Indiana, Montana, Nevada, New Jersey, Oregon, Texas, and Utah."[164] In 2005, the Illinois regulations were further amended to forbid health or disability insurance contracts from "contain[ing] a provision purporting to reserve discretion to the [insurer] to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of th[e] State."[165]

The question of whether such regulations, as applied to ERISA plans, will survive ERISA's preemption clause[166] (under its exception for state insurance regulation[167]) awaits resolution. As part of Unum's October 2005 settlement with the California regulators, the company agreed to cease using discretionary review clauses in insurance policies sold in that state.[168]

The principle that underlies the insurance commissioners' initiative bears importantly on the question whether ERISA should continue to facilitate plan-dictated standard-of-review clauses. The commissioners contend that allowing an insurance policy to skew the standard of review against the insured interferes with the protective purpose of insurance regulatory law. Similarly, the view developed in this Essay is that allowing ERISA plan drafters to dictate the standard of judicial review of benefit denials undermines the regulatory purposes of ERISA. In the insurance commissioners' initiative against such plan terms there is a further demonstration that when conscientious policymakers think carefully about the issue, rather than toss it off in a hasty aside as the Supreme Court did in *Bruch*, they conclude that

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[163] State of Hawaii, Ins. Div., Memorandum 2004-13H, at 3 (Dec. 8, 2004), *available at* http://www.hawaii.gov/dcca/areas/ins/commissioners_memo/ins_commissioners_memorandum_13H.pdf. (I owe this reference to Mary Ellen Signorille.)

[164] *Id.* at 2.

[165] 50 ILL. ADMIN. CODE § 2001.3 (2005).

[166] ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

[167] ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (2000). The Supreme Court has "repeatedly held that state laws mandating insurance contract terms are saved from preemption under" ERISA's insurance saving clause. Unum Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 375 (1999) (citing Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 758 (1985)); FMC Corp. v. Holliday, 498 U.S. 52, 64 (1990). In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002), the Court sustained as appropriate state insurance regulation an Illinois statute that "undeniably eliminates whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials . . . ." However, in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 50 (1987), the Court held that Mississippi's state-law cause of action for bad faith in claims processing sounded in tort or contract law rather than insurance and was not therefore protected from preemption under the exception for insurance regulation.

[168] Cal. Settlement Agreement, *supra* note 34, at 13 (cited in Quillen, *supra* note 160, at 79). For a recent ERISA disability plan case reversing Unum's benefit denial under a policy whose terms did not attempt to alter the standard of review, see Silver v. Executive Car Leasing Long-Term Disability Plan, 457 F.3d 982, 986 (9th Cir. 2006).

the standard of review of benefit denials ought not to be subject to self-serving alteration.

CONCLUSION

The Supreme Court in *Bruch* rightly interpreted ERISA to require non-deferential de novo review of plan decisionmaking, but in an ill-considered aside the Court allowed plan drafters to defeat that standard by requiring reviewing courts to defer to plan decisionmaking. The Unum/Provident scandal, by underscoring the dangers that arise when conflicted decisionmakers deny claimed benefits, demonstrates that impartial judicial review in such cases is an essential safeguard against self-serving conduct.

The analogy to trust law on which the Court rested this branch of its decision in *Bruch* is unsound. Although the drafter of a private trust may indeed insist on greater judicial deference to trustee decisionmaking, the courts grant that deference on the premise that the purpose of trust law is to give maximum effect to the wishes of the transferor—that is, to private autonomy. In ERISA, by contrast, Congress employed trust law concepts for regulatory purposes, in order to limit private autonomy. Accordingly, the analogy to "general principles of trust law" on which the Court based its decision to allow plan drafters to defeat the otherwise applicable ERISA standard of review is a misapplication of trust law. When trust principles are transposed to regulatory purposes, as in ERISA, those purposes alter the normal balance in trust law between default and mandatory law. Like ERISA's substantive fiduciary norms of loyalty and prudence, ERISA's provision for judicial review of plan decisionmaking has an essentially protective purpose. Congress did not allow employers and other plan sponsors the option to decline to be subject to ERISA fiduciary law. For much the same reason, the Supreme Court was wrong to assume that ERISA meant to allow plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested benefit denial cases. The Court (or Congress[169]) ought to learn from the Unum/Provident scandal and correct the mistake in *Bruch* before more ERISA plan participants and beneficiaries are victimized by more bad-faith benefit denials.

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[169] Judge Becker suggested that Congress "consider amending ERISA to require more stringent review where an employer acts as its own plan administrator." Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40, 45–46 n.5 (3d Cir. 1993). Former Senator Robert Dole (R-Kansas) proposed such a measure shortly after the decision in *Bruch*. *See* S. 3267, 101st Cong. (2d Sess. 1990). The bill would have amended ERISA to provide that in any civil action under § 502(a)(1)(B), "if the action involves a matter previously decided by a named fiduciary who has a significant interest which would be adversely affected by a decision in favor of the participant or beneficiary, the court shall review the decision of the fiduciary without according any deference to any findings or conclusions of such fiduciary."

— Tab 10 —

September 15, 2007

Senator Byron Dorgan
Chairman
Senate Commerce, Science and Transportation Committee
Subcommittee on Interstate Commerce, Trade and Tourism
Washington, D.C. 20510

Dear Senator Dorgan:

My name is Delvin Williams and I am a retired professional football player. In connection with the hearings of the Senate Committee on Commerce, Science and Transportation Committee (the "Committee") on the administration of the Bert Bell - Pete Rozelle NFL Player Retirement Plan (the "Plan"), I wish to share my experience and the experience of other professional football players who are or were participants in the Plan.

Before I begin, I would like to thank you and the other members of the Committee and the other members of the Senate and of the House of Representatives for reviewing the plight of many disabled professional football players and providing a public forum for the retired disabled players of the National Football League ("NFL") to be heard.

I also wish to extend special thanks to Bruce Laird, Bernie Parish, Coach Mike Ditka, Harry Carson, and all the other coaches and players who have shared their experiences with the Plan and its administrators and law firm, with dignity and resolve. It is my hope that their efforts will ensure that the rights of other retired football players will be protected

I. Background

I played eight years as a running back in the National Football League. I was drafted by the San Francisco 49ers in 1974. I spent four years with the 49ers, three years with the Miami Dolphins and finished my professional football career with the Green Bay Packers. In 2000, I was nominated for consideration for the National Football League Hall of Fame.

After eight years, six surgeries, two concussions, broken ribs, a dislocated thumb, knee injuries and spinal injuries, as well as numerous other joint and vertebrae injuries, my professional football career ended in 1981, when I was released by the Green Bay Packers.

I understand that I am one of approximately 317 of 8000 retired NFL Players who receive football degenerative disability benefits. However, it did not come without a fight and a test in persistence. I started the application process in 1983 and was awarded a football degenerative disability benefit in July of 1995. In twelve years, I was turned down twice and lost an arbitration before I was awarded a disability pension benefit.

Many people believe that the retired football players do not need protection for their pension rights because they had made large amounts of money and have the National Football Players Union (the "Union") to protect their rights. They would be mistaken. Many of the football players in the 1970s and 1980s did not make more than $40,000 per year. Many of them have suffered life-long paralyzing or pain-causing disabilities and have been forced to live on a basic pension of less than $1,200 per month (which is less than the federal poverty level).

These same disabled football players helped build the National Football League (the "League") into a multi-billion dollar industry that continues to grow as a result of its anti-competitive practices that are permitted under current law. Those same anti-competitive practices have helped to permit the owners of the teams in the League with the cooperation of the Union to become wealthier and to disregard the plight of the former football players who built the League.

II. My Experiences with the Plan

A. The Plan was Amended to Provide for a New Disability Pension Benefit on September 30, 1993

In response to a court decision against the Plan, the Plan was amended effective September 30, 1993, by the Management Council (which represents the owners of the teams of the League) and the Union to provide for a new disability retirement benefits for vested players who become disabled from football activities (including from cumulative injuries rather than from a single event) prior to the later of age 45 or 12 years after their last credited season with the League.

Under Section 5.2 of the Plan, to qualify for the new disability benefit, a retired player need only show that he is "substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit." The Plan does not require the individual to be unemployed or unable to work – only that he is "substantially prevented or unable to" work. For that purpose, the Retirement Board of the Plan, which was appointed by the Management Council and the Union to administer the Plan, relied on the opinion of physicians selected by the Retirement Board.

The new pension benefit provided for a monthly benefit of $4,000 per month. A separate disability plan provided an additional, temporary disability insurance benefit, which is expected be terminated. Without the new monthly benefit, many disabled retired players might only qualify for a pension of only $1,200 or less per month.

B. The Retirement Board Breached Its Legal Duty to Notify Participants in the Plan of the New Disability Benefit on a Timely Basis and Denied the Benefit Claims of Participants

It is my understanding that under Section 104 of the federal Employee Retirement Income Security Act ("ERISA"), the Retirement Board was required to distribute information regarding the new disability benefit in a summary of material modification or an amended summary plan description not later than October 31, 1994. However, the Retirement Board did not distribute an amended summary plan description until sometime in November 1995 -- *more than two years after the Plan was amended and more than one year of the time that the Retirement Board was required by Section 104 of ERISA to distribute the amended summary plan description.*

As a result, the Retirement Board denied the benefit claims of individuals who had reached age 45 or for whom 12 years expired since their last credited season during the two-year delay by the Retirement Board. Consequently, many disabled retired players were not notified of the new disability benefits under the Plan until up to one year after they were required to be notified and two years after the Plan was amended, causing them to miss the deadline to establish their right to benefits.

C. The Retirement Board Denied My Claim for Retroactive Disability Benefits Even Though the Plan's Physician Found that I Was Entitled to the Disability Benefits

The Plan states that, "Notwithstanding the above, all benefits provided by this article will be retroactive to the later of (a) the first of the month following the date of the total and permanent disability, or (b) July 1, 1993, and will be payable for life or until cessation of such total and permanent disability."

In Spring of 1995, I contacted the staff of the Retirement Board to inquire as to my pension rights. Only at that time was I notified of the new disability pension benefit. I applied for and was granted the new disability pension benefit under the Plan on July 20, 1995, effective August 1, 1995, based on the opinion of the Plan's physician, Kevin Harrington, M.D., of San Francisco, that found that I was "substantially prevented" or "substantially unable to engage in a profession" as a result of a disability from football activities. At the time that I had applied for the benefit, I was employed. Dr. Harrington nonetheless found that I was sufficiently disabled to qualify for the disability benefit.

After being approved for the total and permanent disability benefits, I requested that my disability benefits be provided retroactive to July 1, 1993, based on the above provision of the Plan. In support of my request, I provided a new report by the Plan's designated physician, Dr. Harrington, who confirmed that based on the severity and nature of my disabilities; I had been sufficiently disabled prior to July 1, 1993, so as to qualify for the new disability benefit on July 1, 1993.

The Retirement Board ignored its own doctor's report and denied my claim for retroactive benefits for any period prior to August 1, 1995, because I had not submitted my application earlier. Had I submitted an application at any time after July 1, 1993, I would have been entitled to the retroactive disability benefit based on Dr. Harrington's opinion. However, the Retirement Board did not notify participants of the new disability pension benefit until November of 1995.

After exhausting the claims procedures of the Plan, I filed a lawsuit in 1997 to recover my entitled retroactive benefits. The District Court Judge awarded me my retroactive benefits. However, six years and $30,000 in legal fees later, I lost on appeal in the Ninth Circuit Court of Appeals based on the case law under ERISA which gives deference to the decisions of plan administrators notwithstanding that the Retirement Board did not give me timely notice of the new disability benefits.

To add insult to injury, the Retirement Board sought to recover attorney fees from me and succeeded. The Retirement Board demanded that I pay its legal fees and court costs of $108,897. At that time the Plan had net assets in excess of $600,000,000. It is unheard of to ask a pension plan participant to pay attorney fees based on the breach of duties of the plan's administrator. However, I believe the $108,897 demand was intended to punish me and to give a warning for other Plan participants not to sue for their benefits.

The District Court Judge awarded the Retirement Board $75,000.00 to be paid in the amount of $625 per month until 2014. Thus, my monthly disability payments were reduced to pay the Retirement Board's legal fees resulting from its failure to comply with its legal obligations under ERISA.

The total legal fees paid to the Plan's attorneys for my case alone was over $1,200,000. The Retirement Board asked for over $100,000 in attorney fees in my case. One can only wonder how much of the funds were used to defeat a beneficiary's claim. Between 1998 and 2003 $1,200,000 would have saved some of the lives of other disabled retired players.

III. Other Retired Disabled Players

I will survive, but I feel the unfair treatment being delivered to other disabled players less fortunate than I cries out to be corrected. Many of these individuals are suffering from debilitating injuries, post-traumatic stress, and dementia after sacrificing their bodies and minds for the League.

My late friend, Neil Colzie, who played for the Miami Dolphins during the 1980s, was denied a disability pension benefit for heart, knee and back problems because the Plan's doctor thought that there must be work that he could work while on his back.

Another friend, Randy Beisler, who played for the San Francisco 49ers during the 1970s, suffered multiple head and neck trauma during his professional football career. As a

result, he will sometimes become paralyzed when he turns his head and he will not know if the paralysis will end. He was denied his disability pension benefit because the Retirement Board did not accept the opinion of the Plan's own physician that given the severity and nature of his disability that he was disabled before age 45. Moreover, the Retirement Board hired a private investigator to invade Mr. Beisler's privacy to provide a report on Mr. Beisler's work activities even though Mr. Beisler had given complete information on his employment, which goes beyond normal plan administration. He needed to be employed to some degree to survive. They used that fact to deny him his benefit.

There are other retired players who are not as fortunate as I am. There are many of them who are too injured to work and some cannot even get around, such as Conrad Dobler, Willie Wood, Brent Boyd, Curt Marsh, Vic Washington, and Richard Woods. Some are so financially devastated they are literally living and dying on the streets or supported by the rest of our society, while the owners of the League with the cooperation of the Union have become richer.

IV. Who Pays the Price for the Growing Wealth of the Owners of the League?

The Executive Director of the Union, Gene Upshaw, and the League point out that they have established a medical fund to cover current or recent players. To Mr. Upshaw and the League, I say that they have not done enough. The plan does not apply to older, disabled players such as myself who must pay for expensive health care coverage like many other unemployed Americans. And, Mr. Upshaw and the League were honest, the modest medical plan would only be a drop compared to the ocean of medical bills and heartbreak that the disabled retired players and their families must bear. Many of these disabled retired players cannot find other employment and medical coverage.

With the cooperation of Mr. Upshaw and the Union, the League has become wealthier without providing for the medical needs and lifetime disabilities of the retired players.

Before the current players dismiss the plight of the disabled retired players, they should also consider that they are possibly one play away from being disabled and likely will suffer a lifetime of pain and disability after their careers end, including from concussions, arthritis, orthopedic and neurological disabilities.

The disabled retired players and I greatly appreciate the support we have received from the American public. The American public has done so even if it did know how much it has been paying for the growth and wealth of the billionaire owners of the League. The American public has made the billionaires wealthier by purchasing game tickets, paying to watch games on cable television, purchasing team merchandise and paying advertising on television.

Many of the players have had to resort to the welfare system and the Social Security system to survive. They have had to resort to the Medicare and Medicaid systems for

health care costs. They have had to resort to our national health care system including the un-reimbursed public hospitals for urgent health care. Yes, we have all subsidized the growing wealth of the billionaire owners of the league in money and lives.

The league and the owners and the union must be required to provide and pay for long-term care and medical care for the disabled retired players. The league and the owners and the union must be required to ensure that the Plan be administered fairly and non-discriminatorily to provide the benefits that it was intended to provide. The Retirement Board and its staff must be held accountable for how they administer the Plan and to avoid the conflicts of interests that have resulted in the shameful treatment of the disabled retired players.

V. Specific Problems with the Administration of the Plan and the Laws in which It Operates

There have been many serious problems with the administration of the Plan and the laws that apply to the Plan.

A. Problems in the Administration

1. There is a clear record of the Retirement Board and its staff of their efforts to deny valid benefit rights of benefits to retired disabled players under the Bert Bell – Pete Rozelle NFL Retirement Plan (the "Plan"), with tragic results for many severely disabled retired players who helped to build the National Football League into a multi-billion dollar business.

