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

DANIEL R. LEVESQUE	:	CIVIL ACTION
	:	
v.	:	NO. 04-4143
	:	
KEMPER NATIONAL SERVICES, INC., AGERE SYSTEMS INC. SHORT TERM DISABILITY PLAN and AGERE SYSTEMS INC.	:	

MEMORANDUM AND ORDER

Juan R. Sánchez, J. **February 6, 2006**

Daniel R. Levesque[1] went to extraordinary lengths to work at Agere Systems despite disabling multiple sclerosis and Agere Systems went to extraordinary lengths to accommodate Levesque's illness. This coincidence of needs ended in October, 2002, when Agere undertook a company-wide reduction in force. Levesque was one of those laid off. Levesque believes he was entitled to short-term disability payments because of his inability to work a normal workday. Agere argues Levesque faced the same perils of lay off as any other employee. I find Kemper's denial of Levesque's short term disability payments does not withstand slightly-heightened scrutiny and will grant Levesque's motion for summary judgment.

[1]Levesque died November 20, 2005; his personal representative is substituted as Plaintiff.

FACTS

Levesque worked for Agere[2] and its predecessors, Lucent and AT&T, for fifteen years before being laid off in October, 2002. As a Global Logistics Business Support Specialist for Agere, Levesque created and maintained a web site which supported the movement of and tracked materials to, from and within Agere. Levesque worked with other departments of Agere and its customers.

Levesque's first indication he had multiple sclerosis came in the late 1970s and was confirmed in 1981. Multiple sclerosis is a generally progressive disease, which takes a different path in each individual. Agere accommodated Levesque's disease by providing a motorized scooter, modifying a men's room, modifying a work area for a power wheelchair, providing a private office to accommodate cognitive deterioration, modifying a home office to permit telecommuting two days a week and allowing two naps and long bathroom breaks each day. Levesque was significantly medicated, receiving one medication through a continuous pump. The only part of his body over which Levesque had any control was his right arm and that control was compromised.

Levesque talked with his supervisor, Patrick Maloney, three times in the six months before Levesque received his lay off notice in October, 2002. Maloney remembered representatives of the human resources department also participating in the meetings. Maloney said the meetings covered both Levesque's lay off and alternatives, such as short-term disability. Levesque says as a result of those meetings, he decided to work until he was laid off and then apply for short term disability payments.

[2]For ease of reference, I will refer to the company, through its iterations, solely as Agere.

Agere's short term disability plan,[3] administered by Kemper National Services Inc., allows twenty-six weeks salary for short-term disability. The definition of disability is an inability to "perform any of the substantial and material duties of the job you had before your disability, and are unable to be accommodated at another job within the company." Plan at 7.

Levesque was laid off October 10, 2002, with sixty days employment, including eligibility for all benefits. Levesque applied to other divisions of Agere, without success. On November 22, 2002, Levesque applied for short term disability benefits by telephone to Kemper.[4] During that telephone call, Levesque gave Kemper the names of his three treating physicians: Dr. John Travers, his family practitioner; Dr. C. Reed, his neurologist; and Dr. Patti Brown, his physiologist.

After receiving Levesque's claim, Kemper opened a file and faxed Initial Physician Report forms to each of Levesque's treating physicians. The form asks for, among other items, initial treatment date, complications, objective physical findings which render the patient disabled from their own occupation, diagnostic tests and results. All three physicians replied promptly.

Dr. Travers responded to Kemper the next day with a diagnosis of multiple sclerosis in which "weakness" disabled Levesque. Ex. 20, Def.'s App. Dr. Travers reported there had been no recent diagnostic tests and treatment was medications and therapy as needed. Dr. Travers said Levesque had no projected return-to-work date, and was permanently unable to work even with restrictions. *Id.* Dr. Travers also faxed four pages of treatment notes to Kemper on December 9, 2002.

Dr. Brown also diagnosed multiple sclerosis with complications of "disability, weakness."

