

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DORA R. GARCIA : CIVIL ACTION
 :
 v. :
 :
 FORTIS BENEFITS INSURANCE CO. : NO. 99-826

MEMORANDUM

Giles, C.J.

January ___, 2000

Dora R. Garcia (“Garcia”) sues under the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001 et seq., seeking to recover benefits due under the terms of a group long-term disability insurance plan. Before this court, for the second time, is the Motion for Summary Judgment of Defendant, Fortis Benefits Insurance Co. (“Fortis”). For the reasons that follow, the motion is granted.

Background

Factual Background

Garcia, an attorney, became employed in February 1995 with non-party John Gerard Devlin & Associates, P.C. (“Devlin”). Devlin arranged to have Fortis provide group long-term disability insurance for its full-time employees, including Garcia.

The Policy

Fortis and Devlin agreed to Policy G 4,003,003 (“the Plan”), which became effective on May 1, 1996. The Plan defines “disability” or “disabled” based on satisfaction of one of two tests in any particular month. Under the “Occupation Test,” a person is considered disabled if “during a *period of disability* (including the *qualifying period*), an *injury*, sickness, or pregnancy requires that [she] be under the *regular care and attendance* of a *doctor*, and prevents [her] from

performing at least one of the *material duties* of [her] regular occupation.” (Plan at 4) (emphasis in original). Under the “Earnings Test,” a person may be considered disabled, even if she actually is working, “if an *injury*, sickness, or pregnancy, whether past or present, prevents [her] from earning more than 80% of [her] *monthly pay* in that month in any occupation for which [her] education, training or experience qualifies [her].” (Plan at 4) (emphasis in original). If a person qualifies as disabled under the Earnings Test, full-time work, that is, performing all the material duties of that occupation, will not interrupt the qualifying period or period of disability. If a person qualifies under the Occupation Test only, less than full-time work, or work in which she is not performing all the material duties of that regular occupation, will not interrupt the qualifying period or period of disability. (Plan at 4).

The Plan establishes guidelines for when benefits will be paid and to whom. The Plan also provides that Fortis has “the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by [Fortis] are conclusive and binding on all parties.” (Plan at 23). Claimants must send Fortis written notice of an insured loss within 30 days after that loss occurs. The Policy also expressly provides that the “time limit for filing a claim is 90 days after the end of the first month (or shorter period) for which [the Plan is] liable,” although if it is not reasonably possible for a claimant to provide proof on time, Fortis will not deny the claim if she provides proof “as soon as reasonably possible.” (Plan at 23). Fortis is entitled to request “whatever reasonable items [it] decide[s] are necessary as proof of loss or to decide [its] liability” and to require the release of medical and dental information; Fortis will not pay benefits if such information is not provided or released. (Plan at 23).

Garcia's Claim

On June 3, 1998, Fortis received documentation in support of Garcia's claim for disability.¹ In her Claimant Statement, signed and dated May 26, 1998, Garcia stated that the relevant symptoms appeared "[o]ver an extended period of time, more evident in winter of 1996-1997;" the first day that she was unable to work because of her medical condition was May 19, 1997. The statement identified three physicians with whom she had consulted for her condition: 1) Dr. Berenbaum, whom she first visited on June 26, 1997; 2) Dr. Landes, whom she first visited on May 14, 1997; and 3) Dr. Gruener, whom she first visited on July 29, 1997. In addition, the statement indicated that Garcia had returned to work, on a part-time basis, on January 12, 1998, although with a different employer. Garcia simultaneously filed a Supplementary Report for Benefits, also signed and dated May 26, 1998, in which she described the terms of her present part-time employment as "[m]inimal stress, half-days, 2 to 3 days per week," on her doctor's advice. The second page of the Supplementary Report, to have been completed by an attending physician, was left blank.

Devlin filed an Employer Long Term Disability Claim Statement, also received by Fortis on June 3, 1998. That form was not signed by anyone from Devlin. According to that statement, Garcia's last day worked was June 20, 1997 and the "effective date" was August 17, 1997. The

¹ Two forms--the Claimant Statement and the Supplementary Report for Benefits--were sent with a cover letter from Allen L. Feingold of A.L. Feingold Associates, Garcia's attorney. The letter was dated May 26, 1998, but copies of the letter and documents submitted on the record bear a date-of-receipt stamp of June 3, 1998. Anne Kidder ("Kidder"), a Supervising Team Leader for Fortis and one of three claims examiners to review Garcia's submission, states in a declaration that the Feingold letter and accompanying forms were received by Fortis on June 3 and that this was the first notice Fortis had of Garcia's claim. Garcia presents no evidence to challenge or contradict Kidder's assertions.

form shows that Garcia was employed by Devlin beginning on February 6, 1995, working five days per week, eight hours per day.

