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

ANNA BRYANT	:	CIVIL ACTION
	:	
v.	:	
	:	
UNUM LIFE INSURANCE COMPANY OF AMERICA	:	NO. 04-3819

MEMORANDUM AND ORDER

McLaughlin, J. October 11, 2005

This case involves a claim for long-term disability benefits under an employee welfare benefit plan ("the Plan") regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. The defendant denied the plaintiff's claim on the ground that a pre-existing condition caused or contributed to her disability, which barred recovery under the Plan.

The parties' cross motions for summary judgment are before the Court. The Court concludes that the defendant's final decision to deny the plaintiff benefits was arbitrary and capricious, as judged under a moderately heightened arbitrary and capricious standard of review. The Court will remand the matter to the defendant as the Plan benefits administrator to determine the proper duration of benefits.

I. Facts

A. The Plan

The plaintiff, Anna Bryant, worked at Workers Comp Rx, Inc. as a pharmacist from June 24, 2002 until January 17, 2003. Workers Comp Rx purchased a group disability policy from the defendant, Unum Life Insurance Company of America ("Unum"), effective January 1, 2003. Unum administers benefits and has discretionary authority to determine claimants' eligibility for benefits under the Plan. UACL 10; UASP 10001, 10014, 10040.[1]

The Plan provides for long-term disability benefits of 60% of monthly earnings, to a maximum benefit of $5,000 per month. USAP 10005. The Plan does not cover long-term disabilities "caused by, contributed to by, or resulting from" a pre-existing condition. USAP 10033. Under the Plan, a claimant has a pre-existing condition if he or she:

> – received medical treatment, medical advice, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to [the] effective date of coverage; and
>
> - the disability begins in the first 12 months after [the] effective date of coverage.

USAP 10034.

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[1] The administrative record is attached to the Defendant's Motion for Summary Judgment as Exhibit A, UACL 1-350. The Plan is attached to the Defendant's Motion as Exhibit B, UASP 10001-10052.

B. The Plaintiff's Medical History

The plaintiff has suffered from avascular necrosis ("AVN") in her right hip since 1996. AVN is a bone disease that arises from a lack of blood supply to the bone. This lack of blood causes the bone tissue to die and can eventually cause the bone to collapse. UACL 321; Pl's Mot'n for Summ. J. Br. at 2-3.

The plaintiff became pregnant in October 2002. On December 3, 2002, she received a pre-natal examination from Vivian Lowenstein, a midwife/nurse practitioner. Nurse Lowenstein recorded the plaintiff's pre-pregnancy weight as 140-147 pounds, and her examination date weight as 170 and 3/4 pounds. Under "Past Medical History," Nurse Lowenstein noted that the plaintiff had no cartilage in her right hip and had taken the drugs Percocet, Ibuprofen, and Tylenol #3. UACL 148-150.

Pharmacy records from the period September 30, 2002 to December 30, 2002 show that the plaintiff filled prescriptions for Tylenol #3 on October 17 and 25, 2002. UACL 156.

On January 15 and 27, 2003, the plaintiff saw Dr. Benjamin Bennov for pain in her right hip. On January 15, Dr. Bennov noted that the plaintiff's right hip pain was secondary to the pregnancy. On January 27, Dr. Bennov wrote that the right hip pain was aggravated by the pregnancy. The plaintiff also consulted with Dr. Raphael DeHoratius on January 29 and April 17,

2003. Notes from the April 17 visit indicate that the plaintiff had stopped taking Motrin two weeks earlier, but should continue to take Percocet. In November 2003, Dr. William Hozack performed right hip replacement surgery on the plaintiff. UACL 28, 29, 169, 167, 288.

C. The Defendant's Denial and Appeals Process

The plaintiff's last day of work at Workers Comp Rx, Inc. was January 17, 2003. On February 6, she submitted a claim for disability benefits beginning January 20. Dr. Bennov completed the Attending Physician's Statement. In response to the question, "Has Patient ever been treated for the same or similar condition?" Dr. Bennov checked the box labeled "Yes" and wrote, "asceptic necrosis [right] hip, aggravated by pregnancy." UACL 19, 24, 26.

The defendant denied the plaintiff's claim on May 30, 2003. The defendant explained that it could not approve benefits because the plaintiff had received treatment for her pregnancy – a condition that caused, contributed to, or resulted in her disability – from a Dr. Murphy on December 3, 2002, which was within the three-month pre-existing period. The defendant cited Dr. Bennov's January 15, 2003 office notes in support of its position that the plaintiff's pregnancy contributed to her disability. The defendant's denial letter also mentioned that

the plaintiff had been “put on” Percocet, but did not state that the plaintiff took any Percocet during the pre-existing period, and did not cite it as a basis for denying her claim. UACL 160-161.