2. The League is a multi-billion dollar business that has grown through its anti-competitive practices with the cooperation of the NFL Players Union (the "Union"). The actions and practices have been allowed to continue because of weaknesses in the Employee Retirement Income Security Act, which is the federal employee benefits law that regulates employee benefit plans including the Plan, and the federal Labor Management Relations Act, which regulates collective bargaining. Those weaknesses need to be addressed as discussed below.

3. There is a clear record of inconsistencies and arbitrary decisions in the administration of the disability retirement benefits under the Plan, with tragic consequences for many disabled retired players.

4. Many severely disabled retired players have had their valid disability benefit claims denied because there is no objective oversight over the actions of the Retirement Board and its staff and the members of the Retirement Board have inherent conflict of interests in their service to the participants in the Plan.

(a) Representatives on the Retirement Board who are appointed by the owners of the NFL teams recognize that denying benefits to the disabled retired players will minimize future contributions to the Plan by the NFL teams.

(b) Representatives on the Retirement Board that were appointed by the Union, have been agents of active players who do not represent retired players. If the executives of the union are more concerned with the active players who re-elect them as executives, they may not look out for the best interests of the disabled retired players. If those Union representatives are more concerned with the pay for the active players, they will also recognize that denying benefits to the disabled retired players will minimize current and future payments for their clients.

5. While the Executive Director of the Union points out that the Union has negotiated new benefits for retired players even though he does not represent them and that the active union employees have "subsidized" those benefits, he neglects to point out that the benefits are, in fact, also for the benefits of the current players and once those benefits are established that the Union has moral and legal obligation to ensure that the benefits are administered objectively and uniformly. That has not happened.

6. The Retirement Board and its staff have breached their fiduciary duties under the ERISA law.

(a) Under the ERISA law, the Retirement Board and its staff are required to act uniformly and not in an arbitrary and capricious basis in administering the Plan. They are required by Section 404(a) of ERISA to act in the best interests of the participants in the Plan to provide them benefits or to pay reasonable administrative expenses of the Plan.

(b) The Retirement Board and its staff have violated their legal obligation under ERISA to notify Plan participants on a timely basis of their rights under the Plan, and they have use that breach to deny disabled retired players their right to benefits under the Plan. The Retirement Board and its staff failed to notify participants of their rights to a new disability benefit under the Plan more than one year after the ERISA law required the Retirement Board to give notice of the benefits. Given the time deadlines to apply for the benefits, the delay denied many disabled retired players to received the benefits they are entitled to.

(c) The Retirement Board and its staff have not published or prescribed rules or standards for the determination of who should be eligible to receive retirement benefits under the Plan, leaving participants to guess what is required to be eligible for benefits under the Plan.

(d) The Retirement Board and its staff have acted arbitrarily and capriciously in establishing ad hoc rules for eligibility for the plan, with the effect of denying benefits to participants who are severely disabled. The Retirement Board and its staff have not applied the conditions for benefits uniformly throughout the United States. The Retirement Board and its staff rely on the opinions of the many physicians they have

selected throughout the United States without providing uniform guidance on how to apply the terms of the Plan.

(e) Yet, when the Retirement Board and its staff did not want to pay benefits, they would disregard the medical opinion of their own selected physicians. That happened in my case.

(f) The Retirement Board and its staff have engaged in what can only be considered to be a campaign to prevent retired players from getting disability retirement benefits. In one case, the Retirement Board and its staff hired a private investigator to follow my friend, Randall Beisler, who had applied for a disability benefit which is unheard of in ERISA benefit cases. The private investigator, I am told, is a friend of Gene Upshaw. I was told by Mr. Beisler that the investigator misrepresented to Mr. Beisler's daughter that he was "helping" Mr. Beisler when he, in fact, was assisting the Plan in attempting to deny benefits to the retired player.

(g) The Retirement Board has paid millions of dollars to its primary outside law firm, The Groom Law Firm, and the law firms throughout the United States selected by the Groom Law Firm, to help deny the valid benefit claims of disabled retired players. In the past 5 years, the Retirement Board has paid over $5,000,000 to the Groom Law Firm. When the Groom Law Firm fought my claim for $160,000 for retroactive pension benefits because the Retirement Board had not given notice of the new disability pension benefit under plan over one year past the date they were required to give notice, the law firm represented that it had incurred over $1,200,000 to fight my claim and wanted me to pay the claim. The court required me to pay $75,000 of the law firm's legal fees.

B. Problems with Applicable Laws

1. ERISA law gives excessive deference to plan administrator, which protects actions of the Retirement Board and the staff and lawyers of the Retirement Board. As a result of the deference, the Retirement Board has prevailed in almost all of its lawsuits on legal technicalities rather than on the medical conditions of the disabled retired players.

2. There is no practical oversight over the actions of the Retirement Board and its staff because of the deference given under the ERISA law.

3. Under current federal labor laws, the Union is only obligated to represent and protect the interests of active employees. Accordingly, the Union and the Management Council of the League have not looked to protect the interests of the retired players. Instead, they have focused on the interests of the active players.

4. Once the Union and the League establish the new disability benefits, they have, in my opinion, a moral duty, and legally a fiduciary duty under ERISA to ensure that the benefits are made available fairly to eligible retirees. Unfortunately, there is not sufficient representation on the Retirement Board who has an interest in looking out for the

interests of the disabled retired players or to ensure that benefits are provided uniformly and objectively and not in an arbitrary and capricious basis. There are inherent conflicts of interests of members of Retirement Board in favor of the owners of the NFL teams and the active players.

5. There have not been any consequences to the members of the Retirement Board and its staff for their violations of their fiduciary and administrative obligations under ERISA. For example, the Retirement Board should have been held accountable for not notifying retired players of changes to the Plan on a timely basis.

6. The Retirement Board and its staff have not been required to prescribe, publish or adhere to objective standards for determining the eligibility for benefits under the Plan.

7. Some states, such as Florida, do not extend workers compensation protection to professional athletes, which leaves the injured players to rely solely on their Union to provide adequate protection for them when they become injured. The Union and the League have provided for a long-term disability plan but is conditioned upon the injured players qualifying for a disability pension benefit under the Plan. Given how the Plan as been administered, many injured players have no real long-term disability protection.

8. Health care is a national issue and the League, and other employers in high risk industries, should be required by Congress to pay for medical insurance for its players. The retired players and our society are subsidizing the billionaires in the League, with the cooperation of the Union, through the public welfare system, the Social Security system, the Medicare System and the Medicaid system.

VI. Closing Remarks

I wanted to use my case to illustrate how unfair the Plan and the current laws are to disabled players and to provide hope for those who are still fighting. I wanted to use my case to explain to the Senate and the Congress who are really for paying for the growing wealth of the owners of League with the cooperation of the Union. I am thankful to the Committee for giving me the opportunity to share my case.

One of the things that we as football players have learned is to never quit and never give up. We have all learned that if we do that, we will always be in a position to win, we will have a chance to win, and that something good will happen. That is what the benefit represents for me, and should be the same for all disabled players.

Were the Committee to be able to bring some measure of fairness to the relationship between the League and retired disabled football players and correct the problems with the laws, you would deserve and have our life-long thanks.

Respectfully,

Delvin Williams, Jr.

CC: Members and Staff of the Senate Commerce Committee

— Tab 11 —

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*CHAIR, NYS TRAUMATIC BRAIN INJURY SERVICES COORDINATING COUNCIL

December 6, 2007

Mike Ditka
The Ditka Corporation
11 Warrington Place
Lake Forest, IL 60045

Dear Mr. Ditka:

Thank you for requesting my opinions in regard to reforming the National Football Leagues Player Disability Program.

As you know, as the three term president of the Brain Injury Association of New York State and the current chair of the New York State Traumatic Brain Injury Services Coordinating Council, a council created by the New York State legislature to provide advice and recommendations to the Commissioner of Health on all matters affecting traumatic brain injury, I am deeply committed to assisting those who suffer from the life long consequences of brain damage.

My professional career is focused on providing legal representation to victims of brain trauma. I have served as Chair of the Traumatic Brain Injury Litigation Group of the American Association for Justice (formerly Association of Trial Lawyers of America) and have been an invited speaker at brain injury medical, legal and professional conferences throughout the United States as well as internationally. I am enclosing my CV for your reference.

Because of my expertise in cases involving traumatic brain injury, I have been asked to review negative determinations made by the NFL disability plan. In each of these cases, I was shocked to see that the league denied a player disability benefits despite overwhelming evidence that the player sustained a brain injury, was still suffering from the effects of the injury and was indeed permanently disabled.

In short, the NFL disability determination process unfairly evaluates the traumatic brain injury claims submitted to them and is insulated from review because existing Federal ERISA law as interpreted by the circuit courts of appeal.

Despite overwhelming evidence of traumatic brain damage submitted by a player's treating medical team including neurologists, physiatrists, neuropsychologists and other health care professionals, the plan has unfairly denied disability benefits to these individuals.

The plan hides behind ERISA preemption which gives them unfettered discretion to rely upon ANY medical opinion that they choose. Even in light of overwhelming evidence of brain damage and even opinions from their own experts who have agreed with a player's treating medical team, the league will continue to seek out opinions from their paid consultants who conclude that either no injury occurred, that the injury has resolved or that the plan does not meet the almost impossible criteria and definition of permanent injury.

The league's paid consultants shockingly even ignore current accepted medical literature which clearly states that traumatic brain injury with lasting and permanent repercussions can exist despite no loss of consciousness at the time of original injury; that CT scans and MRI scans are negative; that an individual's symptoms developed over time and that the consequences of brain injury include not only physical injury but emotional and social damage as well.

The purported examinations are superficial and fail to use accepted testing protocols for the evaluation of cognitive dysfunction.

These so called "experts" even have ignore statements made by the Centers for Disease Control and the National Institute of Health's consensus conference on Traumatic Brain Injury.

The NFL plan needs to be held accountable for their decisions. Fundamental fairness and established principles of due process must be applied to league determinations. The league cannot be permitted to go out and retain the best "experts" that money can buy. They cannot be permitted to ignore or disregard overwhelming evidence of brain damage in favor of opinions that do not meet established principals of medical science with impunity.

The virtual immunity provided to the plan under the ERISA law must be amended to provide for a de novo review in the United States District Court similar to the procedure in Social Security disability determinations.

The evidentiary standard must be changed to mirror that of social security determinations where greater weight is placed upon the opinions of treating medical providers.

Opportunity must be given to players to cross examine the opinions of the leagues paid consultants.

It would be helpful for both league disability determinations and important decisions regarding return to play after a concussion has taken place to obtain a neuropsychological profile of a player at the beginning of each season. In his way, a players cognitive status can be accurately determined. Simple and easily administered testing is now available and widely used which would accomplish this goal. This testing must be made mandatory.

Information in understandable form must be provided to players and their families concerning the application and appeals process.

As you know from our conversations, I am also deeply troubled by the manner in which individual teams handle concussions and return to play determinations. In the past teams have not only placed their player's in danger of further injury because of inappropriate decisions made on as well as off the field but have set the wrong example for high school players and intercollegiate athletes.

The best cure for brain injury is prevention. Players and their families must be provided with information concerning the signs and symptoms of concussion and the post concussion syndrome. They must be given proper information about the dangers in ignoring these symptoms and the impact that further concussions can have on them for the remainder of their life. It is not enough to provide this information to the player who may not be in the best position to either accept the information provided or because of injury, not be able to fully comprehend the information. For this reason, spouses and family members must also be provided with check lists and other useful information.

Strict and uniform standards must be established to prevent further brain injury from occurring when a concussion or a suspected concussion takes place. These include an absolute prohibition from returning to play during the game in which the injury took place, requirements for cognitive evaluation before a player can be cleared to return to play and pre season base line evaluations.

Thank you for allowing me to assist you and the NFL retirees. I look forward to working with you on these important issues now and in the future. Please do not hesitate to contact me in regard to this or any other issue regarding traumatic brain injury and the health and safety of the player's.

With kind personal regards,

Very truly yours,

MICHAEL V. KAPLEN

MVK/df

— Tab 12 —

"THE BOYD PLAN"
STEPS TOWARD FIXING THE NFL DISABILITY "PROCESS"
BY BRENT BOYD
AUGUST 6, 2007

IN RESPONSE TO CHAIRWOMAN LINDA SANCHEZ' WRITTEN FOLLOW UP QUESTION RELATED TO JUNE 26TH, 2007

"HEARING ON THE NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?"

SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON THE JUDICIARY

THE QUESTION FROM CHAIRWOMAN SANCHEZ WAS:

"HAVING GONE THROUGH THE NFL'S RETIREMENT PROCESS AND SEEING HOW OTHER PLAYERS HAVE BEEN TREATED BY THE SYSTEM, HOW CAN THE NFL RETIREMENT PROCESS BE IMPROVED?"

My answer follows:

"THE BOYD PLAN"

BRIEF OUTLINE:

1) FIRE GROOM LAW – THERE CAN AND WILL BE NO TRUST UNTIL GROOM IS REPLACED. GROOM LAW IS A SYMBOL OF YEARS OF TOO MANY UNFAIR DECISIONS, QUESTIONABLE TACTICS, DOCTOR SHOPPING, NEEDLESS SUFFERING, NEEDLESS HOMELESSNESS, NEEDLESS DEATHS, NEEDLESS SUICIDES – GROOM LAW MUST GO BEFORE ANY HEALING BEGINS!

2) ELIMINATE THE "FULL DISCRETION" WORDING OR IMPLICATION IN OUR PLAN; INVESTIGATE ETIOLOGY OF "FULL DICRETION" INTO OUR PLAN; FULL DISCRETION EQUALS ABSOLUTE POWER; ABSOLUTE POWER CORRUPTS – AND PREDICATABLY WE HAVE SEEN THAT ABUSE AS THE OUTCOME OF ALLOWING FULL DISCRETION TO NFL DISABILITY BOARD. WE NEED CHECKS AND BALANCES.

3) DEFINE THE PLAN'S DEFINITION OF "DISABILITY" IN TERMS SET IN STONE AND EASILY UNDERSTOOD BY ALL, IN DEFINITIVE TERMS THAT WILL BE EASILY INTERPRETED THE SAME WAY BY PLAYERS, THE BOARD AND EVERY COURT - NOT OPEN TO GROOM'S MANIPULATION (FULL DISCRETION – AND GROOM - WILL BE GONE SO THAT WILL HELP) AND REMAKE THIS NEW DEFINITION OF DISABILITY SO THAT IT IS NOT SO OVERWHELMINGLY PROHIBITIVE TO APPROVAL OF CLAIM – DON'T CONTINUE WITH GROOM'S EVER CHANGING AND IMPOSSIBLE TO MEET DEFINITION.

CURRENT UNWRITTEN BUT STRICTLY ADHERED TO DEFINITIONS OF DISABILITY INCLUDE THE INFAMOUS "CAN HE SELL PENCILS ON THE STREET CORNER" QUOTE OR "WASH WINDSHIELDS" CRITERIA , WHICH ARE OBSCENE AND MUST BE ELIMINATED ALONG WITH ALL THOSE WHO SUPPORT THESE

DRACONIAN STANDARDS. THE MEN WHO BUILT THIS MULTI-BILLION DOLLAR LEAGUE DESERVE DIGNITY IF NOT WEALTH.

AND ELIMINATE THE "15 YEARS AFTER PLAYING" LIMIT FOR FULL BENEFITS, MOST DISABILITIES DON'T DEGENERATE INTO FULL DISABILITIES UNTIL LONG AFTER THAT PERIOD. IT IS WHEN GUYS ENTER THEIR 50'S AND BEYOND THAT THESE DISABILITIES BECOME DEBILITATING AND THEY CAN'T LIVE ON THE LESSER BENEFIT AMOUNT... AND REMEMBER, OSHA SAYS NFL LINEMEN LIFE EXPECTANCY IS 52 YEARS.

4) ENSURE TRANSPARENCY – SHINE THE LIGHT! PRINT THE MINUTES OF BOARD MEETINGS, RECORD ALL DEBATES, REPORT EACH VOTE – ALLOW CONGRESSIONAL REPRESENTATIVES TO SIT IN ON ANY MEETING AT WILL. THE NFL DISABILITY BOARD SHALL NO LONGER ACT AS A SECRET MEDIEVAL ORGANIZATION.