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[3]The documentation alternately refers to Lucent Technologies; Agere has stipulated the plans are identical and applicable.

[4] The letterhead on Kemper's forms says Broadspire Services.

Ex. 18, Def.'s App. Dr. Brown said "weakness, easy fatigability" rendered Levesque disabled. *Id.* Dr. Brown said "left upper, bilateral lower extremity weakness" prevented Levesque from performing the essential functions of his job. She found him unable to work indefinitely, even with restrictions. Dr. Brown also faxed her office notes which referenced refilling his Baclofen pump and increasing its dosage; her inability to range his upper left arm because of spasticity; her ability to range his legs despite spasticity; Levesque's difficulty in swallowing and weakening of his voice by the end of the day, and a dependency on medication for alertness.

Dr. Reed faxed his form to Kemper on December 10, 2002, reporting "MS" with complications of "fatigue, generalized weakness, poor coordination, etc., decreased memory" which rendered Levesque disabled. Ex. 21, Def.'s App. Dr. Reed stated, "Pt. wheelchair confined; self-catherization." *Id.* Levesque's prognosis was "poor," according to Dr. Reed. *Id.* Dr. Reed stated, "Pt. totally disabled" when asked to fill in a return-to-work date. *Id.* Levesque was prevented from performing the essential functions of his job by "fatigue, weakness, decrease in memory." *Id.* Dr. Reed also found Levesque unable to work even with restrictions. Dr. Reed faxed a second form stating, "pt. has MS, wheelchair bound more than 10 years. Pt. permanently disabled." Ex. 37, Def.'s App. Levesque reported a total of thirteen medications on December 10, 2002. Ex. 23, Def.'s App.

Kemper's claim file reflects a superficial view of Levesque's illness. On November 25, 2002 a file notes asks "is this a new onset of MS or exacerbation?" Ex. 16, Def.'s App. On December 5, 2002, a file notes says "Please let me see meds [the list of medications] once recd. Is this new onset of MS?" *Id.*

By December 9, 2002, Kemper had lost the initial form from Dr. Reed's office. Kemper asked for the report again and office notes, even though Dr. Reed's assistant told Kemper the file

was voluminous. Kemper then told Dr. Reed's office they "only need meds to inform [confirm?] ee's recent episode. . . . Faxed request for office notes." *Id.*

Kemper used a non-examining peer review to determine Levesque's eligibility for short-term disability payments. Dr. Vaughn Cohan found nothing in Levesque's treating physicians's reports to support a change in his status from working to disabled. Dr. Cohan found "the claimant does have evidence of a profound neurologic disorder which is chronic . . . Nevertheless he has been gainfully employed . . . I find no objective evidence . . . of any significant change in the claimant's condition over recent months. . . . I find no evidence to support disability . . . ." Ex. 27, Def.'s App.

The file notes Levesque called December 2 and 9, 2002, wanting to know the status of his case. On January 3, 2003, Kemper notified Levesque of its decision to deny him short-term disability benefits and told him he could appeal. He was told to submit a letter of appeal and objective medical data such as diagnostic test results, functional capacity evaluations, consultation reports, office notes and progress reports and any other available objective medical documentation. Kemper told Levesque he was entitled to receive copies of his claim file and Plan documentation at no cost.

On January 14, 2003, Levesque wrote to Kemper, appealing the denial and asking "my doctors to add to their reports as necessary" because "[n]o doubt they were getting mixed messages since I wanted to continue working." Ex. 30, Def.'s App. Levesque also asked for his claim file and Plan summary. On January 22, 2003, Kemper replied asking for "any pertinent, objective medical data (i.e. office notes, rehab notes, x-ray or diagnostic testing reports . . . etc.)." Ex. 31, Def.'s App. On January 28, 2003, Dr. Jerry Bishop, Dr. Travers's partner, wrote Kemper Levesque

> has continued to work only by very significant accommodations on the part of

> AGERE [sic] for his particular position. I have been quite impressed with Mr. Levesque's tenacity to continue working despite the dramatic medical problems that he has faced. I do not feel that this gentleman is able to work in any environment at this time, even with significant accommodations."

