

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

MARIA J. THORPE : CIVIL ACTION  
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 v. :  
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 CONTINENTAL CASUALTY :  
 COMPANY : NO. 01-5932

O'NEILL, J. DECEMBER , 2002

MEMORANDUM

Plaintiff, Maria J. Thorpe, filed a complaint against defendant Continental Casualty Company alleging violations of the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001 et seq. Plaintiff requests that I order Continental to reinstate her status as totally disabled under the terms of her long term disability plan, award her disability benefits for the time since Continental’s denial of her claim and award her reasonable attorney’s fees and costs. Before me now are defendant’s motion for summary judgment, plaintiff’s motion for summary judgment and the responses thereto.

BACKGROUND

Since 1998, Plaintiff has been employed as a Senior Supervisor at Computer Sciences Corporation and, through that employment, received the benefit of long term disability insurance from Continental. The policy provides for benefits if the employee meets its definition of

disability, which is:

*Injury or Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

- (1) continuously unable to perform the *Material and Substantial Duties of Your Regular Occupation*; and
- (2) not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

Pl.'s Mot. for Summ. J. ex. A (the administrative record), at 10. Plaintiff describes the material and substantial duties of her position as Senior Supervisor as: "ability to concentrate, decision-making, problem-solving, sustained effort, ability to cope with stress and complete detailed work." Pl.'s Mot. for Summ. J. p. 12. Continental described her duties as: "sedentary in nature," "consist[ing] of technical support in the customer service department." Def.'s Mot. for Summ. J. p. 5.

As of September 1, 2000, Continental granted plaintiff long term disability benefits due to her Meniere's disease<sup>1</sup> and chronic fatigue syndrome.<sup>2</sup> Continental paid plaintiff long term disability benefits from September 2000 until June 2001.

On July 11, 2001, Continental advised plaintiff by letter of its decision to terminate her long term disability benefits. The company stated that the medical information in plaintiff's file did not indicate a physical or psychological impairment that rendered plaintiff disabled under the plan as of June 30, 2001. Plaintiff appealed the decision through Continental's administrative process, which ended on October 10, 2001, with a decision from Continental's Appeals

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<sup>1</sup>Meniere's disease is a pathological condition of the inner ear characterized by dizziness, ringing in the ears and progressive loss of hearing.

<sup>2</sup> It was later established that plaintiff was also suffering from depression, anxiety and post-traumatic stress disorder.

Committee that finalized the denial of benefits.

Plaintiff seeks to recover benefits she claims Continental owes her under Section 502 of the Employee Retirement Income Security Act (“ERISA”). 29 U.S.C. § 1132.<sup>3</sup> Her treating doctors are Robert H. Hall, M.D. and Lorraine H. Saints, Ph.D., a licensed psychologist.

## STANDARD OF REVIEW

### **I. Summary Judgment Standard of Review**

Rule 56 of the Federal Rules of Civil Procedure provides that “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,” the moving party is entitled to summary judgment. Fed. R. Civ. P. 56(c). An issue is genuine if the fact-finder could reasonably hold in the non-movant’s favor with respect to that issue and a fact is material if it influences the outcome under the governing law. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986). It is my obligation to determine whether all the evidence can reasonably support a verdict for the non-moving party. See Allstate Ins. Co. v. Brown, 834 F. Supp. 854, 856 (E.D. Pa.1993).

In making this determination the facts must be reviewed in the light most favorable to the non-moving party. See Anderson, 477 U.S. at 248. Further, the non-moving party is entitled to

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<sup>3</sup>Section 502 provides that:  
A civil action may be brought—  
(1) by a participant or beneficiary—  
(B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

all reasonable inferences drawn from those facts. Id. However, the non-moving party must raise “more than a mere scintilla of evidence in its favor” in order to overcome a summary judgment motion and cannot survive by relying on unsupported assertions, conclusory allegations, or mere suspicions. Williams v. Borough of W. Chester, 891 F.2d 458, 460 (3d Cir. 1989). Although the moving party bears the initial burden of demonstrating the absence of genuine issues of material fact, the non-movant must establish the existence of each element of its case. See Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986).