5) TREATING PHYSICIAN RULE- GIVE MORE WEIGHT TO OUR OWN DOCTORS WHO TREAT US REGULARLY FOR YEARS THAN IS GIVEN TO OPPOSING DOCTORS WHO SEE US FOR 30 MINUTES. REIMBURSE THE PLAN FOR ALL FEES PAID TO GROOM LAW WHEN THEY COVERTLY HELPED REMOVE TREATING PHYSICIAN RULE FROM ERISA – BY JOINING NON-FOOTBALL RELATED COURT CASES (e.g., Nord v Black & Decker in Supreme Court) THOSE FEES PAID TO GROOM WERE TAKEN OUT OF OUR OWN PENSION FUNDS - USING OUR OWN MONEY TO TAKE OUR OWN RIGHTS AWAY, ALL WITHOUT OUR KNOWLEDGE!

6) IF NFL'S OWN CHOSEN PHYSICIANS AGREE WITH A PLAYER'S CLAIM, SO SHOULD THE DISABILITY BOARD.

DOCTOR SHOPPING CARRIES "DEATH PENALTY" – SIMILAR TO NCAA FOOTBALL PROGRAMS IN VIOLATION OF CERTAIN RULES - OR GAMBLING IN NFL –

IF NFL'S OWN CHOSEN DOCTOR AGREES WITH PLAYER'S CLAIMS, NO MORE IGNORING THAT DOCTOR AND SENDING

PLAYERS TO ENDLESS DOCTORS UNTIL FINALLY ONE SUPPORTS DENIAL. IF BOARD CLAIMS A DOCTOR TO BE "EQUIVOCAL', SIMPLY PICK UP PHONE AND CLARIFY INSTEAD OF DELAYING FOR MONTHS AND DOCTOR SHOPPING.

ANY KNOWLEDGE OF OR CONNECTION WITH DOCTOR SHOPPING OR FRAUDULENTLY DENYING A PLAYER HIS RIGHTFUL BENEFITS WILL RESULT IN NO FURTHER ASSOCIATION WITH NFL IN ANY CAPACITY, EVER –THIS MUST BE CONSIDERED A SACRED INTOLERABLE OFFENSE!

7) LET RETIRED PLAYERS SELECT OUR OWN 3 ADVOCATES TO THE BOARD, NOT SELECTED BY NFLPA EXECUTIVE DIRECTOR. REPLACE ALL EXISTING BOARD MEMBERS. ACTIVE PLAYERS' AGENTS AND ACTUAL OR DE FACTO EMPLOYEES OF NFL ARE NOT ACCEPTABLE AS PLAYERS REPS BOARD MEMBERS, THEY HAVE BLATANT CONFLICT OF INTEREST.

DESTROY THE LONGSTANDING MENTALITY OF BOARD THAT DEFINES "FIDUCIARY DUTIES" TO MEAN ONLY TO PROTECT THE "POT OF MONEY". PLAYERS RIGHTS AND DISABLED PLAYERS RECEIVING THEIR RIGHTFUL BENEFITS HAVE EQUAL OR GREATER WEIGHT TO THE FIDUCIARIES AS DOES THE "POT OF MONEY".

THE BOARD MUST LOOK EQUALLY AS HARD FOR REASONS TO APPROVE A CLAIM AS THEY LOOK FOR REASON TO DENY A CLAIM. "FIDUCIARY DUTIES" DO NOT MEAN SOLELY TO AUTOMATICALLY REJECT A PLAYER'S CLAIM AND SAVE THE PLAN'S MONEY. GIVE PLAYERS' RIGHTS EQUAL ATTENTION, EQUAL RIGHTS, AND EVEN MORE PROTECTION THAN THE "POT OF MONEY."

8) ALLOW PLAYERS AND/OR REPRESENTATIVE TO ATTEND BOARD MEETINGS – THAT'S NOT CURRENTLY ALLOWED (AT LEAST NOT AT TIME OF MY CLAIM) – ESPECIALLY ALLOW THEM TO ATTEND THE FINAL APPEALS MEETING.

STOP HOLDING BOARD MEETINGS AT 5-STAR RESORTS, MEET AT MORE PRACTICAL LOCATIONS SO PLAYERS CAN AFFORD TO ATTEND; ALSO IT WILL STOP WASTING OUR PRECIOUS PLAN MONEY! (AREN'T THEY CLAIMING WE ARE SHORT ON CASH?)

9) ADD 3 MEDICAL PROFESSIONALS TO BOARD, NOT JUST TO EXPLAIN COMPLEX MEDICAL ISSUES TO THE OTHERWISE ALL-LAYMEN BOARD – BUT GIVE THESE DOCTORS VOTES! THIS WILL ELIMINATE THE 3 TO 3 VOTES THAT LEAD TO DOCTOR SHOPPING. PAY THESE DOCTORS OUT OF A BLIND TRUST FAVORING NEITHER SIDE, ROTATE THESE DOCTORS OFTEN TO PREVENT THE BUYING OF DOCTORS BY THE LEAGUE THAT HAS BEEN SUSPECTED IN THE PAST.

THE DOCTORS ON THE BOARD SHALL HAVE NO INFORMATION AS TO THE FINANCIAL HEALTH OF THE PENSION FUND, AND SHALL LEAVE THE ROOM WHEN ANY ISSUES OTHER THAN MEDICAL ARE DISCUSSED.

10) WRITE THE RULES. ONCE AND FOR ALL. THIS SOUNDS SIMPLE BUT HAS NOT HAPPENED SUCCESFULLY. CURRENTLY GROOM LAW UNILATERALLY MAKES UP OR CHANGES RULES ON THE FLY TO SUIT THEIR NEEDS, AT THE EXPENSE OF PLAYERS' RIGHTS. RIGHT NOW RULES AND REGULATIONS ARE A MOVING TARGET

11) **NO MORE LENGTHY, STRATEGIC, AND PAINFUL DELAYS**. KEEP THE CLAIMS PROCESS AND VOTING A FLUID PROCESS

HOLD MEETINGS MONTHLY INSTEAD OF EVERY 90 DAYS – MORE OFTEN USING MODERN TECHNOLOGY. SEND PLAYER TO A DOCTOR IMMEDIATELY AFTER HE FILES A CLAIM. SEND ALL DOCTOR'S REPORTS IMMEDIATELY TO PLAYER/ATTORNEY TO ALLOW SPEEDY RESPONSE. USE TODAY'S TECHNOLOGY TO KEEP THE PROCESS MOVING.

12)THE CURRENT SYSTEM OF TWO "GATEKEEPERS" WAS NOT IN PLACE AT TIME OF MY CLAIM, BUT LIKE MOST ELEMENTS OF GROOM LAW'S CHANGES TO OUR PLAN, ALL WITHOUT VALID PLAN PURPOSES, THIS ONE DOESN'T PASS THE "SMELL TEST" EITHER. A ONE TO ONE TIE MEANS DENIAL? THIS IS OBVIOUSLY DOUG ELL'S IDEAL VISION OF A PLAN, THE PLAYER HAS NO CHANCE FROM THE GET-GO.

13)THIS ONE IS FOR CONGRESS ONLY – REMOVE "FULL DISCRETION" AND "DEFERENCE" FROM NOT ONLY THE NFL PLAN BUT FROM ERISA; SIT IN ON NFL DISABILITY BOARD MEETINGS AT YOUR PLEASURE;

SET GOALS AND EXPECTATIONS FOR THE DISABILITY BOARD TO MEET ANNUALLY IN ORDER TO KEEP ANTI-TRUST AND OTHER CONGRESSIONAL GIFTS, WITHOUT WHICH THEY COULD NOT EXIST.

DO NOT ALLOW CERTAIN DISABILITIES – **ESPECIALLY CONCUSSIONS!** –TO BE CONSTANTLY DENIED AS DISABILITY CLAIMS. CONGRESS MUST STEP IN TO PERMANENTLY PROTECT THE BRAIN DAMAGED PLAYERS.

FOR THE SAKE OF ALL AMERICAN WORKERS EVERYWHERE, REWORK ERISA! ERISA IS A MESS. ERISA IS A DISASTER FOR AMERICAN WORKERS, A GOLD MINE FOR ATTORNEYS.

KEEP CONGRESSIONAL OVERSIGHT AND PRESSURE ON THE NFL DISABILITY BOARD...PLAYERS DESPERATELY DEPEND ON ***YOUR*** PROTECTION!

— Tab 13 —

The Black Paper: A Response to the Claims Set Forth in the NFLPA's "White Paper"

I have been asked to address the specific content of the document produced by the joint efforts of the two collective bargaining parties, the NFLMC and the NFLPA. The NFLPA "White Paper" was prepared for the September 18th hearing on Capitol Hill before the Senate Committee on Commerce, Science and Transportation. The content, however, is virtually the same as the NFLPA written statement submitted for the June 26, 2007 hearing before the Subcommittee on Commercial and Administrative Law of the House Judiciary Committee. My statement in response to the remarks made by Douglas Ell at the House hearing addresses most of the issues "repackaged" and reintroduced in the September 18th, 2007 hearing and I refer the reader to that statement. I will address some of the issues that require clarification as to the factual content of the declarations made in the White Paper the NFLPA has distributed both to traditional media and Internet-based news outlets. The NFLPA has also initiated a "new" campaign called: "The Truth Squad: Fact vs. Fiction," which I will show is neither substantively new nor factually accurate in the following paragraphs.

In keeping with the theme "fact vs. fiction," I respond on behalf of the NFL Retired Players whom I have represented involving disability and retirement issues. For the record I have, on three (3) different occasions since 2001, been successful in recovering disability benefits that had been arbitrarily taken by the retirement board from Players who were qualified under the Plan's Terms.

I have over 21 years of experience in dealing with this group, who cast themselves as caretakers of the retired Players' future welfare as fiduciaries, in the role of trustees to the Plan, governed by ERISA Law.

I have watched the evolution of the language of the Plan, I can say with absolute explicit facts and evidence that fiduciary misconduct has occurred and it is documented by the very words of the author of the White Paper.

For the record, the term "White Paper" is defined as a detailed or authoritative report. The following is a quote from a docketed Bar Complaint filed against a former Groom Counsel, John McAllister, for lying to a Plan participant. Mr. McAllister is no longer on the Case and has left the Groom Law Group.

> If you have information but it's misinformation, the best you can be is misinformed, if someone is allowed to perfect a concept based upon that misinformation, then what you have is a misconception.

It is with that premise in mind that I set forth my response to the White Paper in this "Black Paper", the title of which describes the ironic distance between what the NFLPA asserts to be true, pure and "white" and the actual practices and policies inherent in their administration of the Plan's disability provisions.

Page 4, paragraph one of the White Paper states: **"Active Players pay for all benefits."**

That statement is categorically false according to the Plan's own terms. The Bert Bell / Pete Rozelle Plan document at page 10, paragraph 3, Article 3.2 states the following:

> The sources of revenue to be used to satisfy *any* contribution obligation of the employer *will be exclusively within the control of the employers.*

Webster defines the term "exclusive" as "limiting or limited to possession control or use by a single individual or group."

It is clear that the active Players in fact *do not* contribute to the fund under ERISA that is governed by the Plan's terms; therefore the statement made in the "White Paper" regarding Player contributions to the Plan is fiction not fact.

Sec. 3.1of the Plan states that, "a contribution to the trust will be made by the employers." Players do not contribute to the ERISA-governed fund.

Another statement from the White Paper, made in paragraph "three" page 4, declares that, "the cost of benefits to former Players comes from the active Players side of the table". That statement is also false and misleading.

Under ERISA law and the Plans terms, there is no "active Players side of the table," in fact there is no "table," there are only fiduciary responsibilities to do two things:

1. Pay benefits
2. Pay expenses.

Under ERISA Law, the language of the Plan, at one time, did have specific instruction as to the course of conduct of the trustees of the Plan regarding specific language under Sec. 404; that defines the duties of those trustees who accept that fiduciary responsibility by Law and operate under the spirit and the letter of the intention of the Plan's terms.

The White Paper states that the active Players each gave up $82,000.00 in salary for medical, disability and retirement benefits."

That statement is misleading because it implies that currently active Players are paying medical and disability benefits for retired Players, which is false. *See* Sec. 3.2 page 10, Plan Document.

From the White Paper, page 5, paragraph one, Mr. Ell seems to imply that "pension for the Retired Players" significantly increased four (4) times, and their benefits "have since been more than tripled."

Webster's defines the term "significant" as:

> Having the meaning of a noticeably or measurably large amount.

Clearly the amount involved here is large only if expressed in relative terms. If the benefits for retired Players were in fact increased 4 times and "triple" the amount they were originally, then the resulting $250 per month, per credited season only shows up as a "large amount" when compared with the paltry size of the original pension benefit.

In 2002, in a collective bargaining negotiation, a new retirement benefit increase of a $100-per-month per credited season was initiated. As I detail in my response to Doug Ell's House testimony, however, in 2004 the same collective bargaining parties devised a "new" benefit paying each current Player $200 each and *every time he steps on the field*.

The collective bargaining parties in 1993 "segregated" themselves from the retired Players. This has now grown into a full-fledged "business within a business." The disability benefits, in fact, *have* dramatically improved, however, *not* for the retired Players. The statement involving "significant increase over the years" by the two (2) collective bargaining parties is false and misleading because it

omits what the NFLPA did for the current Players in the 2004 CBA extension.

"The most generous and flexible disability in professional sports"

However "generous" the collective bargaining parties say these benefits are, the fact is these "benefits" are not accessible to the Players without their meeting complicated requirements. Moreover, even if they are able to do so, the bottom line still rests upon the judgment of the Trustees as to whether or not a person with a disability is "*able to work*"—a judgment that is entirely up to their discretion, rendered according to a criterion itself is so vague that it has no specific definition. How can a doctor, untrained in occupational therapy, make a determination on a person's ability to work in a 25-minute office visit? Moreover, if the theoretical capacity to work *any* job is the *de facto* standard, as experience would suggest it is, and it is subject to the unfettered discretion of the retirement board in application, does this standard have any meaningful function other than to exclude virtually every applicant?

Since my personal involvement with this process began, I have seen the administrative complexities grow steadily to the point where the average Player applying for benefits must now meet technical requirements that involve a mountain of red tape designed to make the Player seeking benefits either give up or sue the Plan. If he has the tenacity to sue, then The Groom Law Group reaps the true "benefits" of this system--litigation to the tune of almost $20 million over the last six years against retired Players pursuing their rights. Yet, when questioned about the make up of the "legal team" in question, Mr. Ell says; "*Oh we try to keep the lawyers down to an absolute minimum.*" And those "few guys" make millions.

Ironically, the suggestion to "give up" often comes from the NFLPA representatives. When you examine the actions of the retirement board you get a completely different perspective about what they are trying to accomplish, which in no way accords with the standard of what a "*prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character with like aims,*" which is their charge in the Plan document in words that are mirrored in the specific language of Sec. 404 of ERISA.

The Groom Law Group, by its own admission, changed the terms of the Plan to exclude the specific language that would permit the

"circumstance" in which a fiduciary could make a decision to spend an amount that would rectify the disparity in value between the benefits of the current Players and the benefits of the retired Players. Under ERISA, the fiduciaries are to "minimize the risk of large losses unless under the circumstances, it is clearly prudent *not* to do so." ERISA, Sec. 404(C).

This specific language appears in the Bert Bell Plan at Sec. 8.20. It also appears in the Bert Bell / Pete Rozelle Plan. Somewhere between 1998 and September 2005, however, the Groom Law Group changed the language of the Plan. This language now appears under Duty and Care, Sec. 8.2 of the Plan. The new plan states:

> Except that the retirement board and the DICC will follow the terms of the Plan.

This changed the ERISA language from Sec. 404 of the ERISA code—a change, in itself, which violates ERISA Law.

By law, you cannot change the terms of a Plan that contains ERISA guidelines. Yet that is exactly what the NFLPA did at Groom's suggestion. Groom claims that, "they (Groom), do not make decisions regarding benefits," yet Doctor Alfred J. Tria, the first neutral Medical Advisory Physician (MAP), states in the Public Record, that Groom chastised him for qualifying a Player under Line of Duty. In 1989, I was the first Player qualified by Dr. Tria under Line of Duty Disability. I was sent to Dr. Tria due to a deadlock of the retirement board pursuant to the Plan's terms. The Owner-Members rejected the qualification even though it was final and binding on the retirement board, which violated the Plan's Terms.

