

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

MARY ANNE T. HEVENER) Civil Action
)
 v.)
)
 THE PAUL REVERE LIFE INS. CO.) No. 02-415

MEMORANDUM

Padova, J.

August 26, 2002

The instant action arises on Defendant Paul Revere Life Insurance Company's Motion for Summary Judgment and Plaintiff Mary Anne T. Hevener's Counter-motion for Summary Judgment. For the reasons that follow, the Court grants Defendant's Motion. Plaintiff's Motion is denied.

I. BACKGROUND

The following is an action for unpaid benefits pursuant to the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 et seq. In May 1997, Plaintiff, an employee of Firsttrust Bank, applied for and began receiving disability benefits under an ERISA long-term disability benefits plan administered by Defendant Paul Revere Life Insurance Company. Plaintiff stopped working as the result of a disabling back condition. On February 26, 2001, Defendant terminated benefits, determining that Plaintiff was no longer qualified for benefits under the policy's definition of total disability. Plaintiff's appeals were denied.

Plaintiff filed this action, originally for breach of insurance contract and insurance bad faith, in the Court of Common Pleas of Philadelphia County. The suit was brought against multiple insurance entities¹ and Betty Johnson, the named administrative contact for the Plan. Defendants removed the action to this Court, which denied Plaintiff's Motion to Remand and determined that the disability plan is governed by ERISA. Plaintiff filed an Amended Complaint bringing an ERISA claim (Count II) as well as various state and federal law claims. Subsequently, the parties agreed to dismiss with prejudice various of the state law insurance claims, and to dismiss without prejudice the state law bad faith claim, the civil RICO claim, and the federal common law fraud claims. The claims were also dismissed against all Defendants except the Paul Revere Life Insurance Company.

Defendant moves for summary judgment on the ERISA claim. Plaintiff opposes the motion and has filed a counter-motion for summary judgment. Plaintiff also seeks reinstatement of the claims previously dismissed by agreement of the parties, and seeks summary judgment on the dismissed claims as well. For the reasons that

¹Originally named as Defendants were: Paul Revere Insurance Company, the Paul Revere Insurance Group, Provident, Provident Life and Accident Insurance Company, Unum Provident Corporation, Unum Life Insurance Company of America, and First Unum Life Insurance Company ("Paul Revere Defendants").

follow, the Court grants Defendant's motion for summary judgment. Plaintiff's motion is denied in all respects.²

II. LEGAL STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). An issue is "genuine" if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). A factual dispute is

²Plaintiff's request for reinstatement of the previously dismissed claims and for summary judgment on those claims is denied. The state insurance law claims are completely barred because they were dismissed with prejudice. With respect to the other claims that were dismissed without prejudice, a stipulation without prejudice terminates the action (or parts of the action) as if never filed. Martino v. Consolidated Rail Corp., 88-0532, 1988 U.S. Dist. LEXIS 14243, at *2 (E.D. Pa. Dec. 31, 1988) (citing Cardio-Medical Assocs., Ltd. v. Crozer-Chester Med. Ctr., 95 F.R.D. 194, 196 (E.D. Pa. 1982), aff'd 721 F.2d 68 (3d Cir. 1983)). The stipulation is a final order. Id. Once the stipulation is filed, the parties may not vacate the dismissal. Id. Ordinarily, Plaintiff may only renew such claims by filing a new action. Id. None of the exceptions to this general rule, either through language in the stipulation or under Federal Rule of Civil Procedure 60, is applicable in this case. See id. at *2-3. Nor has Plaintiff sought, or been granted, leave to file a Second Amended Complaint. As none of the previously dismissed claims is before the Court, the Court may not reach the merits of those claims, such as granting summary judgment on the claims that are the subject of the stipulation. Hinsdale v. H & R Block of Houston, 66 F.3d 77, 80 (5th Cir. 1995).

"material" if it might affect the outcome of the case under governing law. Id.