Ex. 35, Def.'s App.

On February 7, 2003, Dr. Brown wrote Kemper reiterating Levesque was disabled with "extremity weakness and spasticity." Ex. 36, Def.'s App. She wrote, "He is presently undergoing treatment for his symptoms and to slow the progression of his disease. . . . he should qualify for disability benefits." *Id.* On March 4, 2003, Dr. Reed wrote:

> Dan Levesque is my patient, who has secondary progressive MS. HE [sic] is totally disabled from his MS, and, in my opinion, cannot be employed in any manner whatsoever, presently, and hereafter. There is barely any motor function in the lower extremities. He is fatigued, has spasms, impaired memory, and also has weakness of the upper extremities. I have him on various medications to treat the many symptoms of MS that he has.

Ex. 40, Def.'s App.

Without the benefit of Dr. Reed's letter, which Kemper did not send, Dr. Gerald Goldberg conducted a non-examining peer review on appeal for Kemper and found Levesque not disabled on March 9, 2003. Dr. Goldberg found no "functional impairment that precludes work." Ex. 38, Def.'s App. Dr. Goldberg stated "[a]dditional data has not been provided that would indicate claimant could not work at this same type of a position with appropriate accommodations." *Id.*

Five days later, on March 14, 2003, before Levesque received a copy of his case file, Kemper denied his appeal. A month later, Levesque wrote Kemper for the third time asking for a copy of his case file. Only after Levesque retained counsel did Kemper send his file on June 19, 2003, three months after his appeal was denied. That communication did not, however, include a copy of Agere's short-term and long-term disability plan summaries. It was not until August 18, 2003 that

those were sent. It took another year for Kemper to send the full plans and other documentation to Levesque's attorney.

After his appeal was unavailing, Levesque filed suit in this Court.[5] Because I find Kemper's denial of Levesque's claim for short-term disability payments arbitrary and capricious under slightly-heightened scrutiny, I will grant Levesque's motion for summary judgment and deny that of the Plan administrator.

DISCUSSION

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. In a motion for summary judgment, the moving party bears the burden of proving no genuine issue of material fact is in dispute. *Matsushita Elec. Indust. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). A motion for summary judgment will not be denied because of the mere existence of some evidence in support of the nonmoving party. The nonmoving party must present sufficient evidence for a jury to reasonably find for them on that issue. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). "Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial." *Matsushita* 475 U.S. at 587.

ERISA does not provide a standard of review for the denial of benefits. The Supreme Court stated in *Firestone Tire and Rubber Co. v. Bruch*:

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[5] On February 28, 2003, Levesque signed a "Termination Agreement and Release," giving up his right of action against Agere in return for increased retirement benefits. Levesque hand wrote and signed an exception to the contract: "Remaining issue requiring resolution is a disability application appeal. Reference Kemper Insurances (for Agere Systems) case number 1030180."

> a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan . . . . Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion.

489 U.S. 101, 115 (1989). The Third Circuit subsequently held that when the language of a plan gives the administrator discretionary authority, courts must apply the arbitrary and capricious standard of review. *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993).