I will focus on several issues of material fact that are not in dispute in the applicable language of the Plan's Terms. These specific facts contradict what is presented in the NFLPA White Paper on behalf of both collective bargaining units.

On page 5, under "*Disability Benefits Overview,*" the White Paper states:

> Point 1: The award process investigates whether a Player is *able to work*. (Emphasis added)

The question would be why the "extent of the disability" is *not* considered first. ERISA states that the retirement board must carry

out its duties in a manner that considers the Player's interest first, with the secondary inquiry being "what caused the Player's disability?"

But this clear ERISA requirement again is construed as an "opinion" and the retirement board reserves the right to disregard *any* medical finding that does not support the agenda of the retirement board trustees who, as representatives of the collective bargaining unit, not surprisingly have established a record of disqualifying Players seeking *any* type of disability unless that Player is a "friend of the NFLPA."

The Doug Betters Case is illustrative of this point.

Doug Betters was paralyzed in an accident while skiing in 1998. Doug, retired from the NFL in 1988 because of back and neck injuries. When Doug applied for disability, he was denied because the retirement board trustees, with no expertise in the medical field and no expertise in spinal chord injuries, declared that Doug Betters did not get hurt while playing football: "he got hurt skiing". An unlicensed opinion thus became a denial of disability to a classified quadriplegic with no improvement and continued degeneration.

Doug is paralyzed and has been in a wheelchair since 1998. He receives a pension equal to his retirement. Doug is entitled to the active non-football disability. Doug receives something called an "inactive" disability benefit, which is equal to his retirement benefit. They call it a disability benefit, but his check comes from the retirement fund. Inactive disability is a fictional term-of-convenience used to categorize Players in a manner so that they cannot obtain a class of benefits that pay more. (If you have an "inactive" driver's license can you drive?)

In 1989, the retirement board said, "Traditionally, we use Darryl Stingley as a test case for the total and permanent disability."

Tom Condon assured Doug that "there was nothing to worry about!" The retirement board vote was 6 to 0, unanimous against a paralyzed Player. In a retirement board quarterly meeting, Bill Bidwell, the owner of the Arizona Cardinals, theorized that paralyzed players in wheel chairs could "sell pencils on the street corner"—a form of gainful employment that would presumably preclude the disbursement of disability benefits.

The third category of analysis is "**When the disability began.**" This issue is at the heart of the Mike Webster case, in which the Court

declared that it was an "abuse of discretion" by the retirement board to refuse to assign Webster the proper "effective date" on which the disability began.

This, too, is an area of contention, having roots as far back as 1984, documented in explicit detail revealed in the minutes of the Retirement Board meetings.

Under the Bert Bell Plan, the language *was* clear that disability began according to the physician's report, which asked the question of the MAP "Date of Disability?" (The answer was to be determined by the Doctor.)

That question has appeared for the last 30 years on the form to be filled out by the MAP. As stated by the White Paper, the MAP's decision was final and binding on the retirement board.

This became a problem for the collective bargaining units because it meant that a Player could collect a payment that was retroactive back to the date of disability, which meant that a Player's accrued disability benefit could pay as much as 15 years in retroactive payments.

The Groom Law Group removed the "**date of disability**" space from the Doctor's report form. This gives the retirement board the "contrived discretion" to construe the "effective date" to be ***any date*** *they choose*, as opposed to correctly using the Physician's date of disability on the physician's form. All this was done to control the amount of the retroactive portion of the disability benefit, which the Trustees were obligated to pay in full.

I sent a letter to Commissioner Roger Goodell detailing the specific facts and evidence that The Groom Law Group violated Sec. 302 of the ERISA code, as described in my complaint sent to the Commissioner on June 4th, 2007 titled "Fiduciary Misconduct."

For the record, the Commissioner has stated the following:

> *We will continue to do what we have always done, rely on the facts.*

However, in this particular case the Commissioner has ignored "the facts" and has refused to act under the Integrity Clause of the NFL By-laws. This clause allows the Commissioner to rectify almost any situation concerning the NFL.

To date, however, he has refused to investigate any wrongdoing by the Management, the people who put him in that office as Commissioner of the NFL.

The next issue is on page 10, titled: "***Disability application and award procedure***".

I have addressed this issue in my response to Doug Ell's written testimony on June 26, 2007, however, I will make an additional comment concerning the "truth" and regarding the "facts" surrounding the "neutral physician". In the White Paper the author repeatedly declares the importance of the neutral physician, yet on page 15, bottom paragraph, Mr. Ell describes to a Federal investigator "exactly" what is the real role of the neutral physician, Mr. Ell contradicted his own words in the White Paper regarding the responsibilities of the neutral physician. Mr. Ell states:

> **Neutral physicians have no authority and are simply instructed to report their best medical findings.**

Unless, as in the case of Don Bessilieu, the retirement board uses the "opinion" and medical findings of the neutral physician to *disqualify* the Player, then the "neutral physician's" opinion is used by the disability claims committee member (one person) to disqualify the Player who was already receiving disability benefits for 5 years, as was the case with Don Bessilieu.

I can say that the description of the responsibilities declared by the author of the White Paper regarding the neutral physician is false. Any evidence to support the contention in the White Paper would also be false. Mr. Ell told a Department of Labor investigator exactly the opposite of what appears in the White Paper. One of the two statements by Mr. Ell is a false statement made to a government investigator, a criminal violation.

Page 11, "**Appeal Rights**"

This section is a perfect example of the "deception" described in the White Paper as "Appeal Rights".

First of all, appeal rights depend on various situations concerning exactly what is being appealed and who is appealing. One case in point is when a Player is denied by the DICC and it is the Player's *initial*

disability claim, the retirement board must follow the decisions made by the DICC, which amounts to a circle, with no possible way of overcoming the denial, because Groom has changed the language of the Plan from Sec. 8.2 which says:

> **Except that the retirement board will follow the decisions made by the disability initial claims committee.**

Prior to this change, for over 45 years, Sec. 8 of the Bert Bell Plan and the Bert Bell / Pete Rozelle Plan both stated:

> **The retirement board will have the power to decide claims (except that the retirement board will follow the decision made by the Medical Advisory Physician [whose decision will be final and binding on the retirement board]).**

The retirement board now uses whatever language "fits" the denial. This section of the Plan's Terms was changed in order to accommodate the retirement board's ability to have what would appear to be "absolute discretion"[1] and authority over the outcome of disability determinations.

In the White Paper under "**appeal rights**" the author declares that the retirement board gives ***no deference to the decisions made by the DICC*, a patently false statement.** The evidence points to the Groom Law Group as the principal architect and administrator of the attempt to control the disability process on behalf of the two collective bargaining units.

The specific language in the Plan's Terms under Sec. 8.2 of the new Plan document makes that declaration false and the premise declared in the White Paper fiction. In fact, the majority of the three topics I have reviewed in this "Black Paper" all contain "fiction" in their premises and falsehood in their factual content.

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[1] This specific language was changed under the Bert Bell Plan at Sec. 8.4: "**The Retirement Board will have the broadest discretion permitted by the Act**". This is the protective language of ERISA. This means, where there is "no permission there is no discretion." In 1995 Groom changed the Plan's Terms to exclude the specific language that restricted the retirement board's ability to act "outside" the Plan's Terms. In 1995 they removed ERISA governing terms and replaced them with their own made up authority.

I have, in the details contained in my 26-page response to Doug Ell's written testimony on June 26, and the White Paper written for the September 18, 2007 hearing provided a significant amount of facts and evidence to support the contention that misconduct has occurred at the hands of the authors of the White Paper.

There are numerous misstatements of fact that I have not addressed, all of which point to the same conclusion ... "Fraud" is defined by Webster as:

A) Deceit, trickery, intentional perversion of the truth in order to induce another to part with something of value or to surrender a legal right.

B) An act of deceiving or misrepresenting: A trick. One who is not what he pretends to be. An imposter. One who defrauds. Cheat. One that is not what it seems to be or is represented to be.

C) Synonym ... Deception

I have presented some of the ABC's of the White Paper, which may well be misleading and fraudulent in its design.

I welcome any effort by the NFLPA or the NFLMC to refute *any* of the statements contained in the Black Paper.

Sooner or later the truth about the "Truth Squad" will become clear in the form of facts vs. fictions, which will spell themselves out in *black* and *white*.

Submitted to the Members of the Committee on Commerce, Science and Transportation of the United States Senate to aid in their oversight of this issue, and to the NFLPA for its analysis and response.

Sincerely,

Eugene "Mercury" Morris

PS: I am waiting for your response.

— Tab 14 —

Testimony of Gale Sayers
Before the Senate Committee on Commerce
Hearing on Oversight of the NFL's Retirement System
September 18, 2007

Chairman Inouye, Subcommittee Chairman Dorgan, Ranking Member Stevens, Subcommittee Ranking Member DeMint, Members of the Commerce Committee and distinguished guests, my name is Gale Sayers. I was a running back for the Chicago Bears from 1965 to 1971, when my career ended as a result of a knee injury. I have since had rewarding careers in athletic administration and sports marketing, until I launched a business in 1983, which has grown into a major provider of technology products and services. In short, I am a man truly blessed by God and life, like my friends Mike Ditka and Gene Upshaw. Like them, as well, I am not at all a typical NFL retiree who suffered a career-ending injury and then suffered again through the current disability process that is the subject of today's hearing. But my own blessings bring responsibilities, and I am here for those who were not as lucky as I was, many of whom have gone through that unfortunate experience. As a board member of a charity that helps retired players, I have heard many of their horror stories and I want that system reformed. Moreover, as Mike has often said, football owes us nothing and we owe football everything. I agree. So, as I see it, I am here for football, too—a game I love and a family I love. As a member of that family, I am worried about the effects our broken disability system is having on the fabric of the entire game.

I call football a family because that's what it has always been at its best. Now, families don't always get along perfectly. Ask my old friend and teammate, Dick Butkus, about negotiating a contract personally with our old coach and owner, George Halas, as was the common custom in my day, and you might hear a response that I would not dare put in writing before the eyes of the Senate. If, however, you were to speak harshly of Mr. Halas yourself, Dick would jump to the defense of "Papa Bear" the way any of you would respond if a stranger criticized a member of your own family. The violent nature of our game makes us pull together like family members. When someone is playing hurt, we all know in the locker room. We protect the secret so he won't be vulnerable, and we watch his back during the game in an effort to protect him from further injury. Like a family, we watch out for one another.

Extreme financial success can put strain on any family's relationships. The football family is no exception. Today, the NFL is a seven-plus-billion-dollar-per-year industry, yet it still struggles to do right by the retired players whose blood, sweat and sacrifice built the game. Sometimes it seems as if football has been torn apart by its own success. I believe that is what has happened with the NFL today. I also believe that the failure to address this disability issue is at the core of a more general crisis in the game. You've been hearing about the symptoms of that crisis almost every day recently. But what family can remain healthy if its senior members are thought of as a useless burden on its budget? Or if its younger members accept the idea that every dollar spent on the health of their elders is a dollar out of their pockets? Will that family engender respect among

its generations and a sense of authority to support rules of good conduct or common sense? If this disrespect for the history of the game, which is embodied in its retired players, is allowed to continue unchallenged, if generations of older players continue to be seen as expensive and irrelevant, can anyone be surprised if the recent displays of selfishness, irresponsibility, even of criminality, continue to be exhibited by growing numbers of young players? When families break down in this way, such behavior is always the result.

When I came into the league, older players and retired players were, generally, treated with respect and seen as sources of authority and wisdom. Reverence for them inspired reverence for the game itself, its history, its rules and the need to project some image of integrity to the fans who, believe it or not, look to football as more than just a game on the field. This reverence for the people who built the game is no longer common and the results are on display everywhere. I'm not saying my generation of players was a bunch or angels or that the current one is the opposite—far from it. I see a young man like Ladanian Tomlinson or Peyton Manning and I know there is still a sense of stewardship and honor alive among the current generation. But that ethic is coming under greater attack today than ever before and exclusive worship of the bottom line is eroding the strength the game derives from the extended family culture it was founded upon generations ago. We need to turn that around and we must begin that effort today.

We at this table, all members of football's family, must pull together and fix this disability problem. If we fail to do so, I believe we will continue to see more and more signs of moral and social decay in our game. If we succeed, however, I believe many good things will follow. I truly believe we can pull together as a family and save our game, but I am also certain that we will need the help of this Committee to do so, as I will explain.

The current disability system routinely bars retired players from fair access to disability payments that offer a minimal standard of care. The word often heard is that the inconvenient "problem" of disability will eventually pass away--a nice way of saying that the retirees themselves will conveniently die. This is *not* the way a family should work and it is not the face the NFL should present to the world—to the other families that pay for all the tickets, the TV subscriptions, the hot dogs and the jerseys. A game worth over seven billion dollars per year owes the fans that support it something more than just a mirror held up to all of society's problems. Much is given to this game, so much should be expected of it, I would argue, and the game and its players should be held up to a *higher* standard. My friend Charles Barkley once famously said, "I am not a role model." He meant that as a caution to society at large not to hold up athletes up as heroes. I agree with that warning wholeheartedly, but I do not agree that athletes, as public figures, and the games that benefit from presenting their images to the world, do not have a special burden of responsibility to the public. This is not something we choose, it is something that is thrust upon us as and we must accept some sense of responsibility because, frankly, children are

watching. Their parents should pay heed to Charles' warning and teach their children accordingly, but it is our responsibility and the game's to act as if they cannot.

The image this disability issue projects to the public is beneath the dignity of the NFL and it must come to an end before damages our relationship of trust with the fans. I do not blame any single person for this failed system, whether at this table or elsewhere, but we will all share the blame if we don't pull together and fix it now, while these players are still alive and in need. If we do not do so, if we simply allow this problem to "solve" itself by waiting for a generation of gravely injured retirees to die before they can succeed in claiming disability support to which they have a right, then the stain upon the game and it's history will never be removed.

I have heard Gene speak of his efforts to obtain more benefits for retirees. I take him at his word. But whatever has been done to date has not been enough because the problem is still with us. He, the NFLPA and today's players must do more to fund this system adequately.

I have also heard a statement attributed to Mr. Goodell that the owners consider their 40-60 revenue split with the *active* players to be so generous that they cannot do more regarding disability for *retirees*. I want to believe that this was a misunderstanding or misquote and I hope he will correct it here today. But if it is a true reflection of the owners' sentiments, then it is an absolutely inadequate response and an evasion of responsibility to the game and the people who built it

into the financial success the owners enjoy today. As Gene has often pointed out, neither the ownership nor the NFLPA directly represented the interests of retired players in collective bargaining, so the revenue split produced by that bargaining offers the owners no shield whatsoever from their responsibilities to disabled retirees.

No, this problem belongs to the *entire* NFL family and the owners are not exempt from their proportionate share. I'm glad the NFL has hired a "crisis manager," but I disagree with their definition of this "crisis" if it simply means that they might have to spend some more money on health care for the men who helped build their fortunes. The crisis, to me, is this broken system that dishonors our game by compounding the injuries suffered in honest competition by its retired players, and "managing" this crisis must not mean finding ways for the NFL owners to evade their responsibilities. This is not just another stadium that will be built with public money if the owners threaten to leave town. This is a system that demoralizes, shames, bankrupts, injures and, at the extreme of it's cruelty, even kills people. *Everyone* is responsible for a share of curing this misery.

I thank the NFL and the Players Association fro proposing their new "Alliance" plan. It is an important step in that it is a public recognition that this serious problem exists. As a substantive response to the problem, however, it falls far short. That was predictable since, unfortunately, virtually none of the people on the retirees' side of the ball who have worked on this issue for years were invited to contribute to that proposal. Perhaps because the collective bargaining

process has habituated them to think this way, the NFL and the NFLPA are, unfortunately, accustomed to keeping the retirees locked out of actual discussions concerning their fate. As such, as was done with this plan, they simply hand us a plate that we didn't order and tell us to eat it with full enjoyment. This is not an adequate way to construct a plan for the retirees care and, therefore, this plan is not as good as the one we could have hammered out together. We must do better. We can. To do so, we must come together and negotiate. For that, as I said, we will need the help of the Senate.