A party seeking summary judgment always bears the initial responsibility for informing the district court of the basis for its motion and identifying those portions of the record that it believes demonstrate the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). Where the non-moving party bears the burden of proof on a particular issue at trial, the movant's initial Celotex burden can be met simply by "pointing out to the district court that there is an absence of evidence to support the non-moving party's case." Id. at 325. After the moving party has met its initial burden, "the adverse party's response, by affidavits or otherwise as provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). That is, summary judgment is appropriate if the non-moving party fails to rebut by making a factual showing "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex, 477 U.S. at 322. Under Rule 56, the Court must view the evidence presented on the motion in the light most favorable to the opposing party. Anderson, 477 U.S. at 255. "[I]f the opponent [of summary judgment] has exceeded the 'mere scintilla' [of evidence] threshold and has offered a genuine issue of material fact, then the court

cannot credit the movant's version of events against the opponent, even if the quantity of the movant's evidence far outweighs that of its opponent. Big Apple BMW, Inc. v. BMW of North America, Inc., 974 F.2d 1358, 1363 (3d Cir. 1992).

Where, as here, cross-motions for summary judgment have been presented, the Court must consider each party's motion individually. Each side bears the burden of establishing a lack of genuine issues of material fact. Reinert v. Giorgio Foods, Inc., 15 F. Supp. 2d 589, 593-94 (E.D. Pa. 1998).

III. DISCUSSION

A. Standard of Review for ERISA Claim

A denial of benefits under 29 U.S.C. § 1132(a)(1)(B) ordinarily is reviewed under a de novo standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989). However, "ERISA mandates that [the reviewing Court] apply a deferential 'arbitrary and capricious' standard of review to benefits decisions when plan administrators are given discretionary authority to interpret the terms of the plan." Reinert, 15 F. Supp. 2d at 596 (citing Abnathya v. Hoffman-LaRoche, Inc., 2 F.3d 40, 44-45 (3d Cir. 1993)); see also Firestone Tire & Rubber Co., 489 U.S. at 109. In this case, language contained in the original group plan application provides:

The coverage applied for provides benefits for the employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act

(ERISA), unless otherwise exempted by law. The employer is the Plan Administrator unless otherwise noted. The Paul Revere Life Insurance Company, as claims administrator, has the full, final, binding and exclusive authority to determine eligibility for benefits and to interpret the policy under the plan as may be necessary in order to make claims determinations. The decision of claims administrator shall not be overturned unless arbitrary and capricious or unless there is no rational basis for a decision.

(Def.'s Ex. 7 ("Group Insurance Application") at 4.) The "arbitrary and capricious" standard is essentially the same as the "abuse of discretion" standard. Abnathya, 2 F.3d at 45 n.4. Under this standard, "the district court may overturn a decision of the Plan administrator only if it is 'without reason, unsupported by the evidence or erroneous as a matter of law.'" Abnathya, 2 F.3d at 45 (quoting Adamo v. Anchor Hocking Corp., 720 F. Supp. 491, 500 (W.D. Pa. 1989)). "This scope of review is narrow, and 'the court is not free to substitute its own judgment for that of the [administrator] in determining eligibility for plan benefits.'" Id. (quoting Lucash v. Strick Corp., 602 F. Supp. 430, 434 (E.D. Pa. 1984)).

Where an insurance company both determines eligibility for benefits and pays benefits out of its own funds, however, the standard of review is "heightened" arbitrary and capricious review. Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 2000). This modified standard recognizes that when an insurance company both funds and administers benefits, it is "generally

acting under a conflict" that warrants the heightened form of review. Pinto, 214 F.3d at 378. In this case, Defendant both funded and administered benefits under the long-term disability benefits plan. Under the terms of the policy, Defendant pays benefits under the policy.³ (Def. Ex. 5 at PD8FACE) ("The Paul Revere Life Insurance Company agrees to pay the Group Insurance Benefits set forth in this Policy.") Defendant also is the administrator of claims. (Def.'s Ex. 7 at PRLMS00018.) Because Defendant makes claims determinations and pays the benefits, the heightened standard applies.

Under this "heightened" approach, the courts apply a "sliding scale" approach that integrates the conflict as a factor in applying the arbitrary and capricious standard. Pinto, 214 F.3d at 393. Courts must consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decisionmakers. Id. Factors a court may take into account in determining the appropriate degree of deference include: "the sophistication of the parties, the information accessible to the parties, . . . the exact financial arrangement between the insurer

³Although the language suggests that the Defendant pays the cost of benefits, the papers are somewhat vague as to the ultimate source of funds to pay benefits under the policy. As the Court is granting Defendant's Motion for Summary Judgment under a heightened standard, which is a more rigorous standard of review from the standpoint of the Defendant, this distinction has no effect on the outcome of the disposition of the summary judgment motions here.