Finally, Dr. Berenbaum submitted an Attending Physician's Initial Statement of Disability, also received by Fortis on June 3, apparently signed on March 13, 1998. According to Dr. Berenbaum, Garcia's symptoms first appeared prior to May 19, 1997 and her first visit to him for that condition was June 26, 1997. Dr. Berenbaum stated that Garcia was totally disabled from May 19, 1997 until January 12, 1998, after which point she was partially disabled, able to work half-days, 2 to 3 days per week, subject to minimal stress. He stated her prognosis as "poor" and indicated that she would be re-evaluated during summer 1998. The physician statement also indicated that Garcia was hospitalized for her condition on two occasions, in July 1997 and October 1997.

The statement listed various subjective symptoms: "abdominal and intestinal pain and discomfort, severe at times; bloating, diarrhea, gas, cramping, acid indigestion." Spaces on the form marked "Diagnoses" and "Objective findings" were left blank. However, in the space on the form marked "Describe Treatment Program," Dr. Berenbaum stated that on July 22, 1997, he had performed a gastroscopy and biopsy, from which he diagnosed ("DX") Garcia with "GERD," which apparently is gastroenterological reflux disorder; bile reflux alkaline gastritis; and erosive gastritis. He also listed several medications prescribed for these conditions. On October 23, 1997, Dr. Berenbaum performed a colonoscopy, from which he diagnosed irritable bowel syndrome, nonspecific colitis, and anxiety stress situational reaction. Additional medications were prescribed. It appears that Dr. Berenbaum did provide Fortis with his diagnoses and objective conclusions as to Garcia's condition, but wrote this information in the wrong space on

the attending physician's form.

Fortis' Denial of Benefits

On June 16, 1998, the first of three Fortis claims examiners provided comments on a New Claim Recommendation Form as to Garcia's claim for disability benefits. Jane Hansen noted that she had used June 26, 1997 as the onset date of Garcia's disability, being the day Garcia first was seen by her attending physician, Dr. Berenbaum, although Garcia's last day worked was June 20. Hansen noted that "no diagnosis listed," but that symptoms and treatment "indicate gastritis w/ surgery, situational stress (work)." Hansen also noted the late submission and that Garcia's employer had not signed the relevant form. Hansen finally recommended that Fortis "[d]eny for late sub."² Karri Sartain reviewed the file and on June 18, 1998 wrote on the form "agree with above." Finally, on June 26, Kidder reviewed the file and wrote on the form "agree to deny Late Sub."

On June 26, Kidder sent a letter to Garcia's attorney, stating that "[a]fter thoroughly reviewing the information you presented to us, we must inform you that we are unable to determine our liability and consequently must deny her claim due to the untimely submission." The letter quoted Plan provisions outlining the timing requirements for filing a claim. It then stated as follows:

Since the onset date of Ms. Garcia's disability appears to be June 26, 1997, the time limit for filing a claim is April 26, 1998. Since you did not file and we did not receive this claim until after this latter date, the time limit for filing this claim was exceeded.

Nevertheless, we reviewed Ms. Garcia's claim submission in an

² There does not seem to be any disagreement that "sub" is an abbreviation on this form for "submission."

attempt to determine if we could establish our liability. The evidence you presented has not yet established to our satisfaction that Ms. Garcia is disabled from performing the material duties of her regular occupation. Consequently, we must deny her claim.

(June 26, 1998 Letter at 2). The letter went on to outline the procedures for appealing this determination under the plan and to state that there was a time limit of 60 days from the date of receipt of the denial letter for filing such an appeal.

There followed some delay, difficulty, confusion, and disagreement in getting the denial letter to Garcia and her attorney. On July 9, 1998, Hansen had a telephone conversation with Debbie Healy (“Healy”), an assistant to Garcia’s attorney, in which Healy stated that their office had not yet received a letter confirming Fortis’ receipt of Garcia’s claim. A record of the telephone conversation presented to this court indicates that Hansen told Healy that the claim had been processed, that the letter should come “any day,” and that Healy should call if the letter does not arrive. On July 29, 1998, Hansen called the office of Garcia’s attorney, attempting to confirm the fax number in order to re-send the denial letter, which Garcia’s attorney still had not received. That same day, Hansen also mailed a copy of the June 26 denial letter to Garcia’s attorney. Fortis’ records indicate that Garcia was given 60 days from July 28 to appeal the denial of the claim for late submission; when she had not done so by October 30, the file was closed. Closure of the file was approved by Hansen and Brenda Martin on that date. It is not clear when Garcia or her attorney first learned of the denial of benefits and the appeals procedures. However, that is not relevant to and does not affect the present inquiry, because neither the issue of Garcia’s failure to take an administrative appeal of the denial nor the timeliness of such an appeal is at issue on this motion.