## **II. ERISA Standard of Review**

When an ERISA plan gives the administrator discretionary authority to determine eligibility for benefits, I may decide only whether its denial of benefits was arbitrary or capricious. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40, 45-46 (3d Cir. 1993). Page six of plaintiff’s policy provides that “When making a benefit determination under this policy, *We* have discretionary authority to determine *Your* eligibility for benefits and to interpret the terms and provisions of the policy.” Pl.’s Mot. for Summ. J. ex. A, at 8 (emphasis in original). The term “We” is defined in the policy as the Continental Casualty Company. Id. at p. 19. Continental clearly has discretionary authority to determine eligibility for benefits. Accordingly, this case will be decided under the arbitrary and capricious standard of review.

In applying the arbitrary and capricious standard, however, I must consider the conflict of interest that arises from Continental’s dual role as both the entity that determines who qualifies for benefits and the entity that pays for those benefits. Pinto v. Reliance Standard Life Ins. Co.,

214 F.3d 377, 387 (3d Cir. 2000). This conflict of interest is made clear from the language contained in the policy issued by Continental. The first page of the policy states that Continental agrees to insure “certain eligible employees of the Employer” and promises “to pay benefits for loss covered by the policy in accordance with its provisions.” When considered with the language from page six of the policy that reserves Continental’s right to determine eligibility to receive benefits under the plan, it is clear that Continental determines who receives benefits under the plan and also pays those benefits. A heightened arbitrary and capricious standard of review is, therefore, warranted.

In this Circuit, the amount of deference given to the insurer under the heightened arbitrary and capricious standard is determined on a case-by-case basis along a sliding scale. Pinto, 214 F.3d at 392. Continental argues that the standard should be on the more deferential end of the sliding scale under the factors listed in Pinto, namely: (1) the sophistication of the parties, (2) the information accessible to the parties, (3) the exact financial arrangement between the insurer and the company, and (4) the current financial status of the fiduciary. Id.

Contrary to Continental’s analysis of the case, however, the Pinto court did not set down a mandatory or exclusive list of factors that must be considered in each case, but rather suggested some factors that a court may consider. In fact, a decision by the Court of Appeals earlier this year stated that the facts listed in Pinto should be considered “inter alia.” Ceccanecchio v. Continental Casualty Co., 202 U.S. App. LEXIS 21496, at \*12. The Court of Appeals has also said that:

a court should examine how the plan is funded, if the plan is administered by an entity independent from the employer-employee relationship, whether the decisionmaker has any reason to be concerned about employer-employee relations,

and the amount of money that is at stake in the decision at issue. In other words, a court should look at any and all factors that might show a bias and use common sense to put anywhere from a pinky to a thumb on the scale in favor of the administrator's analysis and decision.

Gritzer v. CBS, Inc., 275 F.3d 291, 295 n.3 (3d Cir. 2002) (citations omitted). In light of these rulings, I will not limit my consideration of factors affecting the sliding scale of the standard of review to those listed in Pinto, but will consider all of those facts particular to this case that indicate a bias on the part of Continental. One important factor that affects the sliding scale is the presence of procedural anomalies. Pinto, 214 F.3d at 394.

In this review, I will consider the administrative record as it appeared before Continental's Appeals Committee when it made its final decision on October 10, 2001. See Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997).

## DISCUSSION

After consideration of all of the information before Continental, I find that Continental's decision to terminate plaintiff's long term disability insurance was not supported by substantial evidence and therefore was arbitrary and capricious. Accordingly, I will deny Continental's motion for summary judgment and grant plaintiff's motion for summary judgment.

In light of the procedural anomalies that exist in this case, I will apply a heightened arbitrary and capricious standard of review. Under the heightened standard of review, I will be "deferential, but not absolutely deferential" and "look not only at the result—whether it is supported by reason—but at the process by which the result was achieved." Pinto, 214 F.3d at 393.