and the company [and] the current status of the fiduciary." Id. at 392. The degree of review increases in proportion to the intensity of the conflict. Friess v. Reliance Standard Life Ins. Co., 122 F. Supp. 2d 566, 572 (E.D. Pa. 2000). Though a court may not look outside the administrative record when reviewing an administrator's decision, a court may consider evidence outside the record to evaluate the level of an administrator's conflict of interest and to determine the appropriate standard of review. Dorsey v. Provident Life & Accident Ins. Co., Civil Action No. 01-1072, 2001 U.S. Dist. LEXIS 16353, at *8 (E.D. Pa. Oct. 5, 2001). Evidence of significant conflict of interest places a case at the far end of the sliding scale, under which the court reviews the administrator's decision with a "high degree of skepticism." Pinto, 214 F.3d at 395.

In this case, Plaintiff asserts that the higher standard of review applies, but makes little by way of specific argument that demonstrates a very high degree of heightened review is appropriate. There is no evidence here to suggest that Plaintiff was a sophisticated applicant for benefits who would be on equal footing with the Defendant, thus suggesting the appropriateness of heightened review. See Davies v. Paul Revere Life Ins. Co., 147 F. Supp. 2d 347, 356 (M.D. Pa. 2001). However, none of Plaintiff's allegations of procedural irregularities in the administration of the claim are sufficient to establish substantially heightened

review. Accordingly, based on the inherent conflict caused by an insurer's role in both funding and administering the claims, and on the difference in level of sophistication of the parties, the Court will apply heightened review that falls in the middle of the Pinto sliding scale.

1. The 24-month limitation period

Plaintiff's Amended Complaint alleges various deficiencies in the administration of her disability claim. Her principal complaint is that the Defendant arbitrarily and capriciously applied a different definition of total disability after the first 24 months of benefits. Plaintiff argues that this change in definition was improper under the policy, and that even if it were part of the original policy, it was unconscionable and a violation of Pennsylvania insurance law because it was deceptive and not included in the "exclusions" portion of the policy. Defendant contends that the definition change was clear in the policy and was valid. This change in definition, which Defendant explicitly applied in reevaluating Plaintiff's benefits claim, is the primary reason that benefits were ultimately denied.

Plaintiff's argument is without merit. The group disability policy explicitly provides:

We pay monthly disability benefits to an Employee who satisfies the following definitions. . . .

24 Month Own Occupation Benefit with Partial Disability

TOTAL DISABILITY or TOTALLY DISABLED means that during the Elimination Period and the first 24 months after completing the Elimination Period, the Employee:

1. is unable to perform the important duties of his own occupation on a Full-time or part-time basis because of an Injury or Sickness that started while insured under this Policy; and
2. does not work at all; and
3. is under Doctor's Care.

After 24 months of Own Occupation benefits have been paid, the Employee will continue to be Totally Disabled if he can not work in any occupation for which he is or may become suited by education, training or experience.

(Def.'s Ex. 5 at PD82000.)

Notwithstanding this clear language in the policy, Plaintiff argues that other language in the documentation promised to apply a different definition. Plaintiff points to a statement on the "general information" page of the policy explanation, which states: "If you are Disabled and not able to work for your Employer for an extended period of time, group long term disability insurance pays a cash benefit to replace a portion of the Earnings you lose from your Employer as a result of your Disability." (Pl.'s Ex. A "Booklet-Certificate Q&A" at CD8-GEN G-1.) Relying on this language, Plaintiff argues that the policy "promised to pay her [Plaintiff] indefinitely if she was unable to work for her employer." (Pl.'s Mem. at 26.) Plaintiff's reliance on this language is untenable. The language of the policy makes clear that

in order to be entitled to benefits, the employee must be totally disabled under the meaning of the policy. The policy provides two different definitions of total disability, one applicable to the first 24 months of disability, and the other applicable thereafter. There is nothing ambiguous about any of the language in the policy or supporting documentation that would support Plaintiff's position. Accordingly, Defendant's use of this definition as outlined in the policy cannot be considered to have been arbitrary and capricious, even under a heightened standard of review.