As for the charitable efforts in which we retired players have engaged for the sake of our NFL family members, as Mike has said, they will continue. We must do more, too, and we will. But such private charity is a mere band-aid upon this enormous systemic problem. It cannot ever substitute fully for responsible engagement with the problem on behalf of the rest of the NFL family, the owners and the NFLPA, which are obviously not doing enough. We will all know when we've done enough because the problem will simply not exist anymore. Till then, there is responsibility to take and work to do.

But funding this system adequately is not the only problem that must be addressed. The unfairness of the system's procedures must be reformed immediately, before they do further harm to retirees and their families. Inconsistent and arbitrary administration of retirement benefits is common under the Plan and the tragic consequences are everywhere. Because of weaknesses in the Employee Retirement Income Security Act, which is the federal employee

benefits law regulating employee benefit plans, including the Plan, and the federal Labor Management Relations Act, which regulates collective bargaining, those practices have been allowed to continue. I would direct the Committee's attention to the letter provided it by my fellow Kansas Jayhawk alumus and running back for the San Francisco 49ers. Miami Dolphins and Green Bay Packers, Delvin Williams, for a fuller discussion of these issues and an example of the punitive lengths to which the representatives of the disability plan have gone in litigation against a disabled player who dared to pursue his rights in court. Because that letter treats these issues in detail, I have attached it to this testimony as an "addendum" and ask the Committee to accept it into the record as an extension of my own remarks.

Here are but some of the problems I see in the Plan, as it exists today, which I hope can be addressed in negotiation or, failing that, through legislative action:

1. There is no one on the Retirement Board of anyone with a sufficient incentive either adequately to represent the interests of the disabled retired players or to ensure that benefits are provided uniformly and objectively. Indeed, there are inherent conflicts of interest among members of Retirement Board in favor of the owners of the NFL teams and the active players.

2. Many severely disabled retired players have had their valid disability benefit claims denied because there is no objective oversight over the

actions of the Retirement Board and its staff and the members of the Retirement Board have inherent conflict of interests in their service to the participants in the Plan.

a. Representatives on the Retirement Board who are appointed by the owners of the NFL teams recognize that denying benefits to the disabled retired players will minimize future contributions to the Plan by the NFL teams.

b. Representatives on the Retirement Board appointed by the Union have included among them agents of active players who do not represent retired players. If the executives of the union are inherently more concerned with the active players who re-elect them as executives, they lack sufficient incentive to look out for the best interests of the disabled retired players, which is their charge under ERISA. If those Union representatives are more concerned with the pay for the active players, they will also recognize that denying benefits to the disabled retired players will minimize current and future payments for their clients.

c. Gene has often said that the Union has negotiated new benefits for retired players, even though he does not represent them, and that the active union employees have "subsidized" those benefits. He

has not, however, sufficiently emphasized that these benefits are, in fact, also for the current players and that, once those benefits are established, the Union has a moral and legal obligation to ensure that they are administered objectively and uniformly among both current players and retirees. That has not happened. If the Committee would request and obtain data concerning the actual relative distribution of these funds, the full picture would become clear and public, as it should be.

3. The Retirement Board and its staff have not been required to prescribe, publish or adhere to objective standards for determining the eligibility for benefits under the Plan or to publish Plan changes in a timely manner.

4. There is no adequate administrative help for applicants, many of which have brain injuries and corresponding short-term memory loss due to multiple concussions, to fill out applications and proceed through the process. Simply posting application information on a website, without the availability of objective, real-time human help, is a particularly egregious shortcoming in the context of such injuries, which are common among ex-NFL players. Moreover, since the NFL has frequently argued that players have not sent in their paperwork (a claim which stretches credulity when referring to totally disabled people who have little else to depend upon but a successful application, but which is nevertheless conveniently

impossible to disprove in the absence of better recordkeeping safeguards), these interactions should be recorded and an evidentiary chain firmly established to keep the process honest.

5. The time for processing of claims is inordinately long. Plan representatives have often quoted an "average" processing time of 18 months, which is interminable in itself if one is disabled, but if the Committee could look behind this "average" time to a true distribution of processing times (considering that many claims are disallowed almost instantaneously), I believe it would find that the processing of claims actually meriting the largest levels of compensation takes a much longer period. Those that cannot be denied immediately are, thus, often delayed inordinately. This, again, is particularly egregious because, by the NFL's own computations, the average ex-player lives to an age of only 55, with linemen averaging only 52. [It should be noted that these figures have been used historically by the Plan's representatives to urge ex-players to take retirement at an earlier age, which results in dramatically lower levels of compensation]. This convergence of facts has given rise to a popular characterization of the Plan's tacit strategy as "Delay, Deny and Hope They Die."

6. There is no adequate deference given to medical opinion in the entire process. As noted above, Plan medical experts are routinely undermined

and circumvented after they have made a disability finding in favor of a retired player. Moreover, as in the case of Brent Boyd, non-Plan experts have been specifically enlisted to overturn the decision of Plan doctors who made disability findings. Medical expertise functions as sword to deny disability, but it is no shield against the aggressive strategies of administrative denial and, if necessary, litigation by the Plan staff and the Groom Law Group.

7. All numerical data associated with the Plan is non-public and inaccessible, making misrepresentations by the Plan's representatives common and not immediately arguable. How many retirees are there? The Plan's own representatives have given numbers ranging from 8,000 to 13,500, seemingly dependant upon which number was more advantageous under the circumstances. How many receive disability payments? At a hearing earlier this year before the Administrative Law Subcommittee of the House Judiciary Committee, Plan representatives said 317. Later, they amended this to 428. On information and belief, which is as good as we can get with respect to such unpublished data, the number is actually less than 200. Crucially, at what *levels have people been compensated*? (Again, like the "average" claim processing time, what is the *distribution*?). This has never been answered. How many have applied for disability predicated upon brain injuries resulting from concussions? As recently as this Friday, Plan representatives told Senate staff that *they did not know*

this number—this even though the NFL is supposedly seeking to implement a new, progressive policy to protect players from the effects of concussions. How many have been successful in obtaining disability based on concussions? According to a statement by Attorney Douglas Ell of the Groom Law Group to a reporter, that number is *four (4)*—for the most violent game since the Roman Arena, often played on a surface consisting of concrete covered with a quarter-inch layer of indoor-outdoor carpeting called "Astroturf", which was incorporated in stadium construction to save on grounds-keeping bills, without regard to the havoc it visited on men's bodies. If that number is accurate, the Committee can draw it's own conclusions about the adequacy of the Plan's protections. *I implore the Commerce Committee, consistent with its oversight function, which is the reason for this hearing, to seek extensive and complete data on all aspects of the Plan, its procedures and its funding. The truth, which has been artfully and thoroughly hidden to date, is in these numbers. Without the thorough examination and publication of these data by the Committee, any private negotiations held in an attempt to solve this problem cannot bear fruit.*

8. The NFL Retirees have no bargaining power to negotiate an end to this inequitable situation without the continuing oversight of the Senate. The collective bargaining entities, the NFL and the NFLPA, do not and cannot represent the retired players. Indeed, as noted above, the Plan

representatives have not even fulfilled their fiduciary and representative duties to the retired players with respect to the distribution of pension and disability distributions. *The light of common day and, with it, the power of public and governmental scrutiny of this process is the only bargaining power available to the NFL Retirees. Nevertheless, if the Committee would continue its oversight of this issue and demand regular reports of negotiating progress by the parties represented at this hearing, the NFL Retirees would like to engage the collective bargaining entities in a true negotiation in an effort to settle this matter privately, without the need for specific legislative relief. I therefore ask the Committee to exhort the parties to come together in such a negotiation immediately after this hearing and to subject that process to your regular oversight in the form of such periodic reports, which we propose be produced to the Committee every 30 days from the date of this hearing.*

Some legislative actions might help this situation but today I want to make a more immediate appeal to the Members of the Commerce Committee: please help us pull together as a family and try to fix this problem ourselves.

You've called this an "oversight" hearing. I like that word. I think that's just what we need. As I've said, at its best, football is a family, with no need for an overseer, where "bargaining power" is not an issue. But in this new rich NFL bargaining power is crucial and the retired players have none without

your help. I don't ask you to play for our side, only to keep the game fair and keep it going until the job is done. We need a referee. I think that if this Committee would ask the parties to come together, starting tomorrow, and negotiate a true solution to this problem, and if it would take oversight of a bargaining process among the owners, the Players Association and representatives of the retired players, with each party making periodic reports to the Committee about the progress of those negotiations every thirty days or so, we should be able to get this job done ourselves. I ask this Committee to take such oversight and to request and publish all numbers and data necessary to a fair negotiation, so that one can go forward. I am told the most effective mechanism to obtain such data is a study and report by the Government Accountablity Office. I respectfully request that such a study be performed and such a report be written. If you do these things, I think we in the NFL family can get this job done and clean an ugly stain upon our great game before it becomes permanent. For my part, if you will be referees, I promise you my best game.

Thank you for your consideration and for your oversight of this important subject.

— Tab 15 —

MLB/NFL Pension Comparison
(Note erratic contributions by owners compared to Baseball owners)

		Employer Cont.		Vested Players		Plan Assets	
Year		NFL	MLB	NFL	MLB	NFL	MLB
1968		900,000	6,500,000				
1970		3,950,000					
1971		4,125,000					
1972		4,275,000					
1973		4,425,000					
1974		None*					
1975		None*					
1976		7,145,000					
1977		7,395,000					
1978		7,495,000					
1979		7,643,000					
1980		8,045,000					
1981		8,195,000					
1982		12,500,000					
1983		12,500,000					
1984		7,500,000**					
1985		12,500,000	33,000,000	4,422			
1986		12,500,000	33,000,000	4,549			
1987		12,500,000	33,000,000	4,765			
1988	***	1,160,000	33,000,000				
1989		1,160,000	39,000,000				
1990		None***					
1991		None***		5,258			
1992		14,157,622					
1993		14,157,622		4,863			
1994	****	1,000,000		6,559			
1995							
1996		13,714,194	68,000,000	7,107	5,688		
1997		14,460,500	68,000,000	7,318	5,707		
1998		16,810,568	68,000,000	7,530	6,498		
1999		24,211,136	70,780,000	7,860			
2000		26,675,399	70,780,000	8,284			
2001		23,654,464	70,780,000	8,621			
2002		43,074,347	74,000,000				
2003		49,599,601	74,000,000	9,144	7,211	595m	1.2b
2004		59,436,976	113,000,000	9,361			
2005		64,769,237	115,000,000	9560	7531	841m	1.6b

	Employer Cont.		Vested Players		Plan Assets	
Year	NFL	MLB	NFL	MLB	NFL	MLB
2006		115,000,000				
2007		115,000,000				

* No CBA
** Over funded
*** No CBA & Low benefits fully funded
**** Don't know?

— Tab 16 —

MEMORANDUM

To: Ordell Braase
Jim Mutscheller
Mike Pyle
Pete Retzlaff

From: Gene Upshaw

Date: December 2, 2005

Re: Pension Benefits

I received a copy of your November 16, 2005 letter to Paul Tagliabue. Your letter reflects several misunderstandings.

Let's start with the basics. You complain about your representation by the NFLPA (although you did not send me or anyone else at the NFLPA a copy of your letter). All of us at the Players Association are proud of everything we do for former players. The NFLPA is recognized as the sole and exclusive bargaining representative of present and future employee players in the NFL in a bargaining unit. But please keep in mind that we help former players not because we have to, but because we want to, and perhaps most importantly, the active players want us to. Like any other labor union, we represent only active employees. You are not union members and we do not represent you.

Second, you, me, and all other players have absolutely no right to any pension benefits other than what we currently have. All of what we currently have exists solely because of collective bargaining agreements, in which active players gave up salary. There is no legal requirement to increase benefits. The Plan document forbids the Trustees to increase benefits, so your criticism of them is misguided. Benefits can only be increased by a CBA.

No law requires a pension plan to be created, or that pension benefits previously granted be increased. You have no rights here. What you have is an opinion that your pension should be greater. And that opinion may be based in part on a misunderstanding of the Plan's history.

To begin, Plan benefits have never been indexed for inflation. Prior to 1970, the Plan was designed, in part, so that guys got only their proportional share of certain accounts. This exposed them to market fluctuations. In 1970, this was changed so that their entire pension was guaranteed. I think this was a good change; you may disagree. In any event, your suspicions about a bargaining decision made 35 years ago are unfounded.

In recent years the active players have made enormous sacrifices to increase the pension benefits of those who came before. In 2002 the active players gave up $110 million in current compensation to increase pensions for others. They had absolutely no legal duty to

do this; it was a staggering gift. You "view the 100% increase as a public admission of gross neglect." You are entitled to your opinion, but you are being ungrateful. You might also consider whether criticizing the active guys who doubled your pension is likely to get you a further increase.

Please note also that normal retirement under the NFL Players Retirement Plan is 55, not 65 as in MLB. The actuaries tell me our plan compares favorably with MLB.

I hope this clears up the misunderstandings in your letter. I appreciate your desire to obtain further pension increases, and will keep it in mind during negotiations.

ANSWERS TO POST-HEARING QUESTIONS FROM HARRY CARSON, RETIRED NFL PLAYER

Questions from Subcommittee Chair Linda Sanchez for Harry Carson

Question 1. Having gone through the NFL's retirement process and seeing how other players have been treated by the system, how can the NFL's retirement process be improved?

As a player I was warned by other players who preceded me into retirement that the teams and the League didn't care about players once they didn't have anything to offer. Toward the end of my career I was able to clearly see for myself the coldness of the business of professional football and the "what have you done for me lately" mentality. I made certain that I was in control of my destiny in regard to ending my career than for others to make that call.

I firmly believe the NFL retirement process could be greatly improved by being more compassionate, empathetic and concerned about players post football lives. As an active player, football coaches demand that to be the best, players need to focus most of their attention on preparing for and playing the game. Once a player leaves the game many have no sense of direction because their focus has been solely on playing the game. Their transition to life after football is very confusing and sometimes unforgiving. The transition for many of the "modern day" players consists of a relationship with each team's Director of Player Development who has probably instituted programs to help the transition. Such is not the case with most players who played in the 1960's 70's and 80's.

I also believe that the League and Players Association should be more aware and understanding that many injuries sustained by players during their NFL or football careers do not manifest themselves until 5 to 15 years after playing. Then the burden is on the player to prove the effects of an injury are a result of playing football.

Question 2. The NFL and the NFLPA have argued that the dollar levels of benefits have increased over the years. What is your response to that argument?

I will agree with the NFL and the NFLPA that the dollar levels of benefits have increased. The bulk of those increased dollar levels apply to players who played during and after the 1993 Collective Bargaining Agreement between the League and Players Association. Some improvements were made to the benefits of players in prior years but not to the extent of those of the "modern day era". Because the greater benefit levels apply to players after 1993 it diminishes the value and the contributions of those who played the same positions, who wore the same jersey numbers and who played on the some of the same football fields in prior years building the brand of the National Football League.

Answers to Post-Hearing Questions from Curt Marsh, Retired N.F.L. Player

1. Having gone through the NFL's retirement process and seeing how other players have been treated by the system, how can the NFL's retirement process be improved?

Going through the disability qualification process was very long and cumbersome. I was fortunate in that my injuries were extremely obvious an amputated leg a hip replacement and one to come, rods, screws and plates in my back neck arm and hand. Even the "arbitrarily" NFL appointed doctors could not ignore these as being caused by football. Even so, it took me 3 DR visits 2 votes both tied 3 to 3 until the third doctor as required by contract had the final say and passed me. Having seen and heard of the others who have gone through the process with just as painful and debilitating injuries but less obvious ones get rejected and doctor shopped is appalling to me.

2. The NFL and NFLPA have argued that the dollar levels of benefits for retired players have increased over the years. What is your response to that argument?

The dollar levels for retired players has increased over the years. But it is such a tiny amount that it is embarrassing. Many could not even make a used car payment on their monthly allotment. I received notice from the NFL and NFLPA of changes instituted immediately after the hearing to increase some of the benefits paid to wives when their husbands die, some increases of health benefits to players who played after 2006 or so, and some increases to some players who get partial disability payments. When I called the office to see what increases I should expect, they said that because I was totally and permanently disabled I was getting all I was going to get. There were going to be no increases to my category. In other words, besides the process itself the other two main problems I testified about at the hearing were not addressed at all. We as disabled veterans who receive disability because we are totally and permanently disabled are at a fixed amount that we will receive the rest of our lives without any consideration of the increase of cost of living, EVER! And second because I can never work again I will never qualify for health insurance again unless I can come up with at least $1,500.00 or so a month payment just to cover large life threatening events. My belief is still that there is enough money to put in a cost of living increase and include the totally disabled in the NFL Players healthcare plan.

