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

LINDA THOMPSON-HARMINA, Plaintiff,	:	CIVIL ACTION
v.	:	
RELIANCE STANDARD LIFE INSURANCE COMPANY, Defendant.	:	NO. 04-425

Opinion and Order

Newcomer, S.J. November 23, 2004

Presently before the Court are the Parties' Cross-Motions for Summary Judgment. Plaintiff seeks review of Defendant Reliance Standard Life Insurance Company's ("Reliance") decision to deny her claim for long-term disability benefits. For the reasons set forth below, Plaintiff's Motion is denied and Defendant's Motion is granted. Plaintiff's request for an oral argument is denied pursuant to Local Rule 7.1(f) because the record is already well developed, and because the scope of review is restricted to the Administrative Record.[1] The Court's reasoning follows.

I. BACKGROUND

Plaintiff brings this action against Reliance to recover long-term disability ("LTD") benefits after her claim was denied. The insurance policy at issue ("Policy") is part of an employee benefit plan governed by the Employee Retirement Income

[1] The Court notes that the heightened standard of review analysis is not restricted to the Administrative Record. See *infra* III, A.

Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* Plaintiff was employed by North Arundel Hospital Association, Inc. ("NAHA"), located in Glen Burnie, Maryland, as a Home Health Staff Speech & Language Pathologist. Plaintiff participated in the Policy issued to the NAHA. Reliance is an insurance carrier that funded the distribution of benefits under the Policy, and also administered the Policy as a fiduciary within the meaning of ERISA.

On October 26, 2000, Plaintiff underwent surgery on her wrists and her physician Dr. Terrance O'Donovan instructed her not to return to work. On March 10, 2001, while attending her mother's funeral, Plaintiff fell and sustained more injuries to her wrists. Plaintiff was disabled and not working at the time. From October 26, 2000 to August 27, 2002, Plaintiff underwent seven (7) surgeries on her hand, wrist, and shoulder, and as a result, her employment attendance was intermittent. On November 30, 2001, Reliance terminated the short term benefits Plaintiff was receiving, which prompted her to submit a claim for LTD benefits. On February 2, 2002, Reliance initially denied Plaintiff's application for LTD benefits in a four (4) page letter drafted by Carol Timlin, a senior claims examiner in Reliance's LTD Claims Department. The denial turned on the Policy language which states that Reliance will pay LTD benefits for a "Total Disability" as a result of "Injury or Sickness" if:

"during the Elimination Period, an Insured cannot perform each and every material duty of his/her regular occupation . . .." For employees in the same class as Plaintiff, the Policy defines an Elimination Period as one-hundred eighty (180) consecutive days of Total Disability. In the letter, Reliance's position was that Plaintiff could perform at least one, if not several, duties of her regular occupation as a speech pathologist.

Plaintiff timely appealed the denial to Reliance's Quality Review Unit, and on March 27, 2002, she received a letter drafted by Jamil Jackson, a senior benefits analyst, affirming the initial denial. In this letter, Mr. Jackson discussed at some length the reasons for the claim denial, referencing the review of medical and vocational information. In the letter, Mr. Jackson references a medical review and a vocational opinion performed by Reliance, which concluded that Plaintiff could perform several material duties of her occupation.

After Reliance failed to respond to a second appeal, Plaintiff filed suit in federal court seeking a review of Reliance's denial of LTD benefits. Both parties have filed cross-motions for summary judgment and have briefed the issues extensively for the Court.

II. JURISDICTION

This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 because the Policy is an "employee benefit plan"

as defined by 29 U.S.C. § 1002(3) of ERISA.

III. DISCUSSION

A. Standards of Review

Two standards of review are applicable here: the summary judgment standard and the standard of review. Summary judgment is appropriate "if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law." FED. R. CIV. P. 56(c). Essentially, the inquiry is "whether the evidence presents a sufficient disagreement to require submission to the jury or whether it is so one-sided that one party must prevail as a matter of law." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 251-52 (1986). The moving party has the initial burden of informing the court of the basis for the motion and identifying those portions of the record that demonstrate the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). An issue is genuine only if there is a sufficient evidentiary basis on which a reasonable jury could find for the non-moving party. Anderson, 477 U.S. at 249. A factual dispute is material only if it might affect the outcome of the suit under governing law. Id. at 248. Finally, in considering cross-motions for summary judgment, the Court must consider each party's motion individually. Each party bears the burden of demonstrating that there are no genuine issues of material fact. Reinert v. Giorgio Foods, Inc., 15 F.