2. Finding of total disability

Plaintiff next claims that Defendant acted arbitrarily and capriciously by determining that Plaintiff was not totally disabled. In denying Plaintiff's claim, Defendant determined that Plaintiff was capable of performing sedentary work, and identified a number of sedentary positions for which she would be suited. (Def.'s Ex. 29 "Letter of Feb. 26, 2001"). Defendant based this decision upon the restrictions and limitations identified by Plaintiff's attending physician, Dr. Neil Mallis, (id.), and the report of a vocational expert, who identified sedentary positions using the criteria established by Dr. Mallis. (Def.'s Ex. 27.) Plaintiff appealed the decision, and in support of the appeal submitted two additional notes from Dr. Mallis.⁴ (Def.'s Ex. 30.)

⁴In the first, a note dated March 23, 2001, Dr. Mallis observed that Plaintiff "remains totally disabled from work due to her lower back disorder." (Def.'s Ex. 30.) In a subsequent, more

On both levels of appeal, UNUMProvident upheld the denial of benefits, concluding that there was no objective medical evidence - including the new letters by Dr. Mallis - to indicate that Plaintiff was not capable of performing sedentary work like the work identified by Defendant's vocational expert. (Def.'s Ex. 31 "Letter of May 23, 2001"; Def.'s Ex. 35 "Letter of Oct. 23, 2001.")

Defendant's denial of Plaintiff's claim was not arbitrary and capricious. In denying the claim, Defendant did not dispute that Plaintiff was suffering from limitations and restrictions as the result of back injuries, and did not disregard objective medical evidence of her back disorder. See (Def.'s Ex. 10 "Statement of Dr. Mallis dated May 5, 1997"); (Def.'s Ex. 14 "Report of Dr. Erwin R. Schmidt dated January 13, 1998"). Rather, Defendant relied on the results of the vocational expert's report, which in turn were based on the restrictions provided by Plaintiff's own treating physician. See (Def.'s Ex. 29); (Def.'s Ex. 27). The consistency of the results of the vocational expert report and the restrictions

detailed letter, he noted that:

The above-captioned patient [Ms. Hevener] has been under my care on a regular basis for the treatment of degenerative disc disease in the lumbar spine with associated multiple disc herniations.

The nature of this condition is one of a progressive disease, generally worsening over a period of time. As a direct result of this lumbar disc disease, the patient is unable to sit or stand for prolonged periods of time, as this will exacerbate her symptoms.

(Def.'s Ex. 30.)

given by Dr. Mallis were verified by a medical expert reviewer. (Def.'s Ex. 28 "Review by Dr. Frank dated July 7, 2000.")

Moreover, Dr. Mallis' statements and reports regarding Plaintiff's condition that are contained in the claims file largely support Plaintiff's ability to engage in the type of sedentary work recommended by the vocational expert. In his initial May 5, 1997 statement of her condition, he listed no heavy lifting, pulling, pushing, prolonged standing, or sitting as restrictions on her work abilities. (Def.'s Ex. 10.) In the functional capacity form dated November 23, 1999, Dr. Mallis indicated that Plaintiff's strength level was sedentary, in that she could lift less than 10 pounds occasionally, and that she could sit, stand, and walk up to a maximum of four hours during an 8-hour workday with breaks at least every half hour. (Def.'s Ex. 21.) In his subsequent functional capacity form dated June 8, 2000, Dr. Mallis indicated that Plaintiff could sit for one hour at a time 4-6 hours per day, could walk and stand 2 hours at a time 4-6 hours per day, and could lift 10 pounds occasionally. (Def.'s Ex. 26.)

Thus, Defendant's disability determination was largely based on Dr. Mallis' diagnoses and treatment notes. The only evidence that supports Plaintiff's position is the March 23, 2001 note from Dr. Mallis indicating that Plaintiff is "totally disabled from work due to her lower back disorder." (Def.'s Ex. 30.) However, Dr. Mallis' statement does not clarify, for example, whether she is

totally disabled from her position at Firsttrust Bank, or totally disabled from any other similar position, or whether she is able to carry out sedentary type work. Dr. Mallis' April 10, 2001 note is more specific, but again states nothing about Plaintiff's ability to carry out sedentary work, except that he once again states that she is "unable to sit or stand for prolonged periods of time," which is consistent with his prior treatment notes.⁵ See (Def.'s Ex. 30.) The restrictions in the April 10, 2001 note are unchanged from those indicated in prior notes in the claims file.