ANSWERS TO POST-HEARING QUESTIONS FROM BRENT BOYD, RETIRED NFL PLAYER

"CHASING THE EVER CHANGING DOLLAR AMOUNTS CLAIMED BY THE NFL/NFLPA"
BY BRENT BOYD
AUGUST 6, 2007

IN RESPONSE TO CHAIRWOMAN LINDA SANCHEZ' WRITTEN FOLLOW UP QUESTION RELATED TO JUNE 26TH, 2007

"HEARING ON THE NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?"

SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON THE JUDICIARY

THE QUESTION FROM CHAIRWOMAN SANCHEZ TO ME WAS:

"The NFL and NFLPA have argued that the dollar levels of benefits have increased over the years. What is your response to that argument?"

My answer follows....

Madam Chair woman and members of the committee, and Hon., Maxine Waters,

The NFL pays Groom Law $3.1 million per year to fight it's own players on disability claims...Major League Baseball spends approximately $170,000 a year to do the same job. THAT is a commitment not to approve claims! That should be a red flag to members of the committee as to the seriousness of the problems facing retired players/disabled players.

Claims of retirement benefits increases for retired players by Gene Upshaw and his PR shills are greatly exaggerated and consistently misrepresented. They are tactics used by the NFL owners and their company union the NFLPA to cheat the retired players out of fair and contracted for benefits.

First off there are no laws that say there has to be professional football or an NFL or a players union and there are no laws against their existence either. This brutal dangerous industry is unique. It is under no obligation to imitate or follow the pattern of any other business in the world.

An NFLPA Retired Members Directory 2004-2006 publication by the NFLPA, says that in "March 1987 Players who played prior to 1959 receive pension benefits for the first time. Six lines later the same publications says "June 1994 Pre-59ers included in Pension Plan." Well, was it 1987 or 1994? The NFLPA's written histories are self serving manifestos rather than accurate accounts of what happened or when it happened.

There is no one in or around the NFLPA today who have any idea what went on in 1959. Their accounts of history are simply self serving lies. They are making it up to try to make the retired players look bad, and to cost those retired players the retirement plan they won at great personal sacrifice and raw courage fighting the most ruthless monopoly in America in 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965. I have the advantage of discussing what happened with the guys who were there, the men who made it happen. One in particular is a writer and historian an expert on the era and the players union and the pension plan.

It was not as if the early NFL players didn't believe they were laying the foundation for themselves and all future of players who would build a tremendous industry. But our earlier players have been double crossed by the owners who are using their control of today's company union. Those owners have always been bitter that the players threw off their yoke and kicked their

butts for a pension and they did it without agents or lawyers holding their hands.

The excerpt from the following memo written by the NFL Commissioner Pete Rozelle explains what happened in 1959 and 1960 and shows the intent of both the veteran active players and the league for the future of the NFL Player Benefit Plan and it wasn't to have thugs like Gene Upshaw/Paul Tagliabue/Roger Goodell come along in the early 1990's and cut those early players out of the plan, and by playing the current players off against the retired players.

The Pete Rozelle Memo follows here:

THE NATIONAL FOOTBALL LEAGUE

20 May 1960

MEMORANDUM TO: NFL Veteran Players

SUBJECT: NFL Player Benefit Plan

Early History and Development of the Benefit Plan

"Upon the advice of competent benefit plan consultants, retroactive service prior to 1959 was not included. The amount of benefit payments was to depend entirely upon the amount contributed to the trust fund. The **league** consultant decided that it would impractical to include service prior to 1959 at the outset of the plan; at least until it was known that there would be sufficient income to cover such service. It should be obvious to all players that the amount of the benefit payments and the possibility of later including retroactive service prior to the 1959 season, are entirely dependent upon one basic factor—namely, adopting measures to produce the highest possible income for the Benefit Plan.

Club owners and players were extremely enthusiastic when the Benefit Plan was first formulated. It was readily and willingly agreed that both the clubs and the players would cooperate completely in developing sources of income for the Benefit Plan. It is significant to note that, unlike benefit plans in other sports, the NFL plan does not call for individual player contributions. This means that not one player is paying one cent toward the cost of the Benefit Plan."

PETE ROZELLE, Commissioner

Now the NFL is a $7.1 billion industry.

1959 to 1993 the retirement benefits were $60 per month per season that is **$0 increase** in 35 years.

In 1994, 35 years after the plan began the benefits were increased by **$24** a month to $84 per month.

In 1998, 5 years later the benefits were increased by a measly **$16** per month to $100 per month.

In 2002 Art Modell, Baltimore Ravens owner and a group of owners increased the benefits by $100 per month to $200 per month. Unbelievably Gene Upshaw opposed this increase but the owners overrode him and jammed that $100 benefit increase down his throat.

That 2002 $100 per month increase cost only **$19.4** million as evidenced by the employer contribution increase from $23.6 million in 2001 to **$43** million in 2002 while Upshaw falsely claims it cost $110 million.

NFLPA attorney Joseph Yablonski's sent a threatening letter dated August 29, 2006 on behalf of Gene Upshaw and the NFLPA to Bernie Parrish the leader of our retired players movement, that in one paragraph claims both a $110 million and $250 million increases both relating to the 25% retirement benefits in a ridiculous distorted mish-mash of typically inaccurate misleading NFLPA propaganda. A 25% benefit increase on $50.58 million of total benefits paid in 2005 costs $12.6 million, not $110 million, and certainly not $250 million, that is **$12.6 million, peanuts**.

A 25% increase amounts to a total of only **$12.6 million** not the phony claimed "$120 million to bring the total to $700 million" as stated by Gene Upshaw and the NFL office's Harold Henderson on July 27, 2006. $110 mil, $120 mil, $250 mil, $700 million are thrown around fast and loose to try to confuse the players and the public and the government in order to cheat the retired players out of their retirement and disability benefits. ($50.58 mil x .25% = $12.6 mil)

Examining what exactly has happened with the only significant increase. The employer contributions were:

$24,211,136
$26,675,399
$23,654,464
$43,074,347

$49,599,601

The entire employer contribution in 2002 was only **$43,074,347** how could the benefits be increased by $110 million as Upshaw have claimed repeatedly? How many times does $110 million go into $43,074,347? How many times does **$110** million go into **$19.4 million** the true increase in 2002?

Upshaw and his gang act like if they say it enough times it will turn into the truth. Their $110 million is "wrong, incorrect, a bald faced..." The NFLPA's attorney Joseph Yablonski knows it is wrong but he and Upshaw and the rest of his cabal continue to make these false statements to financially damage the retired players. I don't believe that that is legal. On page 2 of Yabolonski's 10 page 8/29/06 threatening letter written on behalf of his clients Gene Upshaw and the NFLPA he is spinning the tale that "**This year the NFLPA negotiated for an additional $250 million to be spent on improving retired player benefits as part of the 2006 extension of the CBA.**" In truth and fact the 25% benefit increase proposed will cost 25% of $50.58 million the total benefit payout from 2005 which is **$12.6 million** not $250 million even 6 years times $12.6 million is not $250 million it is $75.6 million.

One must also note that the $50.58 million of retirement plan benefits also include an unknown amount of disability benefits lumped together (hidden) and duplicated in statements depending on what the union or owners are selling at the moment. The estimate is $10 million of the $50.58 million is actually disability payments not retirement benefits. So the cost of 25% should really be 25% of $40.58 million or $10 million not even $12.6 million.

$50 per month increase is $1.63 per day. $50 divided by 30.5 days per month equals $1.63 a day increase, pitiful.

The owners say they dump $700 million in cash in a pile and let a bunch of inmates with diamond earrings and size 10 ball caps worn sideways, with a history of arrests for gun violations and 3AM shootings outside strip clubs, DUI's, and Dog Fighting can decide how much of the pile of cash should go into the Bert Bell/Pete Rozelle NFL Player Retirement Plan which is the one and only **disability**/pension trust fund. They don't tell the inmates that the disability and the retirement plan trust fund is the same fund the single fund. Upshaw and the owner's claim the inmates run the asylum and decide how much goes into the disability/retirement plan, one absurdity after another.

Settling the disability plan without settling the retirement plan is not really possible. It is the same plan. But don't tell the inmates. The owners and their company union are trying to hide behind these fairytales. Gene Upshaw told the press, "And you have to understand, everything we (the NFLPA) are able to do comes from the guys in the locker room today. The active players pay the freight. They write the check. It comes out of their 60 percent that I negotiate on their behalf."
That Upshaw statement doesn't match up with the facts. The active players "write no check".
Pete Rozelle NFL Commissioner said, "It is significant to note that, unlike benefit plans in other sports, the NFL plan does not call for individual player contributions. This means that not one player is paying one cent toward the cost of the Benefit Plan." Further proof is that on IRS Form 5500 for 2006 page page 4 line 9i it says "Employer contribution" $67,938,458 million. There is no reference to any "active player contribution" and these tax returns have had the same "Employer contribution" reference for over 40 years and there has never been a single reference to any active player contributions not in 1962 or 2006 or any year in between. This is another Upshaw/league misrepresentation exposed.

Not only is this claim a fraud but the claim of having negotiated for 60% of the $7.1 billion gross is another fraud just as the fact that active players write no checks to the player retirement or disability plan. The amount that goes to the active and retired players is only 40.5%. That means there is over a billion dollars of union PR BS cash missing somewhere. 60% is another Upshaw myth.

"Side letters" is another Lanny Davis get the bad news out early tactic. A couple weeks ago Bernie Parrish wrote an email to the 1500 in our community about the "secret side letters" that hide Upshaw's true compensation that begins at over $6.7 million. Those secret under the table side letters are between Upshaw and his accomplice Troy Vincent who plans to succeed Upshaw, and would have remained secret if they had not been exposed by our retired players email community. These "secret side letters" amend the CBA and when exposed will tell the real story of NFLPA corruption.

Upshaw new writer Lanny Davis is the author of "I did not have sex with that woman." Upshaw's own "I have not took my pension." has the same ring to it doesn't it.
Diverting employer contributions to complex insurance and investment funds is the way that most labor racketeering works according to the Dept of Labors OIG

website. The CPA firm of Thomas Havey was the NFLPA's accountants through 2003 until their star accountant Frank Massey was convicted of helping the iron workers union leader hide extravagant personal expenses in general overhead. "In a 2003 plea bargain, former partner Francis J. Massey pled guilty to assisting top officers of the fund "in falsifying Form LM-2 reports from 1992 to 1999 to hide in excess of $1.5 million in personal dining, drinking and entertainment expenses," according to the Department of Labor. Separately, former partner Alfred S. Garappolo pled guilty to "knowingly and willfully concealing and failing to disclose" to investigators information regarding the embezzlement of $33,000 from the fund." Massey plea bargained a 5 year sentence and a $35,000 fine. Havey was the Arthur Anderson of labor unions before Frank Massey's corruption took them down. Thomas Havey's Frank Massey was also the person who went to the IRS and Labor Dept with William Hundley and Robert Peloquin to save Upshaw from criminal prosecution for loaning himself $100,000 of union funds when the legal limit is $2000. It was Massey who came up with the argument that Upshaw was taking his severance pay early and the IRS and Labor Dept accept the ridiculous idea which was never used before or since to justify any other illegal union loan.
In 2003 Calibre CPA Group PLLC replaced Thomas Havey as the NFLPA's accountants. Calibre has been very creative in covering up money paid to Gene Upshaw in Retention Bonuses, Trust funds and deferred payment plans.
When the Retirement Plan was initially put into writing the Plan said the following.

BERT BELL NFL PLAYER RETIREMENT PLAN
(As Amended March 15, 1963, May 17, 1963; December 13, 1963; and October 13, 1964)
and
TRUST AGREEMENT
(As Amended May 17, 1963; and May 23, 1963)

ARTICLE 16

16.1 Under no circumstances shall any funds contribution to the Trust or to the Insurer, or any assets of the Trust or funds on deposit with the Insurer ever revert to, or be used or enjoyed by, any Employer or the League, nor shall any funds or assets ever be used other than for the benefit of the Players, Vested Players, and Retired Players, and their beneficiaries. **This section may not be altered or amended. "**

This Article 16.1 does not say may not be altered or amended until Paul Tagliabue & Jeff Pash from Covington and Burling Law Firm and his leashed pet show up and they decide to violate this agreement and screw the Retired Players over.

Tagliabue/Goodell/Pash/Upshaw still have their Groom Law Group violating this clause "altering and amending" the retirement Plan document contract clauses holding down benefits while abusing and exploiting retired players because in their arrogance they believe they can hire guns like Lanny Davis and get away with it.

In 2006 an amendment was added to the Collective Bargaining Agreement called for the NFLPA to make its "best effort" to increase benefits for ALL retired players.

Instead of making the "best effort" on behalf of ALL players as this contract amendment required the Executive Director gave himself a 150% or more increase in his own compensation and unilaterally dictated a 25% benefits increase to retired players. The 25% increase is meant to be a vindictive insult to retired players who criticize Upshaw's outrageous treatment of them and his personal greed and his illegal collusion with the NFL owners. There was no one to negotiate with since CBA "negotiations" were completed and a "best effort" could have been 500% since there was no one to oppose it except Upshaw and his own henchmen. This sort of contorted situation is the norm rather than the exception for the NFL.

In addition to the league cabal working to cheat retired players by diverting funding to new insurance and retirement plans that exclude retired players, there is also the Plan actuary Aon Corporation owned by Chicago bears owner Patrick Ryan a plan employer whose contributions are lowered by what we believe are his own companies cooked actuarial analysis of the NFL Player Retirement Plan. Ryan is also a Republican fund raiser who the Dept of Labor is protecting from prosecution under and order from the Bush administration to the Dept of Labor not to prosecute any high profile white collar crimes.

The Disability Plan scandal should not involve dollar amounts. The fund is there and has $1.1 billion as you found out June 26. A plan is supposedly in place, flawed as it is (see "Boyd Plan" for remedies to the process), everything is already in place but the willingness to part with their money. Theoretically, we do have disability rights. The problem is nobody is getting them! Groom Law of 1701 Pennsylvania Ave makes a fortune corrupting the process and denying

virtually ALL disability claims. That's not a matter of not enough dollars, it's a matter of not enough morals or integrity. And some poorly worded parts of ERISA, including "full discretion."

Because the NFL/NFLPA makes it a priority to hide numbers and confuse people about their financial statements, I am sure you have found out yourselves what a difficult task it is sorting these numbers out. Unlike the answer to your first question, "the Boyd Plan", I had to ask for the some expert help in preparing this answer due to the NFL/NFLPA's expertise at tossing out incorrect or misleading figures. I would like to add this disclaimer, to assure you that to the very best of my knowledge and belief, everything I write here is true.

Thank You
Brent Boyd

"THE BOYD PLAN"
STEPS TOWARD FIXING THE NFL DISABILITY "PROCESS"
BY BRENT BOYD
AUGUST 6, 2007

IN RESPONSE TO CHAIRWOMAN LINDA SANCHEZ' WRITTEN FOLLOW UP QUESTION RELATED TO JUNE 26TH, 2007

"HEARING ON THE NATIONAL FOOTBALL LEAGUE'S SYSTEM FOR COMPENSATING RETIRED PLAYERS: AN UNEVEN PLAYING FIELD?"

SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON THE JUDICIARY

THE QUESTION FROM CHAIRWOMAN SANCHEZ WAS:

"HAVING GONE THROUGH THE NFL'S RETIREMENT PROCESS AND SEEING HOW OTHER PLAYERS HAVE BEEN TREATED BY THE SYSTEM, HOW CAN THE NFL RETIREMENT PROCESS BE IMPROVED?"

"THE BOYD PLAN"

BRIEF OUTLINE:

1) FIRE GROOM LAW – THERE CAN AND WILL BE NO TRUST UNTIL GROOM IS REPLACED. GROOM LAW IS A SYMBOL OF YEARS OF TOO MANY UNFAIR DECISIONS, QUESTIONABLE TACTICS, DOCTOR SHOPPING, NEEDLESS SUFFERING, NEEDLESS HOMELESSNESS, NEEDLESS DEATHS, NEEDLESS SUICIDES – GROOM LAW MUST GO BEFORE ANY HEALING BEGINS!