The procedural anomalies that justify this standard are the following actions taken by Continental: (1) its reversal of its original decision to grant plaintiff long term disability benefits; (2) its selective reading of the administrative record and use of only those parts of the record that supported its decision to deny benefits; (3) its failure to give the appropriate weight to the opinions of plaintiff's treating physicians; (4) its use of a nurse who did not examine plaintiff to make the determination to terminate benefits; and (5) its overemphasis on a cognitive functioning test that it administered to plaintiff. The evidence in the administrative record along with these procedural anomalies lead me to conclude that Continental's decision to terminate plaintiff's long term disability benefits was arbitrary and capricious under the heightened standard of review.

#### **I. Termination of Benefits Without Sufficient New Medical Information**

Continental granted plaintiff long term disability benefits beginning September 2, 2000. See Am. Compl. ex. B. It reversed this decision and denied benefits as of July 1, 2002. See id., ex. C. The new information that Continental relies upon to support this decision consists of: (1) plaintiff's ability to have dinner with friends, conduct research at a Borders store, take tai chi and art classes, do light house work, and manage her finances; (2) Dr. Saint's notation that plaintiff's depression and anxiety had improved; and (3) findings by Mitch Ruoff, Psy.D. that plaintiff has good cognitive function, is confident and has good concentration. Pl.'s Mot. for Summ. J. ex. A, at 112.

A reversal of a decision to grant long term disability benefits without sufficient new medical information to justify that decision is reason to treat the decision with "significant

skepticism.” Holzschuh v. UNUM Life Ins. Co. of Am., 2002 U.S. Dist. LEXIS 13205, at \*18 (E.D. Pa. July 18, 2002). Although Continental cites to reports of doctors for facts in support of its termination of benefits, there had been no new medical opinion that plaintiff was no longer disabled. This is one reason for which I review the decision under the heightened arbitrary and capricious standard.

Notations by plaintiff’s doctors concerning her activities and how she reported feeling on certain days is not medical information. Furthermore, plaintiff reported on September 27, 2000, the first month that she received long term disability benefits, that she was participating in a limited way in a Tai Chi class once a week, alternating days of Tai Chi and walking for exercise and doing her own laundry and shopping. Pl.’s Mot. for Summ. J. ex. A, at 61–62. Such limited physical activity did not contribute to rendering plaintiff not disabled in 2000, yet Continental says that it does in 2001.

Nor is Dr. Saint’s opinion that plaintiff’s anxiety and depression had improved an opinion that plaintiff is not disabled, especially in the context of Dr. Saint’s repeated expressions of her opinion that plaintiff could not return to work. In a case similar to this one, the Court of Appeals rejected the argument that a doctor’s notation that a patient’s depression was “much improved” was evidence that the patient was no longer disabled under the terms of his disability plan. Skretvedt v. E.I. DuPont De Nemours and Co., 268 F.3d 167, 182 (3d Cir. 2001).

Finally, Dr. Ruoff’s psychological assessment, while a good indication of plaintiff’s cognitive functioning on the particular day that it was given, is not a medical opinion that plaintiff could return to work. Dr. Ruoff himself notes that plaintiff’s “physical limitations will be a much greater challenge for Ms. Thorpe to overcome than any cognitive or intellectual

deficits.” Pl.’s Mot. for Summ. J. ex. A, at 75. Furthermore, Dr. Saints provided Continental with information on chronic fatigue syndrome in which she explained that good cognitive functioning on a particular day does not indicate that a chronic fatigue syndrome patient would be able to work full time. Pl.’s Mot. for Summ. J. ex. A, at 37.