With the assistance of counsel, the plaintiff appealed the defendant’s denial on July 2, 2003. The plaintiff argued that the pregnancy had not exacerbated her hip pain during the three-month elimination period. She informed the defendant that she had been treated by Nurse Lowenstein, not Dr. Murphy, on December 3, 2002. The plaintiff also provided a note from Nurse Lowenstein stating that she did not have hip pain during the December 3 visit. UACL 206-208, 214.

The defendant upheld its denial on August 8, 2003. The defendant reiterated that it could not approve benefits because the plaintiff had treated with Dr. Murphy for her pregnancy during the pre-existing period. This time, the defendant cited Dr. Bennov’s Attending Physician’s Statement as well as his January 15 and 27 office notes to support its conclusion that the plaintiff’s pregnancy contributed to her disability. This uphold letter also noted that Percocet, Ibuprofen, and Tylenol #3 appeared in the plaintiff’s past medical history, but did not allege that the plaintiff took any of these medications during the pre-exisiting period. UACL 275-277.

Upon a request from the plaintiff’s counsel, the

defendant agreed to reopen the plaintiff's file in early 2004. On March 10, 2004, the plaintiff submitted a letter from Dr. Hozack. In the letter, Dr. Hozack stated that although he did not have specific knowledge about the plaintiff's pregnancy, hip arthritis generally is not caused or aggravated by pregnancy. UACL 280-281, 283, 286-288.

The defendant referred the case to one of its consulting physicians, Dr. Terrance Farrell. In a report dated May 11, 2004, Dr. Farrell calculated that the plaintiff had gained forty pounds due to pregnancy by the time of her December 3, 2002 pre-natal examination, and concluded that this weight gain directly contributed to her hip disability. Dr. Farrell also opined that the plaintiff took ibuprofen, Percocet, and Tylenol #3 for hip pain during the pre-existing period, based on notes from the plaintiff's December 3, 2002 pre-natal visit and April 2, 2003 visit with Dr. DeHoratius. He noted, however, that "it would be helpful to review pharmacy records during the pre-ex period" to confirm this opinion. The administrative record does not show whether Dr. Farrell ever reviewed the records. In any event, the defendant again upheld its denial on May 18, 2004. The defendant's uphold letter relied heavily on Dr. Farrell's report. This was the first denial letter in which the defendant alleged that the plaintiff took prescription drugs for her hip pain during the pre-existing period. UACL 323, 325-326.

On June 4, 2004, the plaintiff contested Dr. Farrell's report and the defendant's decision. The plaintiff pointed out that the records of the December 3, 2002 pre-natal visit only supported a weight gain of twenty-three to thirty pounds. The plaintiff further claimed that she had gained this weight gradually since her marriage, rather than as a result of the pregnancy. The plaintiff also disputed that she took any pain medications in the first trimester of her pregnancy. UACL 331-332.

On June 28, 2004, the defendant explained that the alleged forty pound weight gain was not the basis for its denial. The defendant claimed that its denial was based on its conclusions that the plaintiff had used prescription medications during the pre-existing period and that the plaintiff's pregnancy had contributed to her disability. UACL 340.

The plaintiff challenged the defendant's denial again on August 2, 2004. This time, the plaintiff provided an affidavit stating that she took Tylenol #3 for a root canal, but did not take any pain medications for her hip during the pre-existing period. The plaintiff also submitted a letter from Dr. Bennov retracting his earlier statement that the plaintiff's pregnancy aggravated her AVN. UACL 344-348.

Just four days later, on August 6, 2004, the defendant upheld its denial again. The defendant reiterated its argument

that the plaintiff had taken prescription medication for her hip pain during the pre-existing period, but did not specifically address the plaintiff's statement that she took the Tylenol #3 for a root canal. The letter also did not address Dr. Bennov's retraction. UACL 350. The plaintiff filed this civil suit on August 12, 2004.

II. Standard of Review

Summary judgment is proper if the pleadings and other evidence on the record "show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

The defendant's decision to deny benefits should be evaluated under a moderately heightened arbitrary and capricious standard of review. If an ERISA plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to interpret the terms of the plan, courts must review the administrator's decisions under the arbitrary and capricious standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). The defendant has such discretionary authority under the Plan in this case. UASP 10014.