2) ELIMINATE THE "FULL DISCRETION" WORDING OR IMPLICATION IN OUR PLAN; INVESTIGATE ETIOLOGY OF "FULL DICRETION" INTO OUR PLAN; FULL DISCRETION EQUALS ABSOLUTE POWER; ABSOLUTE POWER CORRUPTS – AND PREDICATABLY WE HAVE SEEN THAT ABUSE AS THE OUTCOME OF ALLOWING FULL DISCRETION TO NFL DISABILITY BOARD. WE NEED CHECKS AND BALANCES.

3) DEFINE THE PLAN'S DEFINITION OF "DISABILITY" IN TERMS SET IN STONE AND EASILY UNDERSTOOD BY ALL, IN DEFINITIVE TERMS THAT WILL BE EASILY INTERPRETED THE SAME WAY BY PLAYERS, THE BOARD AND EVERY COURT - NOT OPEN TO GROOM'S MANIPULATION (FULL DISCRETION – AND GROOM - WILL BE GONE SO THAT WILL HELP) AND REMAKE THIS NEW DEFINITION OF DISABILITY SO THAT IT IS NOT SO OVERWHELMINGLY PROHIBITIVE TO APPROVAL OF CLAIM – DON'T CONTINUE WITH GROOM'S EVER CHANGING AND IMPOSSIBLE TO MEET DEFINITION.

CURRENT UNWRITTEN BUT STRICTLY ADHERED TO DEFINITIONS OF DISABILITY INCLUDE THE INFAMOUS "CAN HE SELL PENCILS ON THE STREET CORNER" QUOTE OR "WASH WINDSHIELDS" CRITERIA , WHICH ARE OBSCENE AND MUST BE ELIMINATED ALONG WITH ALL THOSE WHO SUPPORT THESE DRACONIAN STANDARDS. THE MEN WHO BUILT THIS MULTI-BILLION DOLLAR LEAGUE DESERVE DIGNITY IF NOT WEALTH.

AND ELIMINATE THE "15 YEARS AFTER PLAYING" LIMIT FOR FULL BENEFITS, MOST DISABILITIES DON'T DEGENERATE INTO FULL DISABILITIES UNTIL LONG AFTER THAT PERIOD. IT IS WHEN GUYS ENTER THEIR 50'S AND BEYOND THAT THESE DISABILITIES BECOME DEBILITATING AND THEY CAN'T LIVE ON THE LESSER BENEFIT AMOUNT... AND REMEMBER, OSHA SAYS NFL LINEMEN LIFE EXPECTANCY IS 52 YEARS.

4) ENSURE TRANSPARENCY – SHINE THE LIGHT! PRINT THE MINUTES OF BOARD MEETINGS, RECORD ALL DEBATES, REPORT EACH VOTE – ALLOW CONGRESSIONAL REPRESENTATIVES TO SIT IN ON ANY MEETING AT WILL. THE NFL DISABILITY BOARD SHALL NO LONGER ACT AS A SECRET MEDIEVAL ORGANIZATION.

5) TREATING PHYSICIAN RULE- GIVE MORE WEIGHT TO OUR OWN DOCTORS WHO TREAT US REGULARLY FOR YEARS THAN IS GIVEN TO OPPOSING DOCTORS WHO SEE US FOR 30 MINUTES. REIMBURSE THE PLAN FOR ALL FEES PAID TO GROOM LAW WHEN THEY COVERTLY HELPED REMOVE TREATING PHYSICIAN RULE FROM ERISA – BY JOINING NON-FOOTBALL RELATED COURT CASES (e.g., Nord v Black & Decker in Supreme Court) THOSE FEES PAID TO GROOM WERE TAKEN OUT OF OUR OWN PENSION FUNDS - USING OUR OWN MONEY TO TAKE OUR OWN RIGHTS AWAY, ALL WITHOUT OUR KNOWLEDGE!

6) IF NFL'S OWN CHOSEN PHYSICIANS AGREE WITH A PLAYER'S CLAIM, SO SHOULD THE DISABILITY BOARD.

DOCTOR SHOPPING CARRIES "DEATH PENALTY" – SIMILAR TO NCAA FOOTBALL PROGRAMS IN VIOLATION OF CERTAIN RULES - OR GAMBLING IN NFL –

IF NFL'S OWN CHOSEN DOCTOR AGREES WITH PLAYER'S CLAIMS, NO MORE IGNORING THAT DOCTOR AND SENDING PLAYERS TO ENDLESS DOCTORS UNTIL FINALLY ONE SUPPORTS DENIAL. IF BOARD CLAIMS A DOCTOR TO BE

"EQUIVOCAL', SIMPLY PICK UP PHONE AND CLARIFY INSTEAD OF DELAYING FOR MONTHS AND DOCTOR SHOPPING.

ANY KNOWLEDGE OF OR CONNECTION WITH DOCTOR SHOPPING OR FRAUDULENTLY DENYING A PLAYER HIS RIGHTFUL BENEFITS WILL RESULT IN NO FURTHER ASSOCIATION WITH NFL IN ANY CAPACITY, EVER –THIS MUST BE CONSIDERED A SACRED INTOLERABLE OFFENSE!

7) LET RETIRED PLAYERS SELECT OUR OWN 3 ADVOCATES TO THE BOARD, NOT SELECTED BY NFLPA EXECUTIVE DIRECTOR. REPLACE ALL EXISTING BOARD MEMBERS. ACTIVE PLAYERS' AGENTS AND ACTUAL OR DE FACTO EMPLOYEES OF NFL ARE NOT ACCEPTABLE AS PLAYERS REPS BOARD MEMBERS, THEY HAVE BLATANT CONFLICT OF INTEREST.

DESTROY THE LONGSTANDING MENTALITY OF BOARD THAT DEFINES "FIDUCIARY DUTIES" TO MEAN ONLY TO PROTECT THE "POT OF MONEY". PLAYERS RIGHTS AND DISABLED PLAYERS RECEIVING THEIR RIGHTFUL BENEFITS HAVE EQUAL OR GREATER WEIGHT TO THE FIDUCIARIES AS DOES THE "POT OF MONEY".

THE BOARD MUST LOOK EQUALLY AS HARD FOR REASONS TO APPROVE A CLAIM AS THEY LOOK FOR REASON TO DENY A CLAIM. "FIDUCIARY DUTIES" DO NOT MEAN SOLELY TO AUTOMATICALLY REJECT A PLAYER'S CLAIM AND SAVE THE PLAN'S MONEY. GIVE PLAYERS' RIGHTS EQUAL ATTENTION, EQUAL RIGHTS, AND EVEN MORE PROTECTION THAN THE "POT OF MONEY."

8) ALLOW PLAYERS AND/OR REPRESENTATIVE TO ATTEND BOARD MEETINGS – THAT'S NOT CURRENTLY ALLOWED (AT LEAST NOT AT TIME OF MY CLAIM) – ESPECIALLY ALLOW THEM TO ATTEND THE FINAL APPEALS MEETING.

STOP HOLDING BOARD MEETINGS AT 5-STAR RESORTS, MEET AT MORE PRACTICAL LOCATIONS SO PLAYERS CAN AFFORD TO ATTEND; ALSO IT WILL STOP WASTING OUR

PRECIOUS PLAN MONEY! (AREN'T THEY CLAIMING WE ARE SHORT ON CASH?)

9) ADD 3 MEDICAL PROFESSIONALS TO BOARD, NOT JUST TO EXPLAIN COMPLEX MEDICAL ISSUES TO THE OTHERWISE ALL-LAYMEN BOARD – BUT GIVE THESE DOCTORS VOTES! THIS WILL ELIMINATE THE 3 TO 3 VOTES THAT LEAD TO DOCTOR SHOPPING. PAY THESE DOCTORS OUT OF A BLIND TRUST FAVORING NEITHER SIDE, ROTATE THESE DOCTORS OFTEN TO PREVENT THE BUYING OF DOCTORS BY THE LEAGUE THAT HAS BEEN SUSPECTED IN THE PAST.

THE DOCTORS ON THE BOARD SHALL HAVE NO INFORMATION AS TO THE FINANCIAL HEALTH OF THE PENSION FUND, AND SHALL LEAVE THE ROOM WHEN ANY ISSUES OTHER THAN MEDICAL ARE DISCUSSED.

10) WRITE THE RULES. ONCE AND FOR ALL. THIS SOUNDS SIMPLE BUT HAS NOT HAPPENED SUCCESFULLY. CURRENTLY GROOM LAW UNILATERALLY MAKES UP OR CHANGES RULES ON THE FLY TO SUIT THEIR NEEDS, AT THE EXPENSE OF PLAYERS' RIGHTS. RIGHT NOW RULES AND REGULATIONS ARE A MOVING TARGET

11) **NO MORE LENGTHY, STRATEGIC, AND PAINFUL DELAYS**. KEEP THE CLAIMS PROCESS AND VOTING A FLUID PROCESS

HOLD MEETINGS MONTHLY INSTEAD OF EVERY 90 DAYS – MORE OFTEN USING MODERN TECHNOLOGY. SEND PLAYER TO A DOCTOR IMMEDIATELY AFTER HE FILES A CLAIM. SEND ALL DOCTOR'S REPORTS IMMEDIATELY TO PLAYER/ATTORNEY TO ALLOW SPEEDY RESPONSE. USE TODAY'S TECHNOLOGY TO KEEP THE PROCESS MOVING.

12)THE CURRENT SYSTEM OF TWO "GATEKEEPERS" WAS NOT IN PLACE AT TIME OF MY CLAIM, BUT LIKE MOST ELEMENTS OF GROOM LAW'S CHANGES TO OUR PLAN, ALL WITHOUT VALID PLAN PURPOSES, THIS ONE DOESN'T

PASS THE "SMELL TEST" EITHER. A ONE TO ONE TIE MEANS DENIAL? THIS IS OBVIOUSLY DOUG ELL'S IDEAL VISION OF A PLAN, THE PLAYER HAS NO CHANCE FROM THE GET-GO.

13) THIS ONE IS FOR CONGRESS ONLY – REMOVE "FULL DISCRETION" AND "DEFERENCE" FROM NOT ONLY THE NFL PLAN BUT FROM ERISA; SIT IN ON NFL DISABILITY BOARD MEETINGS AT YOUR PLEASURE;

SET GOALS AND EXPECTATIONS FOR THE DISABILITY BOARD TO MEET ANNUALLY IN ORDER TO KEEP ANTI-TRUST AND OTHER CONGRESSIONAL GIFTS, WITHOUT WHICH THEY COULD NOT EXIST.

DO NOT ALLOW CERTAIN DISABILITIES – **ESPECIALLY CONCUSSIONS!** –TO BE CONSTANTLY DENIED AS DISABILITY CLAIMS. CONGRESS MUST STEP IN TO PERMANENTLY PROTECT THE BRAIN DAMAGED PLAYERS.

FOR THE SAKE OF ALL AMERICAN WORKERS EVERYWHERE, REWORK ERISA! ERISA IS A MESS. ERISA IS A DISASTER FOR AMERICAN WORKERS, A GOLD MINE FOR ATTORNEYS.

KEEP CONGRESSIONAL OVERSIGHT AND PRESSURE ON THE NFL DISABILITY BOARD…PLAYERS DESPERATELY DEPEND ON ***YOUR*** PROTECTION!

ADDENDUM TO "THE BOYD PLAN"
FROM BRENT BOYD
AUGUST 6, 2007

HOUSE JUDICIARY "CAL" SUBCOMMITTEE

HEARINGS ON NFL DISABILITY

MADAM CHAIR, MEMBERS OF THE COMMITTEE,

I SUBMIT THIS ADDENDUM AS SUPPLEMENTAL EVIDENCE AND EXPLANATION SUPPORTING THE NEED TO REMOVE "FULL DISCRETION" AND "DEFERENCE" FROM OUR NFL PLAN AND FROM ERISA IN GENERAL.

IT IS ALSO TO HELP YOU USE YOUR CONGRESSIONAL POWERS AND PRESSURE TO HAVE MY DISABILITY CLAIM DENIAL REVERSED, AND TO PLEASE PROVIDE MY FAMILY WITH OUR LONG-AGO DESERVED BENEFITS.

As I have said, full discretion gives absolute power, and absolute power corrupts. Especially in the case of the arrogant NFL Board who never thought they would get caught or held accountable by the only ones with the power to hold them accountable, you in Congress.

PLEASE investigate the "mysterious disappearance" of my Vikings medical files that were illegally suppressed as evidence by Groom, and allowed them to abuse "full discretion" to corrupt the process. This is important because the 9th Circuit's decision against me ultimately relied heavily on the fact that the 9th Circuit mistakenly believed there were NO notes taken at the time, when in fact there were, but the 9th was not aware that there WERE notes, and that the contemporaneous notes just were destroyed as evidence. The 9th circuit opinion said that :

"My conclusion that the Board did not abuse its discretion under this standard is based on the fact that Boyd's head injury **was not contemporaneously diagnosed,** and therefore it was not unreasonable for the Board to rely upon Dr. Gordon's opinion that Boyd's head injury did not arise from his football activities."

Madam Chair, as you just read, this point is central to my case – my medical files get strangely "lost" and full discretion then buries me…just as Doug Ell

knew would happen…my injuries **WERE** contemporaneously diagnosed, I even begged for a brain scan on my "exit exam" in October 1986 after being released because I had been complaining for years of headaches and head pain. These requests for brain scans by me in the 1980's and all notes by team medical staff regarding my concussions **DID** exist!

Groom had them destroyed, and I STILL was darn close to winning my claim despite all this. But Groom could not allow these files, the hard evidence, to be seen, if seen my case would have been approved instantly. My files were stolen and evidence suppressed. This is the kind of temptation that arises from "full discretion." The Court did not know this, in fact me and my attorneys did not know this until after the case when the NFL finally released all files in my case.

The 9th assumed the files DID exist – the Court simply believed there were just no references to my concussions amongst my files…not true, ALL files went missing! Allowing my files to be reviewed would have meant automatic approval of concussion, of a head injury claim that they vowed never to "open that can of worms". This was all possible because criminal behavior followed by the abuse of "full discretion"

Trying to win a case without benefit of the best evidence to prove my case was an impossible burden to put on me, but even without the files , remarkably the NFL's first two doctors agreed with my claim.!

The critical wording in the Plan, the wording that caused the fake neuropsych testing and Dr. Gordon's report that that other neurologists will testify could NOT have been written by a neurologist but was written by an attorney instead, the language that worried them was this…claims must be approved if the disability is "Caused by, OR RELATES TO… A HEAD INJURY!!! It doesn't call for full causation in order to approve a claim, just "relates to" a head injury.

My disability certainly has been proven at the very least to "relate to" a head injury. This wording of our Plan explains the oddly drastic wording of Dr. Gordon's report on me. In fact, please subpoena other neurologists, including my own current treating, they will tell you Gordon's report was NOT written by a doctor, it had to be written by an attorney.

Before I forget, I know that if you subpoena the NFL's own first two doctors in my case, you will find enough evidence of fraud and corruption for you to take serious steps. In the least, their reports were called "equivocal", but even my advocates on the Board didn't want to know for sure, no one ever contacted them again for clarification. Both doctors, the NFL's own chosen doctors mind you, will tell you under oath that my claim was "profound" and clearly met standards for approval and then some.

And don't forget, Dr. Gordon (the NFL's 3rd and "bought" doctor) to this day has NEVER turned in his mandatory questionnaire form from the NFL, where he checks boxes simply "yes" or "no" to questions of is he disabled? Is the disability from injury? Was this injury football related?

We ***STILL*** do not know Gordon's answers to these questions, therefore I could have been awarded benefits. Gordon only says he doubts concussions caused my symptoms, but he DOES offer alternative causes that were also football related. The Board and Groom jumped the gun, we have no proof that Gordon believes my disability is NOT football related! And then there is the messy bit about his own research contradicting his writings in my case.