## **II. Selective Reading of the Administrative Record**

Another reason to view Continental’s decision with suspicion is its selective reading of the administrative record and use of only those portions of reports that supported its position. The most striking example of this is Continental’s use of Dr. Hall’s notation that plaintiff “felt better emotionally,” while ignoring the rest of his sentence and the context in which it appeared. Def.’s Mem. at 6. The full sentence follows several in which Dr. Hall reports that plaintiff had been suffering from extreme exhaustion, dizzy spells, mental fogginess, headaches, nausea and aching in her joints. Pl.’s Mot. for Summ. J. ex. A, at 22. The full sentence reads “In spite of all her physical symptoms she felt better emotionally.” Id.

Another example of Continental’s selective reading of the administrative record is its use of several sentences of a report from Dr. Saints without addressing the doctor’s conclusion in that same report that plaintiff “cannot return to work at this time because she cannot sustain a consistent or predictable effort for 8 hours or for 2 days in a row.” Pl.’s Mot. for Summ. J. ex. A, at 77. Such selective and self-serving reading of the administrative record is reason to raise the standard of review. See Pinto, 214 F.3d at 393-94. It is also grounds for finding that an insurer’s denial of benefits was arbitrary and capricious. Holzschuh, 2002 U.S. Dist. LEXIS 13205, at \*23-24; Edgerton v. CNA Ins., 2002 U.S. Dist. LEXIS 15490, at \*22 (E.D. Pa. August 6, 2002);

Mitchell v. Prudential Health Care Plan, 2002 U.S. Dist LEXIS 10567, at \*24-25, 28 (D. Del. June 10, 2002).

### **III. Treatment of the Opinions of Plaintiff's Treating Physicians**

Further suspicion is raised by Continental's treatment of the opinions of plaintiff's treating physicians. On September 25, 2001, Dr. Hall wrote that "[i]n my opinion [plaintiff] is unable to work at this time and for the foreseeable future." Pl.'s Mot. for Summ. J. ex. A, at 23. Dr. Saints advised plaintiff on July 24, 2001 that "In my opinion, you remain unable to work and should appeal CNA's decision regarding your disability benefits." Id. at 38. On September 21, 2001 Dr. Saints wrote that plaintiff "cannot perform at any job in a consistent and predictable manner at this time or in the foreseeable future. I cannot think of a job that would allow [plaintiff] to come and go as needed, to work for 10 minute to two hour intervals followed by hours of sleep, to miss days or weeks at a time, and would tolerate and accommodate her fatigue, muscle pain, dizziness, and cognitive impairment." Id. at 24.

In determining eligibility for ERISA disability benefits, the opinion of the claimant's treating physician is to be given substantial and sometimes even controlling weight. See Skretvedt, 268 F.3d at 184; Edgerton v. CNA Ins., 2002 U.S. Dist. LEXIS 15490, at \*22. Continental accepts plaintiff's doctors' diagnosis of her conditions, but rejects their conclusions regarding the limitations those conditions place on her functionality. Def.'s Mem. at 6-7. In accepting the doctors' diagnoses but rejecting, without stated reason, their opinion that plaintiff cannot return to work, Continental "impermissibly limits the scope of [plaintiff's doctors'] opinion[s] that plaintiff was disabled." Edgerton v. CNA Ins., 2002 U.S. Dist. LEXIS 15490, at

\*29. Continental's rejection of the opinions of plaintiff's treating physicians that plaintiff is unable to work is another reason that I am applying a heightened arbitrary and capricious standard of review and granting plaintiff's motion for summary judgment.

Continental states that it is not obliged to accept the opinions of doctors which are not supported by any objective tests. On the contrary, doctors' opinions do not have to be supported by objective evidence on disability if the condition is not one susceptible to objective testing. Skretvedt, 268 F.3d at 184. In fact, the Court of Appeals has granted a plaintiff's motion for summary judgment despite the insurance company's argument that the plaintiff's diagnosis was not supported by objective evidence of disability. Skretvedt, 268 F.3d at 184 (granting summary judgment for plaintiff suffering from depression and anxiety).