Moreover, to the extent that the Defendant disregarded aspects of Dr. Mallis' opinion, the decision was not arbitrary and capricious under heightened review in light of the other evidence considered by the Defendant. Aside from Dr. Mallis' treatment notes and reports, Defendant relied on: evaluations by the independent medical examination by Dr. Erwin R. Schmidt, Jr.⁶ (Def.'s Ex. 14); a non-examination medical records review by Dr.

⁵Plaintiff also relies on Dr. Mallis' statement that "[t]he nature of this condition is one of a progressive disease, generally worsening over a period of time." (Def.'s Ex. 30.) This statement, however, sheds little light on the issue of whether Plaintiff was currently able to perform sedentary work.

⁶In his January 13, 1998 report, Dr. Schmidt concluded that Plaintiff demonstrated: "objective findings of S1 nerve root irritation based on EMG evaluation. She demonstrates no other objective evidence of radiculopathy. She subjectively cannot sit for any period of time which precludes her working at the occupation described. This could relate to nerve root irritation, but there is no evidence of damage." (Def.'s Ex. 14.)

Edward C. Alvino, M.D.⁷ (Def.'s Ex. 20); and a non-examination file and record review by Dr. Michael Theerman.⁸ (Def.'s Ex. 24). Defendant also considered the administrative law judge opinion denying Plaintiff's claim for social security benefits⁹ (Def.'s Ex. 25.); a home interview with the insured (Def.'s Ex. 22); and an interview with Dr. Mallis. (Def.'s Ex. 23.)

Considering all of this evidence contained in the claims file, and applying heightened review, the evidence does not support Plaintiff's conclusion that the Defendant acted arbitrarily and

⁷In his June 14, 1999 report, Dr. Alvino opined that the medical records "would support the impression of 'chronic pain' . . ." He further opined that "I would think that the insured may be physically capable of performing an appropriate 'any occ' job with her reported diagnosis. . . . I would not expect that this 29 y.o. should remain totally precluded on a physical basis from performing an appropriate 'any occ' job . . ." (Def.'s Ex. 20.)

⁸In his December 22, 1999 report, Dr. Theerman opined that: "A discogram on 9-10-99 was reportedly positive at four levels, but one of those levels which produced her exact pain had a totally normal disc. This is usually considered evidence of symptom magnification or embellishment, as a normal disc should not produce pain when injected. Therefore, there is some doubt as to the credibility of the insured's allegations. Nevertheless, we cannot ignore the extensive disc abnormalities found on her imaging studies, and therefore we cannot be sure that she does not have the degree of pain she alleges. It is quite possible for someone with her degree of disc disease to have that much pain. And if she truly has that much pain, then she could be precluded from 'any occ'." (Def.'s Ex. 24.)

⁹In the opinion, the ALJ determined that: "The medical evidence establishes that the claimant does not have an impairment or combination of impairments . . ." and "The claimant's testimony is not accepted to the extent she has described limitations exceed[ing] what is shown by or could reasonably be expected from the objective medical evidence." (Def.'s Ex. 25.)

capriciously in denying the claim, and is not sufficient to establish a genuine issue of material fact as to Plaintiff's ERISA claim. The Defendant's decision was based on restrictions and limitations specified by Plaintiff's own physician. The only medical conclusion which Defendant arguably disregarded was Dr. Mallis' one-sentence statement that Plaintiff was totally disabled as the result of her back disease, but even this statement lacks specificity or support in the objective medical record contained in the claims file. The Court grants Defendant's Motion for Summary Judgment and enters judgment in favor of Defendant and against Plaintiff. Plaintiff's Motion is denied in its entirety.

An appropriate Order follows.

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

MARY ANNE T. HEVENER) Civil Action
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 THE PAUL REVERE LIFE INS. CO.) No. 02-415

ORDER

AND NOW, this 26th day of August, 2002, upon consideration of Defendant's Motion for Summary Judgment (Doc. No. 22), Plaintiff's Reply to Defendant's Motion for Summary Judgment and Counter Motion for Summary Judgment (Doc. No. 23), and any and all supporting and opposing briefing thereto, **IT IS HEREBY ORDERED** that said Defendant's Motion (Doc. No. 22) is **GRANTED** and Plaintiff's Motion (Doc. No. 23) is **DENIED**. **JUDGMENT** is entered in favor of Defendant and against Plaintiff. This case shall be closed for statistical purposes.

BY THE COURT:

John R. Padova, J.