Procedural History

Garcia filed her initial complaint in the Court of Common Pleas of Philadelphia County on or about February 3, 1999, asserting state-law claims for breach of contract, negligent and intentional infliction of emotional distress, and violations of the Pennsylvania Bad Faith Statute, the Pennsylvania Unfair Trade Practices and Consumer Protection Law, and the Pennsylvania Unfair Practice Act. Garcia sought to recover benefits owed under the insurance plan and damages from the breach of the agreement. Fortis removed the case to this court, pursuant to 28 U.S.C. § 1441(a), on or about February 18, 1999; Fortis then moved to dismiss the claims pursuant to Fed. R. Civ. P. 12(b)(6), arguing that Garcia’s state law claims were pre-empted by ERISA. By Order Dated March 26, 1999, this court granted that motion and dismissed Garcia’s complaint without prejudice, finding that her state law claims were preempted by ERISA, which expressly supersedes all state law claims that relate to any employee benefits plan. See 29 U.S.C. § 1144(a); see also Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (describing the “expansive sweep” of § 1144(a) and its application to any claim that “has a connection with or reference to” an employee benefits plan). Garcia was given leave to re-plead any meritorious ERISA claims.

In April 1999, Garcia filed her Amended Complaint, asserting that Fortis’ denial of disability benefits was arbitrary and capricious and therefore constituted a breach or violation of the Plan. Fortis then moved to dismiss the Amended Complaint or for summary judgment, arguing that Garcia had failed to exhaust her administrative remedies by not appealing the denial of benefits under plan procedures prior to seeking relief in this court. See Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir. 1990) (“To the extent the Employees seek to enforce the terms of the Plan, they must exhaust their administrative remedies before seeking judicial

relief.”) (citations omitted), cert. denied, 499 U.S. 920 (1991). By Order Dated July 26, 1999, this court treated the motion as one for summary judgment and denied the motion. This court stated that the denial letter was confusing as to whether the denial of benefits was based on the untimeliness of the filing of the claim or on the merits of the claim. Given the possibility that the letter also confused Garcia and her attorney, this court was unable to declare as a matter of law that Garcia’s failure to appeal would not have been futile so as to excuse the failure to exhaust administrative remedies. See Brown v. Continental Baking Co., 891 F. Supp. 238, 241 (E.D. Pa. 1995) (Brody, J.) (describing the “clear and positive showing of futility” necessary to excuse a failure to exhaust under ERISA).

On September 2, Fortis filed the instant motion for summary judgment. By Memorandum and Judgment Order Dated November 23, 1999, this court granted the motion and entered summary judgment in favor of Fortis, holding that there was no evidence in the record suggesting that Fortis acted arbitrarily and capriciously in denying Garcia’s claim as untimely and therefore summary judgment was proper. However, by Order Dated December 1, 1999, vacated and withdrew that opinion and order in order to reconsider that ruling in light of the Supreme Court’s decision last term in UNUM Life Ins. Co. v. Ward, 119 S. Ct. 1380 (1999). The parties were ordered to brief the applicability of that decision to the instant case. Having considered the parties’ arguments as to the applicability of Ward, this court renews its consideration of Fortis’ motion.

Discussion

This court has federal question jurisdiction over this matter as the claim arises under ERISA, a law of the United States. See 28 U.S.C. § 1331. Venue is proper in this judicial

district, as Fortis, a corporation, can be said to reside in this judicial district. See 28 U.S.C. §§ 1391(b)(1), (c).