Think about it... It took mysterious missing files, a linguistics student administering a sophisticated neuropsychological exam with NO experience, and a crooked doctor whose OWN independent medical research is ironically the best evidence against his "bought" opinion against me... plus this crooked doctor was the lone opinion ever against me and is characterized as the "most thorough" exam even though he didn't look at my brain scans and didn't order his own, Gordon **NEVER** filled out the questionnaire asking whether I am disabled and if it was caused by an NFL injury...

Madam Chair, it took ALL this fraud and corruption to deny my claim, that's how strong and legitimate my claim is...it took those great lengths to deny me even WITHOUT my medical files, so you know as well as anyone that my claim is legitimate and should be immediately reversed through your pressure and the threat of removing Congressional gifts such as anti-trust.!

Thank You,

Brent Boyd

LETTER FROM DOUGLAS W. ELL, PLAN COUNSEL TO THE BERT BELL/PETE ROZELLE NFL PLAYERS RETIREMENT PLAN, TO LINDA T. SÁNCHEZ, CHAIR, SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW

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July 3, 2007

Honorable Linda Sanchez, Chair
Subcommittee on Commercial and Administrative Law
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Sanchez:

Thank you again for the opportunity to appear at the Subcommittee's hearing on June 26, 2007 on benefits for former NFL players. I did my best to provide the Subcommittee with a variety of data on the subject. However, as I listened to some of the other testimony, and read some of the other written statements, I became concerned that the Subcommittee was not getting an accurate picture in many respects. Frankly, some key statements made by critics of the current system were patently false or misleading, or both. It also concerned me that defamatory remarks were made without any factual basis.

I am certain you agree that the official record of the Subcommittee's proceedings should contain an accurate, truthful, and full accounting of the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan"), the role of my law firm, and the role of the NFLPA. With that goal in mind, I respectfully request that my supplemental comments in this letter be included in the hearing record.

The Testimony About Disability Claims was Inaccurate and Misleading

1. Brent Boyd

Mr. Boyd is receiving total and permanent disability benefits from the Plan. He became unable to work 13 years after his NFL career ended. To our knowledge, it is extremely unusual for any plan in the private sector to pay disability benefits when inability to work occurs so many

years after the end of covered employment. Mr. Boyd did not acknowledge this generous feature of the Plan.

Instead, Mr. Boyd's testimony focused on the decision by the Retirement Board (the named fiduciary of the Plan) that his inability to work did not result from NFL football. Here are the facts behind that decision. Mr. Boyd applied for total and permanent disability ("T&P") benefits in June 2000. He claimed that he was totally and permanently disabled due to a single concussion he sustained in an August 1980 game during his rookie season, which caused him briefly to be unconscious. He was sent to a psychiatrist and a neurologist for examination. Each doctor stated that Mr. Boyd was unable to work because of memory loss, headaches, dizziness, fatigue, and depression. Each doctor wrote that he was not sure whether football was the cause.

Based on these medical reports, the Retirement Board promptly awarded Mr. Boyd Inactive T&P benefits. But the Retirement Board could not agree on whether football was the cause of the condition. The three retired players on the Retirement Board, who had been appointed by the NFLPA, wanted to award Mr. Boyd benefits in the higher, football-related category. The three members of the Retirement Board appointed by the NFL Management Council believed that the record did not support that conclusion.

To resolve this impasse, the Retirement Board referred Mr. Boyd for further examination and invited him to submit more medical evidence that might link his impairments to concussion-related brain injury. The Plan paid for Mr. Boyd to be extensively examined by the most qualified person it could find – a renowned physician at Johns Hopkins University Hospital with specialties in cognitive neurology, neuropsychology, and memory. This physician concluded "to a reasonable degree of medical probability" that the August 1980 concussion "could not be organically responsible for all or even a major portion of the neurologic and/or neuropsychologic problems that Mr. Boyd is experiencing." After receiving this report, the Retirement Board unanimously denied Mr. Boyd's request for the Football Degenerative classification.

The Retirement Board provided Mr. Boyd with another opportunity to make a case for the Football Degenerative classification, and sent a copy of Dr. Gordon's report to Mr. Boyd's attorney for comment and rebuttal. Mr. Boyd's attorney did not submit any further evidence. The Retirement Board affirmed its Inactive classification of Mr. Boyd's total and permanent disability on appeal.

Mr. Boyd sued, and two federal courts ruled in favor of the Plan. The decisions upholding the Plan make clear that Mr. Boyd's written and oral testimony to the Subcommittee is false and misleading. According to U.S. District Court Judge Napoleon Jones,

> The Board based its decision to deny [Football Degenerative T&P benefits] on the only definitive expert opinion regarding causation, which was the only issue to be decided. The remaining expert reports that bore on the issue of causation

> included statements cutting against and in favor of granting benefits. Plaintiff had multiple opportunities to submit evidence in his favor to Dr. Gordon but, for reasons unknown, did not. Plaintiff also had the opportunity to rebut Dr. Gordon's opinion with evidence on appeal but again, for reasons unknown, did not. Neither has Plaintiff pointed to any piece of evidence that would have required the Board to grant the benefits requested.

And a unanimous panel of the Ninth Circuit Court of Appeals remarked,

> What is transparent from the record is that the cause of Boyd's disability is far from clear. That is, the evidence can reasonably be interpreted to conclude that Boyd's disability either is or is not linked to his football career. The Retirement Board reasonably concluded, based on Dr. Gordon's extensive evaluation and report, that Boyd's disability did not arise from his League football activities.

Because of the conclusion that Mr. Boyd's disability did not result from NFL football, his monthly benefit is considerably smaller than the over $100,000 a year that he would have received if it did result from NFL football. We appreciate that Mr. Boyd desired the higher benefit, but this desire does not excuse patently false and defamatory remarks, such as his suggestion that the Groom Law Group intentionally destroyed his medical files with the Minnesota Vikings. Those files were never in the possession or control of the Plan, the NFLPA, or the Groom Law Group.

2. Mike Webster

The testimony of Cyril Smith, attorney for the Estate of Mike Webster, was carefully crafted to falsely suggest that the Retirement Board (1) decided that Mr. Webster was not totally and permanently disabled; (2) denied that football was the cause of Mr. Webster's condition; and (3) delayed the process and caused Mr. Webster to be homeless at the end of his life. The truth is that it took the Retirement Board (which generally meets four times each year) only one month to decide that Mr. Webster was totally and permanently disabled, that his condition did result from NFL football, and to begin paying him over $100,000 each year.

Mr. Webster left NFL football in 1991. When Mr. Webster applied for T&P benefits in June 1999, the Retirement Plan immediately awarded him Football Degenerative T&P benefits because of the head injuries he had sustained. In other words, the Retirement Board immediately concluded that Mr. Webster's cognitive impairments arose out of League football activities. Until he died in September 2002, Mr. Webster received over $9,000 per month, or more than $100,000 per year, in T&P benefits. After the Retirement Board determined that Mr. Webster became totally and permanently disabled as of September 1996, the total value of Mr. Webster's T&P award exceeded $640,000.

Mr. Webster appealed the initial classification of his T&P benefits. Through his attorney, Mr. Webster argued that he was so mentally impaired when he left football in 1991 that he could not even file an application. The Retirement Plan undertook a thorough investigation into the matter, carefully reconstructing the details of Mr. Webster's life almost a decade earlier. The Plan learned that in the years immediately following football, Mr. Webster set up businesses, bought property, promoted products, and traveled extensively. He filed lawsuits. Although his businesses ultimately failed, there was no indication of serious medical impairment until Mr. Webster was hospitalized in September 1996. The Retirement Board unanimously decided to pay Mr. Webster benefits retroactively to September 1996

The charges that the Retirement Board improperly delayed payment are simply false. Again, the Retirement Board immediately granted Mr. Webster Football Degenerative T&P benefits. It did take time, however, to reconstruct Mr. Webster's activities in prior years – Mr. Webster's attorney requested and received additional time to make a case that Mr. Webster was totally and permanently disabled upon his retirement from NFL football. The matter became complicated when the IRS presented a tax levy based on unpaid taxes for income received during 1992 and 1993, during which Mr. Webster was claiming total and permanent disability. Mr. Webster's then-attorney took many months to explain Mr. Webster's income during those years.

3. Curt Marsh

Curt Marsh's testimony stated, without equivocation, that he endured an 18-month ordeal to obtain total and permanent disability benefits under the Plan. The record is to the contrary. Mr. Marsh requested an application for disability benefits in April 1997, and he signed and dated his application on April 28, 1997. Even though it did not receive the application until June 9, 1997, the Plan had already begun processing his claim. On the same June 9, 1997, Mr. Marsh had a scheduled physical examination with a Plan neutral physician. The physician found that Mr. Marsh was not totally and permanently disabled and was capable of sedentary work. There also was evidence that Mr. Marsh was also employed at the time.

Despite the report of the Plan neutral physician and despite the evidence of Mr. Marsh's employment, the members of the Retirement Board appointed by the NFL Players Association voted to award Mr. Marsh the benefit. This resulted in a deadlock, and the case was referred to a Medical Advisory Physician for the final and binding opinion. Promptly after receiving this physician's report, the Retirement Board unanimously awarded Football Degenerative T&P benefits on October 16, 1997.

Less than 6 months passed from the date Mr. Marsh signed his application to the date the Retirement Board awarded him a Football Degenerative T&P benefit. Mr. Marsh may review his Plan file at any time to verify these facts. If Mr. Marsh will give his consent, we would be pleased to provide Mr. Marsh's file to any member of the Subcommittee for their review.

4. Summary

It is incongruous that Messrs. Boyd, Smith, and Marsh, the three harshest critics of the Plans with the most detailed and emotional testimony at the hearing, discussed cases in which the retired player was promptly awarded and paid a T&P benefit. In two of the cases, the benefit exceeded $100,000 per year, an amount that is more than double the median income in our country, as reported by the United States Census Bureau.[1] These examples do not evidence a broken or inadequate system.

Nevertheless, the NFLPA and the NFL repeatedly have taken steps to further improve the situation of retired players. Just recently, the parties have agreed to create an alternate path an award of disability benefits, based on Social Security disability determinations. Also, as described in the testimony of Dennis Curran, the NFLPA and NFL have joined to form a new alliance to provide payment for the medical needs of retired players. These and other ongoing enhancements to the benefits for NFL players demonstrate a strong and ongoing commitment to meeting the needs of retired players. They are in stark contrast to the situation of retired workers in many other industries, whose benefits have declined or even disappeared.

The Charges of Corruption and Fraud against Me, Groom Law Group, Gene Upshaw, and the NFLPA Are False

1. Groom Law Group and I

For well over a decade, my colleagues and I have been proud to serve the Plan and the Retirement Board. We have provided the highest levels of legal service to the Plan, at the exacting levels of ethics and integrity required by the legal profession. We do not engage in illegal activity.

Brent Boyd's testimony alleges that my colleagues and I at Groom Law Group destroyed documents and manipulated the Retirement Board to deny him benefits. His allegations are false and defamatory, and he has no basis for his outlandish testimony. The Committee should reject Mr. Boyd's repeated smears of me and my colleagues at Groom Law Group.

Cyril Smith similarly criticizes me and my colleagues when he states that "the procedures at the NFL Plan, and the people who design them and carry them out, are not serving the

[1] The median household income in the United States was $46,326 in 2005, according to an August 2006 study by the U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, called Income, Poverty, and Health Insurance Coverage in the United States: 2005.

purposes for which the Plan was created, or the retired players who participate in the Plan." As with Mr. Boyd, Mr. Smith has no basis for his comments. His limited exposure in litigation to the complex and varied activities of the Plans does not give him any basis to denigrate the hard-working and honorable individuals who serve the Plans and their participants. His misrepresentations are part of a self-serving advocacy campaign in support of his continued litigation against the Plan and the NFLPA.

2. Gene Upshaw and the NFLPA

The testimony of Messrs. Smith, Boyd, Carson, Ditka, and Marsh takes aim squarely at the leadership of the NFLPA. These comments are unjustified and contrary to the record. Perhaps the simplest rebuttal is to enumerate the staggering improvements that Gene Upshaw has achieved during his tenure at the NFLPA:

Pension Benefits. Until Gene Upshaw negotiated the 1993 Collective Bargaining Agreement, most retired players had no pension whatsoever or only a minimal pension. That is because prior union officials, including some of the NFLPA's current critics, did not make pension benefits a priority in earlier negotiations. With the 1993 CBA, retired players from the 1920's through most of the 1950s (i.e., "the pre-59ers") – almost 4 decades of football players – received a guaranteed pension from NFL football for the very first time. In addition, the pension benefits of all other retired players were increased. There was no legal or moral compulsion for the bargaining parties to undertake these liabilities, but it was done nevertheless.

Since the 1993 CBA, the NFLPA has fought for and won further massive increases in pension benefits for retired players. The benefits of many older players have more than tripled. The most impressive improvements came in 2002, when active players voted to give up $124 million in current compensation, and in 2006, when active players voted to give up an additional $214 million, to increase pension benefits for others. When the 2002 CBA improvements were announced, the head of the Pension Rights Center, a Washington D.C. association that works to improve pensions, stated that "[N]obody has reached back and given a pension raise to retired workers of anything approaching this magnitude."

Disability Benefits. As with pension benefits, there have been dramatic increases in disability payments since 1993. Prior to the 1993 CBA, the annual T&P benefit to a player who became totally and permanently disabled due to a career-ending injury on the field was $48,000 per year, and all other T&P benefit payments were $9,000 per year. Today, that $48,000 benefit has grown to $224,000 per year, and the $9,000 benefit translates into an annual benefit of $134,000, $110,000, or $21,000, depending on the category of total and permanent disability. Today, the Plan pays more than $20 million annually in disability benefits to former players. As noted above, the top three categories of T&P benefits pay more than the twice the median annual income in America.

Dementia Benefits. In the 2006 CBA, the NFLPA and the NFL agreed to create the nation's first-ever benefit plan to provide for the care of retired players with dementia and their families. This 88 Plan, named after former Baltimore Colt and NFL Hall-of-Famer John Mackey, whose jersey number was 88, provides benefits to retired players of any era who suffer from dementia. This benefit is directed mainly at the oldest generation of NFL players. Other than cases of substance abuse, the 88 Plan does not discriminate among forms of dementia. Retired players with alzheimer's disease and retired players with dementia caused by concussions or head trauma are covered equally. The 88 Plan pays up to $88,000 per year for retired players who are institutionalized or $50,000 for retired players who are not institutionalized. The Alzheimer's Association in New York City recognized Gene Upshaw and Harold Henderson of the NFL for establishing this ground-breaking arrangement.

Severance Benefits. Beginning in 1982, players became eligible to receive severance pay. Over $18 million is paid out in severance payments to players each year.

Extended Health Care Benefits. Vested players now have continuing medical and dental coverage at no cost to them for up to five years after they leave the playing field. Until 1998, there was no post-career health coverage for football players. In addition, as a result of the 2006 CBA, many players will leave the game with a health reimbursement account of up to $300,000 that they can use throughout their lives to pay for health care for themselves and their dependents.

Retired Players Services. The NFLPA maintains a five-person department whose sole purpose is to provide services to retired players. In addition, the NFLPA's in-house benefits department contains four individuals who spend the majority of their time on issues related to former players. These nine people assist retired players with applying for charitable and educational assistance, finding low or no cost health services such as preventive screenings and orthopedic surgery, transitioning to retirement, and otherwise remaining active in the football community in retirement. The Retired Players Department also supports studies on medical and other issues of interest to retired players. All of these activities are fully funded by the NFLPA.

Players Assistance Trust. The Players Assistance Trust provides money to former players who cannot pay for medical care, medication, relocation, mortgage costs, burial expenses, and other expenses. It is funded by active players through the bargaining process. In 2006, the Players Assistance Trust paid out more than $1.5 million.

Many Players Fail to Take Advantage of Workers Compensation, Another Important Benefit

Many of the retired players who today complain that they cannot receive proper medical attention did not follow the advice of the NFLPA to pursue Workers Compensation. This program was negotiated by the NFLPA and is charged against the players' share of League

revenues. It provides a panel of experienced lawyers to assist players in filing and obtaining relief under Workers Compensation. In general, this system gives players who qualify the opportunity to obtain lifetime medical care for their NFL injuries.

* * *

Thank you for the opportunity to supplement my testimony and for including it in the hearing record.

Respectfully,

Douglas W. Ell

cc: Honorable Chris Cannon