Supp. 2d 589, 593-94 (E.D. Pa. 1998).

Because the Plan provides discretionary authority to the claims fiduciary, the arbitrary and capricious standard of review is appropriate in this case. See Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989). The term "arbitrary and capricious" has been interpreted to mean "without reason, unsupported by substantial evidence or erroneous as a matter of law." Abnathya v. Hoffmann-LaRoche, Inc., 2 F.3d 40, 45 (3d Cir. 1993). In this case, Plaintiff argues that Reliance's decision must be subject to a heightened level of scrutiny because of the inherent conflict of interest in funding *and* administering the Policy. Reliance agrees that the standard should be modified in accordance with the "sliding scale" approach adopted by the Third Circuit in Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377 (3d Cir. 2000). Under this approach, the standard begins with the arbitrary and capricious review and applies less deference if the evidence reveals that the claims fiduciary's decision was influenced as a result of the conflict. See Pinto, 214 F.3d at 379. Pinto provides a nonexclusive list of factors to consider in determining whether a structural conflict of interest warranting heightened review exists, including: the sophistication of the parties, the information available to the parties, the exact financial arrangement between the insurer and the employer, and whether the

decision-maker is a current employer, former employer, or insurer. See Pinto, 214 F.3d at 392. Finally, a court may look outside of the administrative record when setting the standard of review on the Pinto sliding-scale. See McLeod v. Hartford Life and Accident, Ins. Co., 247 F. Supp. 2d 650, 654 (E.D. Pa. 2003).

Although Reliance has stipulated that the sliding scale approach applies, it denies any conflict of interest. Yet, almost invariably, cases in which employers pay an independent insurance company to fund, interpret, and administer a plan warrant a heightened standard of review. See Bill Gray Enters. v. Gourley, 248 F.3d 206, 216 (3d Cir. 2001). Because of the potential for bias and of the disparate sophistication of the Parties, the Court will apply a slightly heightened standard of review. The Court, however, does not find any financial conflict of interest and will not substantially heighten review. The mere generalization that "Reliance saves money, and increases its profit, if it denies a claim." (Def.'s Br. at 1.) is insufficient to establish a financial conflict of interest. Similarly, the Court does not find any procedural irregularities in the claim review, nor does it find a self-serving examination of the available medical evidence. Plaintiff's claim was reviewed on multiple levels, and both the initial denial and the appeal denial letters were detailed and comprehensive. Contrary to Plaintiff's assertions, Reliance was under no obligation to

provide an independent medical examination. See McGuigan v. Reliance Standard Life Ins. Co., No. 02-7691, 2003 U.S. Dist. LEXIS 17593, at *20 (E.D. Pa. Oct. 6, 2003) (explaining that "Pinto makes clear that an insurance company is under no specific duty to gather [medical] information."); Perri v. Reliance Standard Life Ins. Co., No. 97-1369, 1997 U.S. Dist. LEXIS 12741, at *21-2 (E.D. Pa. Aug. 19, 1997). Accordingly, this Court does not find an "inattentive process" surrounding the medical information available at the time the determination was made that would warrant a substantial heightening of the standard of review. See Freiss v. Reliance Standard Life Ins. Co., 122 F. Supp. 2d. 566, 574-5 (E.D. Pa. 2000) (discussing that Reliance's failure to order an independent medical examination, *combined with other procedural anomalies*, caused that court to examine the administrative record with "great skepticism").

B. Review of Reliance's Claim Denial

The primary issue before the Court remains whether Defendant acted arbitrarily and capriciously when it determined that Plaintiff was not "Totally Disabled" as defined under the Policy. For this analysis, the Court may only review the evidence that was before the administrator at the time the decision was made. See Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997). In this case, the burden of proof to make her prima facie case remains on the Plaintiff because her

insurer is not calling into question the scientific basis of the physicians' reports. See Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 391 (3d Cir. 2003) (discussing the burden of proof in disability cases). For the reasons discussed below, the Court finds that Plaintiff has not met her prima facie burden of proving that she could no longer perform "each and every material duty" of her "regular occupation."