This is an ERISA civil enforcement action, brought pursuant to 29 U.S.C. § 1132(a)(1)(B), which permits a participant or beneficiary of an employee benefit plan to bring a private civil action to challenge the denial of benefits and to recover the benefits due under the terms of the plan. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 108 (1989); 29 U.S.C. § 1132(a)(1)(B). However, the statute does not dictate the appropriate standard of review for such actions. Firestone, 489 U.S. at 109. The Supreme Court filled this gap in Firestone, holding that “a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Id. at 115. Where the plan vests the administrator with such discretionary authority, this court reviews the benefits decisions only to determine whether the decision was arbitrary and capricious. Moats v. United Mine Workers of America Health and Retirement Funds, 981 F.2d 685, 687 (3d Cir. 1992); Nazay v. Miller, 949 F.2d 1323, 1335 (3d Cir. 1991); see also id. at 1336 (suggesting that the arbitrary and capricious standard requires the court to determine if the administrator abused its discretion). Such discretion either may be expressly granted or implied by the terms of the plan. See Nolen v. Paul Revere Life Ins. Co., 32 F. Supp. 2d 211, 214 (E.D. Pa. 1998) (Robreno, J.); see also Luby v. Teamsters Health, Welfare, and Pension Trust Funds, 944 F.2d 1176, 1180 (3d Cir. 1991) (“Discretionary powers may be implied by a plan’s terms even if not granted expressly.”). This deferential review applies both as to factual determinations and as to interpretations of the policy. Nolen, 32 F. Supp. 2d at 214. It generally is agreed that the plaintiff bears the burden of showing

that the denial of benefits was arbitrary and capricious. See Stout v. Bethlehem Steel Corp., 957 F. Supp. 673, 691 (E.D. Pa. 1997) (Van Antwerpen, J.); Tomczyscyn v. Teamsters, Local 115 Health & Welfare Fund, 614 F. Supp. 403, 405 (E.D. Pa. 1985) (Luongo, C.J.); Carr v. Trustees of the Hotel & Restaurant Employees and Bartenders Int’l Union Pension Fund, 585 F. Supp. 949, 950 (E.D. Pa. 1984) (Shapiro, J.).

This court thus undertakes a two-part inquiry. First, it must determine whether the terms of the plan grant to Fortis the discretion to find facts, interpret the policy, and make the conclusive determinations of Garcia’s eligibility for benefits, thus warranting the high degree of deference to its determinations that demands arbitrary and capricious review. See Luby, 944 F.2d at 1180. Second, this court must review the decision under the appropriate standard of review to determine if Fortis exercised its power in violation of ERISA. See Nazay, 949 F.2d at 1335.

Standard of Review

Taking the first step, as discussed supra, the plan in the instant case explicitly declares that Fortis “shall have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy. All determinations and interpretations made by [Fortis] are conclusive and binding on all parties.” (Plan at 23). Given this express and unambiguous statement of discretionary authority, it is clear that the language of the plan vests in Fortis the authority to construe and interpret its terms and to make determinations as to claims and claimants’ entitlement to benefits. See Nolen, 32 F. Supp. 2d at 215 (citing cases and stating that similar language has been held to bestow discretionary authority to construe and interpret the policy).

This court concludes therefore that it must decide this case under the arbitrary and

capricious standard of review and the parties do not suggest or argue otherwise. Under this standard “a district court may overturn a decision of the Plan administrator only if it is without reason, unsupported by substantial evidence or erroneous as a matter of law.” Abnathya v. Hoffman-LaRouche, Inc., 2 F.3d 40, 45 (3d Cir. 1993) (citations and internal quotation marks omitted). The scope of review is narrow and this court is not free to substitute its own judgment for that of the plan administrator in determining eligibility for benefits. Id.; Nolen, 32 F. Supp. 2d at 214. As applied to the interpretation and application of a provision of a pension plan, this standard requires that the decision ““should be upheld even if the court disagrees with it, so long as the interpretation is rationally related to a valid plan purpose and not contrary to the plain language of the plan.”” Moats, 981 F.2d at 687-88 (quoting Gaines v. Amalgamated Ins. Fund, 753 F.2d 288, 289 (3d Cir. 1985)).

There is a time limitation within the arbitrary and capricious review standard. An ERISA plan administrator is obligated to discharge his duties “with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.” 29 U.S.C. § 1104(a)(1)(B) (emphasis added). This court examines the whole record, which consists of, and is limited to, the facts and evidence that were before the administrator when it made the decision under review. Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997) (citations omitted); see also Sandoval v. Aetna Life and Cas. Ins. Co., 967 F.2d 377, 381 (10th Cir. 1992) (stating that the district court generally may consider only the evidence before the administrator at the time it made the decision); Voliva v. Seafarers Pension Plan, 858 F.2d 195, 196 (4th Cir. 1988) ([T]he court must consider only the record before the plan

administrator at the time it reached its decision.”). As the tenth circuit put it, “[i]n effect, a curtain falls when the fiduciary completes its review,” Sandoval, 967 F.2d at 381; thus, this court only should ask whether the administrator’s denial was arbitrary and capricious on the basis of the record before the administrator. Mitchell, 113 F.3d at 440.