"Under the arbitrary and capricious (or abuse of discretion) standard of review, the district court may overturn a decision of the Plan administrator only if it is 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Abnathya*, 2 F.3d at 45 (citing *Adamo v. Anchor Hocking Corp.*, 720 F. Supp. 491, 500 (W.D. Pa. 1989)). The court may not, however, substitute its own judgment for that of the Plan administrator. *Id.*

"[W]hen an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000).[6] In this case the structural

[6]The sliding scale approach of the Third Circuit is not the only approach. In the First Circuit, a conflict does not change the arbitrary and capricious standard of review. *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005). The Tenth Circuit puts the burden on administrators to show a denial is supported by substantial evidence. *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004). The Eighth Circuit applies a *de novo* standard of review in a conflict situation. *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000). The Ninth and Eleventh Circuits presume a conflict and shift the burden to the insurer. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990) . The Fourth and Fifth Circuits follow the Third Circuit's sliding scale. *Doe v. Group Hospitalization & Med. Serv.*, 3 F.3d 80, 87 (4th Cir. 1993); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 638-42 (5th Cir. 1992). The Seventh Circuit presumes "a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Kobs v. United Wis. Ins. Co.*, 400 F.3d 1036, 1039

arrangement between Agere and Kemper precludes heightened review based on conflict; procedural irregularities, however, warrant a moderately heightened arbitrary and capricious standard of review. *Kosiba v. Merck & Co.*, 384 F.3d 58, 68 (3d Cir. 2004); *see also Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 283 (3d Cir. 2005) (finding error in heightened scrutiny without conflict or procedural irregularity scrutiny).

When there is procedural irregularity, bias, or unfairness in the review of the claimant's application for benefits, the Third Circuit allows heightened review.[7] A Third Circuit panel suggested "[t]he *Pinto* panel's decision to apply heightened review turned almost as much on the procedures afforded to Pinto as it did on her insurer's financial conflict of interest."[8] *Kosiba*, 384

(7th Cir. 2005).

[7]The Third Circuit calls its holding that procedural irregularities may raise the level of scrutiny a

> negative pregnant appear[ing] in several of our cases. *See Skretvedt* [*v. E.I. DuPont de Nemours and Co.*], 268 F.3d [167,] 175 [(3d Cir. 2001)], (considering but rejecting allegations of decisionmaker bias in the benefits review system); *Goldstein* [*v. Johnson & Johnson*], 251 F.3d [433,] 435-36 [(3d Cir. 2001)] (noting that heightened review would be required when "the beneficiary has put forth specific evidence of bias or bad faith in his or her particular case"); *Bill Gray Enters., Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206, 216 (3d Cir. 2001) ("[U]nless specific evidence of bias or bad-faith has been submitted, plans . . . are reviewed under the traditional arbitrary and capricious standard."); *id.* at 216 n.8 ("Gourley has failed to allege bias on the part of the plan administrator....").

Kosiba v. Merck & Co., 384 F.3d 58, 66 (3d Cir. 2004).

[8]The "procedural anomalies" in *Pinto* were: "(1) the insurer's reversal of its original determination without the examination of additional evidence; (2) a self-serving selectivity in the use of evidence; and (3) a bias in decision-making to the benefit of the insurer." *Russell v. Paul Revere Life Ins. Co.*, 148 F. Supp. 2d 392, 406 (D. Del. 2001) (interpreting and citing *Pinto*). Other examples of procedural anomalies include an administrator who: relies on the opinions of non-treating physicians over those of treating physicians without explanation, *Kosiba.*, 384 F.3d at 67-68; fails to follow the plan's notification provisions and conducts self-serving paper reviews of medical files, *Lemaire v.*

F.3d at 66. The *Pinto* court adopted a sliding scale approach, "allow[ing] each case to be examined on its facts," considering the sophistication of the parties, the information accessible to the parties,[9] the financial arrangement between the insurer and the company, and the fiscal status of the fiduciary and the stability of the employing company. *Id.*

The first two factors yield a slightly heightened standard of review in this case. First, Levesque lacked knowledge of the legal intricacies of ERISA and was not represented by counsel during the claim process.[10] Second, Kemper hindered the exchange of information by refusing Levesque's repeated requests for his file and failing to send his treating physician's notes on to its peer review physician on appeal. The third and fourth factors do not raise the standard of review because Kemper is financially healthy and there is no conflict in the financial arrangement between the insurer and the company. Even without the structural conflict which would yield a heightened standard of review, I find sufficient procedural anomalies to apply a slightly heightened level of scrutiny.