#### **IV. Review of File by Non-Examining Nurse**

Continental did not have a physician review plaintiff's record and examine her, but relies instead upon the decision of a nurse who reviewed the record. Pl.'s Mot. for Summ. J. ex. A, at 42. Failure to obtain an independent physical examination of plaintiff in the face of her treating physicians' opinions that she could not work may suggest that Continental's review was inadequate. See Edgerton, 2002 U.S. Dist. LEXIS 15490, at \*25-26; Holzschuh, 2002 U.S. Dist. LEXIS 13205, at \*19; Mitchell, 2002 U.S. Dist. LEXIS 10567, at \*26.

#### **V. Reliance on Psychological Examination**

Continental did have a doctor of psychology, Mitch Ruoff, Psy.D., examine plaintiff. Continental relies heavily on Dr. Ruoff's conclusions that plaintiff's cognitive functioning was in

the high average range and that she would function well in positions involving problem solving or decision making in its determination to terminate her benefits. See Def.'s mem. at 5. Plaintiff's claim for disability, however, was not based upon a consistent problem with cognitive functioning, but rather upon the physical symptoms of Meniere's Disease and chronic fatigue syndrome, which induces intermittent problems with cognitive functioning. Continental's focus on cognitive functioning is misplaced and, accordingly, does not support its claim that plaintiff is not disabled under the terms of her plan. See Pinto, 214 F.3d at 394 (addressing examination by pulmonologist where plaintiff's disability was not pulmonary). Furthermore, Continental ignores Dr. Ruoff's conclusion that "physical limitations will be a much greater challenge for Ms. Thorpe to overcome than any cognitive or intellectual deficits." Pl.'s Mot. for Summ. J. ex. A, at 75. Thus, Continental relies on Dr. Ruoff's report to support its decision to deny plaintiff benefits despite his own admission that plaintiff's physical symptoms are more likely to keep her from being able to work. Continental could have hired a doctor to examine plaintiff and her medical records to determine whether physical limitations prevented her from working, but it did not do so.

## CONCLUSION

Continental gave more weight to the results of a cognitive function test and the opinion of a nurse who reviewed the file and whose only contact with plaintiff was over the phone than it did to the opinion of two treating physicians. Such a decision merits a heightened arbitrary and capricious standard of review. Under this standard of review, there is insufficient evidence to support Continental's termination of plaintiff's long term disability benefits under the terms of

her plan.

This conclusion is bolstered by the Social Security Administration's (SSA) grant of disability benefits to plaintiff on December 2, 2001 for a period beginning on September 1, 2000. Pl.'s Amended Compl. ex. I. Although the SSA's decision was not available to Continental when it made its decision, and therefore I cannot consider it as evidence that Continental's decision was not supported by evidence, the SSA's decision supports my determination that the evidence shows that plaintiff is disabled under the terms of her plan. See Edgerton v. CNA Ins., 2002 U.S. Dist. LEXIS 15490, at \*23 (stating that decision to grant Social Security benefits could be a factor in determining whether insurance company's denial of disability benefits was arbitrary or capricious).

Plaintiff's request for attorney's fees and costs will be denied without prejudice. Should plaintiff seek reimbursement for attorney's fees, she should file an appropriate supplementary brief accompanied by evidence. Continental may respond thereafter.

An appropriate Order follows.

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

MARIA J. THORPE

v.

CONTINENTAL CASUALTY  
COMPANY

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CIVIL ACTION

NO. 01-5932

**ORDER**

AND NOW, this            day of December, 2002, after consideration of defendant's motion for summary judgment, plaintiff's motion for summary judgment, the responses thereto, and for the reasons set forth in the accompanying memorandum, defendant's motion is DENIED and plaintiff's motion is GRANTED. It is ORDERED that Continental Casualty Company:

- (1) calculate and pay plaintiff the benefits owed to her from June 30, 2001 through the date of this Order plus interest accrued thereon and
- (2) reinstate plaintiff to the status of disabled under the long term disability plan effective December 18, 2002.

Plaintiff's request for attorney's fees and costs is DENIED without prejudice.

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THOMAS N. O'NEILL, JR., J.