When an insurance company both administers and funds an ERISA plan, however, courts in the Third Circuit must apply some level of heightened scrutiny. Pinto v. Reliance Standard Life

Ins. Co., 214 F.3d 377, 387 (3d Cir. 2000). Heightened scrutiny is appropriate because the insurance company's profit motive creates an inherent conflict of interest. Id. at 388-389. Pinto directs district courts to use a "sliding scale approach, according different degrees of deference depending on the apparent seriousness of the conflict." Id. at 391, 393. When conducting a heightened arbitrary and capricious review, a court looks not only at whether the result is supported by reason, but also at the process by which the result was achieved. Id. The defendant does not dispute that it both administers and funds the Plan here, and that some level of heightened review is appropriate. See Def's Opp. Br. at 7, 10; 7/29/05 Oral Arg. Tr. 48:17-20.

On Pinto's "sliding scale," the level of review in this case should be moderately heightened. The administrative record does not contain much evidence of the bias or procedural anomalies that have prompted other courts to apply substantially heightened review.[2] Nor did the plaintiff present any evidence

[2] Pinto applied a highly skeptical level of review "on the far end of the arbitrary and capricious 'range,'" where the insurer reversed its own initial determination without receiving any additional medical information, selectively used the treating physician's report without adequately explaining why it rejected the physician's contrary conclusion, and rejected a staff worker's recommendation that benefits be provided pending further testing. 214 F.3d at 393-394. McGuigan v. Reliance Standard Life Ins., Civ. Act. 02-7691, 2003 U.S. Dist. LEXIS 17593 at *16-22(E.D. Pa. Oct. 6, 2003), substantially increased the standard of review where the insurer selectively used portions of the

or arguments regarding other factors that might justify heightened scrutiny, such as the sophistication of the parties, the information accessible to the parties, the financial arrangement between the employer and insurer, or the financial status of the plan fiduciary. See Pinto, 214 F.3d at 392.

At least one procedural irregularity justifies heightening review beyond a minimal level, however. The defendant did not allege that the plaintiff took prescription medicines during the pre-existing period in its initial denial and denial uphold letters. The defendant did not cite drug use as grounds for denial until its second uphold letter on May 18, 2004. This irregularity suggests that the defendant may have reviewed the plaintiff's file on appeal with an eye toward finding additional reasons to deny her claim.

III. Analysis

Under the terms of the Plan, the defendant may deny long-term disability benefits when a claimant's disability begins in the first twelve months after the effective date of coverage, and the claimant received medical treatment or took prescribed drugs for a condition that caused or contributed to the disability in the three months prior to the effective date. UASP

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treating physician's report, failed to consider the treating physician's contrary conclusions, and had only an administrator and in-house nurse review the initial claim.

10034. The parties do not dispute that the plaintiff's disability arose within twelve months after her effective date of coverage. The controversy centers on whether it was arbitrary and capricious for the defendant to deny the plaintiff benefits because she received medical treatment for pregnancy, which allegedly contributed to her disability, during the pre-existing period, and/or because she allegedly took prescription medicine for her hip pain during the pre-existing period.

The answer to this controversy depends in large part on when the defendant made its final decision, what it knew, and what reasons and support it provided at the time. The defendant's May 18, 2004 denial uphold letter stated that all administrative remedies had been exhausted and that the claim would be closed at that time, but the defendant continued to respond to the plaintiff's letters through August 6, 2004. It is appropriate to treat the defendant's August 6 letter as its final decision for two reasons. First, in additional briefing requested by the Court, both parties state that the defendant made its final decision on August 6, 2004. See Pl's 9/23/05 Letter to the Court; Def's 9/23/05 Letter to the Court. Second, the defendant raised two justifications for denial in its May 18, 2004 letter that it had not raised before – the plaintiff's consumption of prescription drugs and alleged forty pound weight gain. It would not be fair to the plaintiff to treat the May 18

letter as the defendant's final decision, because doing so would essentially deny her the right to an administrative appeal.

Taking August 6, 2004 as the date of the defendant's final decision, the Court finds that the defendant's denial of benefits was arbitrary and capricious. The defendant bears the burden of proving facts that show that a pre-existing condition caused or contributed to the plaintiff's disability. Smathers v. Multi-Tool, Inc./MultiPlastics, Inc., 298 F.3d 191, 200 (3d Cir. 2002) ("The law is well-settled that the insurer must prove facts that bring a loss within an exclusionary clause of the policy.") (citing McGee v. Equicor-Equitable HCA Corp., 953 F.2d 1192, 1205 (10th Cir. 1992) (although the insured bears the initial burden of showing that a loss is covered, the insurer bears the burden of showing that an otherwise covered loss comes under an exclusionary clause)).