Fortis’ Denial of Disability Benefits

Turning to the second step, this court must apply that standard of review to the case at bar. This court will serve as the finder of fact should this case proceed to trial. See Pane v. RCA Corp., 868 F.2d 631, 636 (3d Cir. 1989) (stating that private actions under ERISA are equitable and carry no right to a jury trial). However, that does not change the standard on summary judgment. See Josey v. John R. Hollingsworth Corp., 996 F.2d 632, 637 (3d Cir. 1993) (citing Healy v. New York Life Ins. Co., 860 F.2d 1209, 1219 n.3 (3d Cir. 1988), cert. denied, 490 U.S. 1098 (1989)). To survive summary judgment, Garcia must present sufficient evidence from which this court as fact-finder at trial reasonably could conclude that the denial of benefits was indeed arbitrary and capricious or an abuse of discretion under ERISA. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250 (1986) (stating that the inquiry is whether there are issues that only can be resolved by a finder of fact because they reasonably may be resolved in favor of either party).

Basis for Denial

The first issue to determine is the precise basis for Fortis’ denial of disability benefits to Garcia. As discussed supra, Fortis informed Garcia’s attorney of the denial by letter, signed by

Kidder and dated June 26, 1998.³ In the first paragraph, the letter stated that Fortis was “unable to determine [its] liability and consequently must deny [Garcia’s] claim due to the untimely submission.” The letter presented Fortis’ findings that the onset date of Garcia’s disability was June 26, 1997, that the time limit for filing the claim was April 26, 1998, and that because Garcia did not file and Fortis did not receive the claim statement until after that date, “the time limit for filing the claim was exceeded.” The letter then stated that Fortis nevertheless reviewed the claim submission in an attempt to determine if it could establish liability, but that the evidence did not establish to Fortis’ satisfaction that Garcia was disabled, thus Fortis “must deny her claim.” Further, as discussed supra, the notes from the three claims examiners on the New Claim Recommendation Form show explicitly that the denial was based on “late sub[mission],” and also that there apparently were other problems with the submitted documentation going to the merits of the claim.

The record therefore suggests two possible bases for the denial of benefits. On one hand, the reviewers’ comments focus solely and exclusively on untimeliness and suggest untimeliness to be the only basis. On the other hand, the denial letter suggests that the decision was based on alternative grounds, that Fortis concluded both that Garcia’s submission was untimely and that even had it been timely the materials submitted did not establish that Garcia met the plan’s standards for disability. This court finds support for this interpretation of the denial letter in Tomczyscyn, supra. There, a subcommittee of the plan trustees recommended, and the trustees accepted the recommendation, that the claimant “was not eligible for benefits because of his

³ As discussed supra, it is not entirely clear at what point Garcia’s counsel received this letter, although that is not relevant for present purposes.

failure to submit proof of total and permanent disability within one year of the accident and because the medical records did not establish that [the claimant] met the plan’s disability criteria.” Tomczyscyn, 614 F. Supp. at 405 (emphasis added). That court held that such language indicated that the denial rested on two independent and sufficient grounds: that the claimant failed to meet the plan’s requirements and that even had he done so, he had failed to submit proof within the required period of time. Id. This court reads the Fortis denial letter of June 26, 1998 to have the same meaning.

What is clear from this record is that the untimely submission was central to the denial of benefits, whether as the sole basis or as one of two independent and sufficient alternative bases. Thus, in order to prevail, Garcia must, at a minimum, present evidence showing that Fortis acted arbitrarily and capriciously in concluding that her submission was untimely.⁴ If the denial indeed was based on alternative grounds, Garcia then would have to present evidence showing that Fortis’ decision on the merits of her claim also was arbitrary and capricious. See Tomczyscyn, 614 F. Supp. at 405 (holding that where trustees based the decision on alternative grounds, plaintiff must show that the decision cannot stand on either ground). Unless Fortis acted arbitrarily and capriciously or abused its discretion in reaching both alternative determinations, its denial decision must stand.