Plaintiff fails in her attempt to establish a prima facie showing of "Total Disability" through her physician reports. On November 16, 2001, Plaintiff's physician, Dr. Terrance O'Donovan informed Reliance that she had "achieved maximum medical improvement" and that she could return to work at least part-time on November 29, 2001. (Admin. R. at 201.) This notification occurred within the Elimination Period, which began to run on June 8, 2001 and extended through December 6, 2001.[2] Dr. O'Donovan also indicated that Plaintiff could lift at a sedentary capacity, could perform fine manipulation tasks with both hands, and could perform repetitive grasping and pushing/pulling with her right hand. (Admin. R. at 201.) On

[2] While Plaintiff now argues that the Elimination Period ran from October 26, 2000 to April 29, 2001, the Court finds no support for this argument in the Administrative Record. See Admin. R. at 63 (indicating, in what appears to be Plaintiff's handwriting on the disability claim form, that the first day Plaintiff was unable to work on a full time basis was 6/08/01, and that the last day Plaintiff worked before the disability was 6/07/01); Admin. R. at 33 (Plaintiff's letter to Carol Timlin writing to appeal the initial denial did not include any information that the disability occurred in October, 2000). Accordingly, the Court is precluded from considering this argument because it was not before the claims administrator at the time the decision was made. See Mitchell, 113 F.3d at 440.

November 19, 2001, Dr. O'Donovan released Plaintiff to five hours field work, including light office work and meetings. On November 29, 2001, Plaintiff reported to her employer's occupational health department for a duty determination. On November 30, 2001, Dr. O'Donovan released her for "full day/full duty office work." (Admin. R. at 127.) On December 3, 2001, Dr. O'Donovan lifted Plaintiff's driving restrictions. (Admin. R. 125.) These releases to drive and work light hours during the Elimination Period demonstrate that Plaintiff could have performed several duties of her occupation. The next issue turns on whether these duties are material. Yet, before the Court turns to that question, it must address Plaintiff's argument that she was refused the opportunity to work for medical reasons within the Elimination Period. In her Motion, Plaintiff argues that she had to return to work for economic reasons and that her attempts to return to work were rejected for medical reasons. Contrary to Plaintiff's assertions, her employer cleared her to work in a second Duty Determination on November 30, 2001, only one day after the first Duty Determination informed her she could not work. (Admin. R. 129, 133.) It is worth noting that the first determination did not explain why she could not return to work. Nevertheless, her employer's doors were not closed to her in late November, 2001.

In addition, Plaintiff misconstrues the Third Circuit's

finding in Lasser that "[a] claimant's return to work is not dispositive of his or her disability when economic necessity compels him to return to work." 344 F.3d at 392. The Third Circuit in Lasser restated findings of other circuits that "[a] desperate person might force himself to work despite an illness that everyone agreed was totally disabling." See id. (citing Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 918 (7th Cir. 2003)). In Lasser, the Third Circuit merely explained that an employee returning to work is not dispositive of whether the employee is disabled. Returning to work, without more, is inapposite to an insurer's determination as to whether an employee is totally disabled, at least under a policy such as the one at issue here. The only remaining question is whether the Plaintiff's occupational duties were material, and whether Plaintiff could in fact perform them.

In its review of Plaintiff' claim, Reliance performed a comprehensive vocational review to determine the material duties of Plaintiff's occupation. Reliance reviewed the Department of Labor's Dictionary of Occupational Titles ("DOT") as well as the NAHA's job description. "A duty is 'material' when it is sufficiently significant in either a qualitative or quantitative sense that an inability to perform it means that one is no longer practicing the 'regular occupation.'" Lasser v. Reliance Standard Life Ins. Co., 146 F. Supp. 2d 619, 636 (D. N.J. 2001),

aff'd 344 F.3d 381 (3d Cir. 2003). "'Regular occupation' is the usual work that the insured is actually performing immediately before the onset of disability." See Lasser, 344 F.3d at 386. In this case, the Court finds that Reliance reasonably determined that the following duties listed for a "Speech Pathologist" according to the DOT were material:

> (1) Diagnose and evaluate speech and language skills as related to educational, medical, social, and psychological factors;
>
> (2) Provide counseling and guidance and language development therapy to handicapped individuals;
>
> (3) Evaluate and monitor, individuals, using audio-visual equipment, such as tape recorders, overhead projectors, filmstrips, and demonstrative materials;
>
> (4) Instruct individuals to monitor their own speech and provides ways to practice new skills. (Admin. R. at 30.)