In Smathers, the plaintiff was injured when driving while intoxicated. The defendant denied the plaintiff's claim for medical benefits under a provision that barred payment of benefits where the claimant's commission of a crime "caused or contributed to" the injury. Id. at 193. The defendant argued that it was reasonable to conclude that the plaintiff's illegal drunk driving contributed to the accident and resulting medical expenses. The defendant did not provide any support for its conclusion. Instead, the defendant argued that it was the

plaintiff's responsibility to show that his drunk driving did not contribute to the accident. The court rejected the defendant's attempt to shift the burden of proof to the plaintiff. The court held that, under a moderately heightened standard of review, the defendant's denial was arbitrary and capricious because the defendant failed to establish facts showing that the exclusionary clause applied to the plaintiff's claim. Id. at 199-200.

Here, the defendant received Dr. Bennov's retraction letter and the plaintiff's affidavit on August 2, 2004. Both items undermined the evidence that the defendant had used to support denial; yet, the defendant upheld its denial four days later, without conducting any further investigation or review by a doctor. The defendant generally does not have a duty to investigate. Pinto, 214 F.3d at 394 n.8. Smathers, however, establishes that the defendant must be able to point to facts on the record that support its decision to deny coverage in spite of Dr. Bennov's retraction and Ms. Bryan's affidavit.

Dr. Bennov's retraction letter undermined the defendant's first ground for denial – that the plaintiff's pregnancy contributed to her disability. The defendant may have been entitled to discount Dr. Bennov's later opinion, because it came after the defendant's initial denial. See Sell v. UNUM Life Ins. Co. of America, Civ. Act. No. 01-4851, 2002 U.S. Dist. LEXIS

22472, *18-20 (E.D. Pa. Nov. 19, 2002).[3] In light of the retraction, however, it would not have been reasonable for the defendant to rely solely on Dr. Bennov's earlier opinions. See Ellis v. Schweicker, 739 F.2d 245, 248 (6th Cir. 1984) (unreasonable to rely on a medical diagnosis that the diagnosing doctor has retracted in light of subsequent events); Saephan v. Barnhart, C-02-2374, 2004 U.S. Dist. LEXIS 2654 at *16-17 (N.D. Cal. Feb. 18, 2004) (party cannot rely on a doctor's opinion that the doctor has retracted as being erroneous). Sell is not to the contrary. There, the court found that substantial evidence on the record outweighed the retraction. See Sell, 2002 U.S. Dist.

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[3] Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329 (5th Cir. 2001), also cited by the defendant, is not directly on point. There, the plaintiff submitted an Attending Physician's Statement and a letter written by the same doctor in support of his claim for benefits. In the Statement, the doctor concluded that the plaintiff could return to work on a specified date. In the letter, however, the doctor wrote that the plaintiff was disabled and could never return to work. Id. at 331. The court found that the letter was unpersuasive, because it was written after the plaintiff learned that he would be fired, and because the doctor failed to provide any evidence showing that the plaintiff's physical condition had changed between the time of the Statement and the letter. Id. at 334.

Whereas the doctor in Gooden contradicted his earlier opinion regarding the severity of his patient's disability, Dr. Bennov retracted only his earlier statements regarding the link between the plaintiff's pregnancy and her AVN. Although the timing of Dr. Bennov's retraction raises similar questions about his impartiality, it is less significant that Dr. Bennov did not provide any evidence showing that the plaintiff's physical condition had changed between the time of his initial diagnosis and later retraction. Dr. Bennov reasonably could have based his retraction on a review of medical literature or a reassessment of his own knowledge, without any change in the plaintiff's condition.

LEXIS at *4-5, 7, 17 (record contained "substantial countervailing evidence," including an independent medical examination, a Functional Capacity Evaluation, and a review of the record by another doctor after the retraction).