Timeliness

This court therefore will look to the decision as to timeliness first. The evidence in the

⁴ In briefing this motion for summary judgment and defending its denial of benefits, Fortis focuses on both of its conclusions, as to the untimely submission of the claim and as to the merits of the decision. Contrary to Garcia’s suggestion, Fortis did not “resurrect” the timeliness argument in its Reply Brief, but has relied on it as one basis for its decision from the beginning.

record shows that Fortis received the documentation in support of Garcia's claim on June 3, 1998. That date was stamped by Fortis on all four documents it received--Claimant Statement, Supplementary Report for Benefits, Attending Physician Initial Statement of Disability, and Employer Long Term Disability Claim Statement--and on the cover letter from Garcia's attorney. Kidder states in her declaration that Fortis first received notice of the claim on June 3, 1998, the date on which those documents were received, and had no notice of the claim prior to that date. The denial letter and supporting documents also show express findings as to the relevant dates of Garcia's claim: a last day worked of June 20, 1997; a designated onset date of June 26, 1997 (based on her first visit to Dr. Berenbaum); and a time limit for filing of April 26, 1998. Moreover, the cover letter signed by Garcia's attorney and accompanying Garcia's Claimant Statement was dated May 26, 1998, one month after what Fortis found was the filing deadline. The record shows that Garcia did not even submit her claim within what Fortis found to be the relevant time limit.

Garcia presents no evidence as to the timeliness issue and no evidence to counter the substantial evidence presented by Fortis. She provides nothing to show that her submissions to Fortis were received prior to June 3, 1998 or any filing deadline or that the materials even were submitted prior to such a deadline. She provides nothing to show that Fortis erred in its findings as to the date on which her submissions should have been filed in order to be timely or as to the onset date of her alleged disability, much less that such findings were arbitrary and capricious.⁵ Garcia provides nothing to challenge or dispute the facts contained in Kidder's declaration or to

⁵ In fact, Dr. Berenbaum's attending physician report states that Garcia became disabled prior to or on May 19, 1997, which suggests an earlier onset date that would carry with it an even earlier deadline for submission of the claim.

challenge the basis for Kidder's knowledge of those facts. She provides nothing to show that it somehow was not reasonably possible to submit her claim statements within the prescribed time period or that she actually submitted them as soon as reasonably possible. She presents nothing to show that Fortis' conclusion as to that point was arbitrary and capricious. The only thing Garcia does provide is the conclusory statement in her point-for-point Reply to Motion for Summary Judgment that "[i]t is believed that defendant had notice of plaintiff's claim as early as September of 1997." (Pl. Rep. to Mot. for Sum. Judg. ¶ 17). But Garcia points to no evidence or materials of record that support such a statement. Such a conclusory statement, without more, and particularly in the face of the other evidence in the record, is insufficient to withstand summary judgment. See Smith v. Hartford Ins. Group, 6 F.3d 131, 137 (3d Cir. 1993); Fed. R. Civ. P. 56(e).

Garcia's only argument as to timeliness is a legal one. She argues that in order to deny claims based on untimeliness, Fortis must show not only that the claim was not filed on time but also that it suffered some prejudice to its position by such untimely submission of notice. Garcia relies for this position on Brakeman v. Potomac Ins. Co., 371 A.2d 193, 198 (Pa. 1977), in which the Pennsylvania Supreme Court established the prejudice requirement as a matter of Pennsylvania state law in a case involving the denial of benefits for untimely submission under an automobile liability insurance policy. In rejecting this argument in its prior ruling, this court relied on the third circuit's decision in Nazay, 949 F.2d at 1337, in which the court of appeals explicitly and unambiguously rejected Brakeman and the prejudice rule, finding that "[i]mportation of the prejudice rule into the ERISA context is unwarranted and improper." Nazay, 949 F.2d at 1337.

In Nazay, the health insurance plan at issue required that a participant or someone on her behalf notify the insurance company prior to hospitalization and obtain certification for the treatment sought. Nazay, 949 F.2d at 1326. Failure to obtain certification would result in a penalty of 30% of the otherwise covered expenses. Id. The plaintiff in Nazay failed to obtain certification and was assessed the penalty. Id. at 1327. The district court analogized the certification requirement to a timely notice provision in an insurance policy and held that, because Pennsylvania law, under Brakeman, required prejudice to enforce a timely notice provision, prejudice also must be shown in order to enforce a certification requirement and assess that penalty. Id. at 1328. The third circuit reversed, finding the adoption of the prejudice rule into ERISA cases improper. Id. at 1337. It is true that Nazay did not address a notice provision such as the one at issue in the instant case. However, no case law has been found within this circuit addressing the application of Brakeman or a prejudice requirement specifically to a timely notice provision under ERISA. Moreover, the language in Nazay reflects a broad rejection of the application of Brakeman and of any prejudice requirement to any provisions of policies governed by ERISA. Under Nazay, therefore, Fortis was not obligated to show prejudice to its position in order to enforce the timely notice requirement in the plan; it only had to show untimely submission of the claim. Since Garcia presented no evidence tending to show that her claim actually was timely submitted, there was no disputed issue of fact and summary judgment was proper. This was the basis for this court's Memorandum and Judgment Order Dated November 23, 1999.