The DOT also states that this occupation is classified as light work, consisting of an occasional lifting of twenty (20) pounds, frequent lifting of ten (10) pounds, or constant lifting of a negligible amount. All of these duties are sufficiently significant to the regular occupation of a speech pathologist, and are thus material. Reliance's determination that Plaintiff could perform any one of these material duties was reasonable.[3] Contrary to Plaintiff's assertions, Reliance did not use the

[3] It is noted however, that Plaintiff was cleared to push/pull no more than five (5) pounds on November 30, 2001, and thus could not perform this material duty for the duration of the Elimination Period. However, this finding does not change this Court's ultimate conclusion that Reliance's determination was not arbitrary and capricious.

"wrong" occupational title ("Speech Pathologist" as opposed to "Home Health Staff Speech & Language Pathologist"). Reliance reviewed the DOT occupational title "Speech Pathologist" as well as the NAHA's title "Home Health Staff Speech & Language Pathologist". (Admin. R. at 71-2.) Even if Plaintiff were correct in asserting that there is a meaningful difference between a "Home Health Staff Speech & Language Pathologist" and "Speech Pathologist", the former's description incorporates several material duties of a speech pathologist by reference.[4]

While the Third Circuit in Lasser found that this inclusive approach was unreasonable with respect to the material duties of "surgeon" and "orthopedic surgeon", that policy contained different language. In that case, the policy paid benefits if a claimant "[were] capable of performing the material duties of his/her regular occupation on [only] a part-time basis or [only] some of the material duties on a full-time basis." See Lasser, 344 F.3d at 383 (emphasis added). Thus, "if providing emergency and on-call services [– the duties at issue –] [were] material duties of Dr. Lasser's regular occupation, and if Dr. Lasser [were] disabled from these activities, then he [was] entitled to benefits under the policy . . .." Lasser, 146 F. Supp. 2d at 632. In this case, however, the fact that Plaintiff may also have possessed other material duties beyond those listed

[4] See Admin. R. at 97 (stating that "[t]he [Home Health Speech & Language Pathologist] will render *speech pathology services* to assigned patients . . .") (emphasis added).

in the DOT or the NAHA description does not mean that she qualifies as "Totally Disabled" under the Policy. Under this Policy, if she can perform even one of her material duties, then Plaintiff is not Totally Disabled under the Policy.

The restrictive Policy language operates to deny coverage in this case, and even heightened scrutiny cannot save Plaintiff's argument. Other circuits have enforced the same policy language, and this Court will not re-write the agreement for the Parties. See Carr v. Reliance Standard Life Ins. Co., 363 F.3d 604, 607 (6th Cir. 2004); (citing Gallagher v. Reliance Standard Life Ins. Co., 305 F.3d 264, 275 (4th Cir. 2002)) (finding that "[i]f a claimant can perform even one material duty of his regular occupation during the Elimination Period, he is not totally disabled" under a policy with identical language to that in the instant case).

C. Claim for Ongoing Benefits

Entering summary judgment in favor of the Defendant is appropriate on Plaintiff's ongoing claim for benefits because, for the reasons stated above, her underlying claim fails.

IV. Conclusion

After a heightened review, the Court finds that Reliance did not act arbitrarily and capriciously when it denied Plaintiff's claim. Because there are no genuine disputes of material fact as to whether Reliance acted arbitrarily and capriciously under the Pinto standard, the Court will grant

Defendant’s Motion for Summary Judgment and deny Plaintiff’s Motion for Summary Judgment. An appropriate Order follows.

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FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LINDA THOMPSON-HARMINA,	:	CIVIL ACTION
Plaintiff,	:	
	:	
v.	:	
	:	
RELIANCE STANDARD LIFE	:	
INSURANCE COMPANY,	:	
Defendant.	:	NO. 04-425

O R D E R

AND NOW, this 23rd day of November, 2004, upon consideration of the Parties' Cross-Motions for Summary Judgment (Docs. 12, 15), and the Parties' Responses, it is hereby ORDERED that Plaintiff's Motion is DENIED and Defendant's Motion is GRANTED. Judgment is ENTERED in favor of Defendant and against Plaintiff on all claims. It is further ORDERED that the Parties Unopposed Motion for Leave to File Motion for Summary Judgment *Nunc Pro Tunc* (Doc. 14) is hereby GRANTED. The Clerk of the Court shall mark this case as "closed" for statistical purposes.

AND IT IS SO ORDERED.

S/Clarence C. Newcomer

United States District Judge