The defendant's denial might have been reasonable if supported by other evidence in the record. Besides Dr. Bennov's statements, the only other evidence in the record regarding pregnancy and AVN were Dr. Hozack's March 4, 2004 letter stating that hip arthritis is generally not caused or aggravated by pregnancy, and Dr. Farrell's May 11, 2004 report. It was reasonable for the defendant to give less deference to Dr. Hozack's letter, because Doctor Hozack conceded that he did not have specific information regarding the plaintiff's pregnancy. It was unreasonable, however, for the defendant to continue to rely on Dr. Farrell's opinion that the plaintiff's pregnancy contributed to her disability. Dr. Farrell's opinion was based on Dr. Bennov's now-retracted statements, and Dr. Farrell's own miscalculation of the plaintiff's alleged weight gain. There is no evidence on the record that Dr. Farrell would have reached the same conclusion, independent of Dr. Bennov's statements, because the defendant did not send the case back to him for evaluation. Moreover, there is no evidence on the record that Dr. Farrell would have made the same assessment for a twenty-three to thirty pound weight gain as he did for a forty pound weight gain. The

question of weight gain is important – despite the defendant's claim in its June 28, 2004 letter that it was not the basis for its denial – because, as the defendant's counsel conceded at oral argument, it is not pregnancy per se, but the weight gain associated with pregnancy that arguably aggravated the plaintiff's hip pain. 7/29/05 Hr'g Tr. 26:3-9.

Nor does the administrative record support a reasonable inference that the plaintiff consumed prescription drugs for her hip pain during the pre-existing period. Notes from the plaintiff's April 2, 2003 visit to Dr. DeHoratius show that the plaintiff was taking Motrin and Percocet around the time of that visit, but they do not support a reasonable inference that she was taking either medication during the pre-existing period three to six months earlier. The plaintiff's pharmacy records from the pre-existing period show that she filled prescriptions for only Tylenol #3. The records further show that the Tylenol #3 was prescribed by a Dr. Rhode, not by one of the doctors who had treated the plaintiff for hip pain. UACL 156. The records support the plaintiff's statement in her affidavit that she took the Tylenol #3 for a root canal, not for hip pain.

The defendant has asserted that the plaintiff's pregnancy contributed to her disability, and that the plaintiff took prescribed medications for hip pain, but it has not met its burden to prove facts that support either of those assertions.

The defendant's decision to deny benefits was without reason and unsupported by substantial evidence. Thus, on the issue of whether the defendant's decision to deny benefits was arbitrary and capricious, the Court will grant the plaintiff's Motion for Summary Judgment, and deny the defendant's cross-motion.

IV. Remand to the Defendant as the Plan Benefits Administrator

The Court will remand the case to the defendant to determine the amount of benefits owed to the plaintiff, consistent with the Court's decision. Courts generally remand benefits decisions to the administrator when the record is somehow incomplete. Hunter v. Federal Express Corp., Civ. Act. No. 03-6711, 2004 U.S. Dist. LEXIS 13271 at *41 (July 15, 2004). The parties dispute the duration of the plaintiff's disability, and there are not sufficient facts on the record for the Court to determine the appropriate amount of benefits. See 7/29/05 Oral Arg. Tr. 57:6-11 (facts regarding the plaintiff's surgery and return to work are outside the administrative record).

The plaintiff argues that the defendant has waived its right to have this matter remanded because the defendant never argued that the plaintiff was not disabled. The plaintiff's waiver argument is inapposite. The defendant concedes that the plaintiff was disabled at the time she applied for benefits, but the defendant does not thereby waive its right to make an initial

determination regarding the duration of the plaintiff's disability. The cases cited by the plaintiff are also inapposite. In McLeod v. Hartford Life and Accident Ins. Co., Civ. Act. No. 01-4295, 2004 U.S. Dist. LEXIS 19242 at *23-24, the court determined that no remand was necessary where the administrative record demonstrated that the plaintiff was eligible to receive benefits for the maximum benefits period. In Lauder v. First UNUM Life Ins. Co., 284 F.3d 375, 384 (2d Cir. 2002), the court held that it was not necessary to remand the case to the plan administrator where the district court had all the information it needed to calculate the plaintiff's damages. In contrast, the administrative record here does not provide the Court with sufficient information to calculate the amount of benefits owed to the plaintiff.

An appropriate Order follows.

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

ANNA BRYANT	:	CIVIL ACTION
	:	
v.	:	
	:	
UNUM LIFE INSURANCE COMPANY OF AMERICA	:	NO. 04-3819

ORDER

AND NOW, this 11th day of October, 2005, upon consideration of the parties' cross-motions for summary judgment and opposition thereto, and after an oral argument on July 29, 2005, for the reasons stated in a memorandum of today's date, it is HEREBY ORDERED that the plaintiff's motion for summary judgment is GRANTED IN PART, and DENIED IN PART. The defendant's cross-motion for summary judgment is DENIED. The matter is remanded to the defendant to determine the amount of benefits due to the plaintiff, consistent with the Court's decision. This case is closed.

BY THE COURT:

/s/ Mary A. Mclaughlin
MARY A. McLAUGHLIN, J.