Following this initial ruling, however, this court turned its attention to the decision last term in Ward, 119 S. Ct. at 1385, in which the United States Supreme Court held that

California's notice-prejudice rule was a law regulating insurance that was saved from preemption under ERISA and therefore became a part of the substantive law of ERISA. Ward did not directly overturn Nazay, because Nazay had not held that the Brakeman rule was preempted, but rather rejected its incorporation into the common law of ERISA. However, the Ward ruling as to notice-prejudice rules became incorporated into substantive ERISA law and Nazay no longer is controlling law in the third circuit.

ERISA broadly supersedes and preempts all state laws that relate to an employee benefit plan, 29 U.S.C. § 1144(a), but exempts from preemption any state law that “regulates insurance.” 29 U.S.C. § 1144(b)(2)(A); see Ward 119 S. Ct. at 1386. The question of whether a law regulates insurance is governed by a two-test. First, this court must ask whether, “from a ‘common-sense view of the matter,’ the contested prescription regulates insurance.” Id. at 1386 (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985)). Second, this court must consider three factors to determine whether the regulation fits within the “business of insurance” as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* See Ward, 119 S. Ct. at 1386. These factors are: 1) whether the rule has the effect of transferring or spreading a policyholder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. Id.

The Ward analysis as to California's rule controls this court's analysis as to the Pennsylvania rule and produces the same result. The Pennsylvania notice-prejudice rule “is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters.” Ward, 119 S. Ct. at 1388. The

Pennsylvania Supreme Court in Brakeman explicitly rejected a strict contractual approach in insurance cases, based on the “true nature” of the insurer-insured relationship, the absence of any real, equal bargaining or negotiating between the parties, and the fact that the terms and conditions of the agreement are dictated almost exclusively by the insurance company. See Brakeman, 371 A.2d at 196. The court also noted that insurance contracts are not purely private matters, but rather contain a strong public interest component that would be disserved in the absence of a prejudice requirement. Id. at 198 n.8. Brakeman therefore was grounded in policy concerns specific to the insurance industry. See Ward, 119 S. Ct. at 1389. The Pennsylvania rule also satisfies two of the three McCarran-Ferguson factors.⁶ The notice-prejudice rule changes the bargain, and therefore the relationship, between the insurer and insured by imposing a mandatory provision in all insurance contracts. Further, the Pennsylvania rule focuses on and is aimed exclusively at the insurance industry and never has been extended to other contractual relationships. The Pennsylvania notice-and-prejudice rule, like the California rule addressed in Ward, is a state law “which regulates insurance” and is saved from ERISA preemption by § 1144(b)(2)(A) and made a substantive part of ERISA cases in Pennsylvania. Were Fortis reviewing Garcia’s claim today, it unquestionably would be required to show not only that Garcia’s submission was untimely, but also that it was prejudiced by that untimely submission. See Ward, 119 S. Ct. at 1389-90; Brakeman, 371 A.2d at 198.

However, the inquiry in the instant case cannot end there. Fortis reached its decision as to timeliness on June 26, 1998; the Supreme Court decided Ward on April 20, 1999,

⁶ Two of the three factors, if satisfied, are sufficient to resolve the question. See Ward, 119 S. Ct. at 1389 (declining to address the first McCarran factor where the remaining factors confirm the common-sense view and are “securely satisfied”).

approximately ten months later. As discussed supra, judicial review under ERISA is confined to the “circumstances then prevailing.” 29 U.S.C. § 1104(a)(1)(B). Fortis argues that the “circumstances” include not only the facts and evidence on the record but also the controlling legal standard. Therefore, just as this court could not consider evidence of disability not available or presented to the administrator, it also may not consider and apply a rule of law that had not been established, and therefore was not applicable, at the time the administrator rendered its decision. In Fortis’ view, this court must look to the state of the law on June 26, 1998, when Fortis rendered its decision on Garcia’s claim, in which case Ward is inapplicable. Instead, Fortis argues, the controlling law was Nazay and that is the legal standard that this court should use in determining whether the denial decision was arbitrary and capricious. Garcia responds that § 1104(a)(1)(B) applies only to the facts and evidence that a reviewing court can consider, not to the legal standard to be applied. Therefore, Ward controls, the Pennsylvania notice-prejudice rule applies, Fortis must present evidence that it was prejudiced by the untimely submission, and its failure to do so establishes an issue of material fact for trial. The parties point to no case law on this point and this court has found none.

This court is of the view that “circumstances then prevailing” necessarily includes not only the factual and evidentiary record, but also the controlling legal standard at the time the administrator interpreted the plan and made its decision. The “curtain falls when the fiduciary completes its review.” Sandoval, 967 F.2d at 381. That curtain necessarily falls not only on the facts and evidence that a district court may consider, it falls on the legal standard it may apply. Just as a district court may not consider evidence that was not available to the administrator, see Mitchell, 113 F.3d at 440, it may not consider a new rule of law that was different from the rule

of law available to the administrator.

To hold otherwise would make it impossible for a plan administrator to make a final interpretation of a plan or decision as to benefits. Fortis' decision was consistent with Nazay, the controlling statement in the third circuit, and therefore in Pennsylvania, as to the applicability to ERISA of a prejudice requirement in June 1998. To now reverse Fortis' decision in reliance upon Ward would be to hold, essentially, that Fortis abused its discretion by failing to predict what the Supreme Court might some day do in an unrelated case. ERISA does not so readily permit reversal of a plan administrator's discretionary decisions. See Abnathya, 2 F.3d at 45 (describing the limited circumstances in which a district court may overturn an administrator's decision under the arbitrary and capricious or abuse of discretion standards).

This court concludes, therefore, that Ward is inapplicable to the instant case. While the notice-prejudice rule established in Brakeman is a rule regulating insurance that is not preempted by ERISA, and while it will apply to ERISA in future cases, it was not the law of ERISA in Pennsylvania in June 1998 when Fortis made the decision at issue. This court continues to rely on Nazay, 949 F.2d at 1337, which was the law at that time. This court therefore rejects as a matter of law the argument that Fortis had to show that it was prejudiced by Garcia's late submission. Fortis has presented evidence tending to show that the denial of benefits on the basis of the untimely submission was proper; Garcia has not presented evidence tending to show that this determination was arbitrary and capricious. She has not met her burden of establishing a genuine issue of material fact requiring trial. Summary judgment is proper.

Merits of Garcia's Claim

If Fortis' denial decision rested on alternative grounds, this court need not decide whether

Fortis abused its discretion in finding the claim materials submitted insufficient to establish Garcia's liability on the merits. See Tomczyszyn, 614 F. Supp. at 406 (finding it unnecessary to decide the second basis for denial where plaintiffs had not met their burden as to the first basis). The fact that there is no factual issue as to timeliness means this court need not decide the merits of the claim, as Fortis urges as an alternate basis for disposition of the summary judgment motion.

However, it is observed that the record before the administrator and before this court is almost entirely devoid of any reasoning underlying the denial of Garcia's claim on the merits. Jane Hansen, one of the Fortis claims examiners, stated that no diagnosis or objective findings were provided by the attending physician. Yet such findings and diagnosis were indeed made and presented to Fortis. They simply were written in the wrong place on the attending physician's form. The claimed lack of diagnosis and objective findings, coupled with the failure of Garcia's employer to sign its claim statement, are the only two explanations for the denial on the merits that appear in this record. Nevertheless, Fortis' concluded in its June 26 denial letter that the "evidence [Garcia] presented has not yet established to our satisfaction that Ms. Garcia is disabled." There would be, in other words, a genuine issue of material fact as to whether Fortis acted arbitrarily and capriciously or abused its discretion in denying Garcia's claim on the merits. However, because the decision denying the claim for untimely submission was not arbitrary and capricious, Garcia is unable to survive Fortis' motion for summary judgment.

An appropriate order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DORA R. GARCIA : CIVIL ACTION
:
v. :
:
FORTIS BENEFITS INSURANCE CO. : NO. 99-826

JUDGMENT

AND NOW, this ___ day of January 2000, upon consideration of the Motion for Summary Judgment of Defendant and the arguments of the parties, for the reasons stated in the attached Memorandum, it hereby is ORDERED that the motion is GRANTED and JUDGMENT is ENTERED IN FAVOR of Defendant and AGAINST Plaintiff.

BY THE COURT:

JAMES T. GILES C.J.

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