Hartford Life & Accident Ins. Co., 69 Fed. Appx. 88 (3d Cir. 2003); or, bases its negative decision on inadequate information and incomplete investigations, *Friess v. Reliance Standard Life Ins. Co.*, 122 F. Supp.2&d 566, 574-75 (E.D. Pa. 2000).

[9]The applicable regulations require "the claims procedures" provide a claimant with reasonable access to documents relevant to the claim, with a prompt review and with the identities of any experts consulted in connection with the determination. 29 C.F.R. §§ 2560.503-1(h)(2)(iii), (f)(1) & (3), (h)(3)(iv).

[10] ERISA plaintiffs who have been found not to be sophisticated include a woman with an advanced college degree, because "there [was] no evidence that she was sophisticated in terms of ERISA," *Rosen v. Provident Life & Accident Ins. Co.*, 2003 WL 22254805 at 7 (E.D. Pa. Sept. 30, 2003); a labor attorney, *Cohen v. Standard Insurance Co.*, 155 F. Supp. 2d 346, 353 (E.D. Pa. 2001); and, an orthopaedic surgeon, *Kaelin v. Tenet Employee Benefit Plan*, 2005 WL 3481327 at 9 (E.D. Pa. Dec. 20, 2005)

The irregularities include: the failure to deliver Levesque's file and Plan materials before denying his appeal; giving insufficient weight to extensive office notes of Levesque's treating physicians and over-emphasizing the demand for objective tests; and, failing to forward the demanded office notes to the peer-review physician conducting the appeal review. I also find irregularity in the failure of Kemper to give reasons for relying on its peer review physicians rather than Levesque's treating physicians. I do not find irregularity, as Levesque asks me to do, in Kemper's use of an appeal coordinator who does not have a medical degree; Kemper's internal staffing decisions are beyond this Court's scope of review. Under *Kosiba*, the irregularities bring me to a slightly heightened level of scrutiny.

While "a court may not substitute its own judgment for that of plan administrators under either the deferential or heightened arbitrary and capricious standard," *Stratton v. E.I. Dupont De Nemours & Co.*, 363 F.3d 250, 256 (3d Cir. 2004) (quoting *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc.*, 298 F.3d 191, 199 (3d Cir.2002)), I will "examine the facts before the administrator with a . . . degree of skepticism." *Pinto,* 214 F.3d at 394.

This "heightened arbitrary and capricious review" standard remains "deferential, but not absolutely deferential" to the decisions of a plan administrator. *Pinto*, 214 F.3d at 393; *Kosiba,* 384 F.3d at 68-69. At the "mild end of the heightened arbitrary and capricious scale," a Plan administrator is entitled to a "moderate degree of deference." *Lasser v. Reliance Standard Life Ins. Co.*, 344 F.3d 381, 385 (3d Cir. 2003).

CONCLUSIONS OF LAW

When I consider the record before Kemper with a degree of skepticism, I find neither of the peer-review physicians recognized the degree to which Levesque was disabled and each of them

gave too much weight to Levesque's working while severely disabled and too little weight to the opinions of Levesque's treating physicians.

ERISA "plan administrators are not obliged to accord special deference to the opinions of treating physicians," *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 825 (2003), because "a treating physician . . . in a close case, may favor a finding for the patient," *Stratton*, 363 F.3d at 258. Plan administrators may not, however, arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician. *Black & Decker*, 538 U.S. at 823-24. Neither Dr. Cohan's nor Dr. Goldberg's reports offered medical reasons or other evidence to disregard the findings of Levesque's treating physicians. Each of Levesque's treating physicians knew Levesque was working with difficulty and with accommodation and each found Levesque was totally disabled. To survive examination under a slightly heightened scrutiny, a Plan administrator's decision must be supported by substantial evidence in the record. *Abnathya*, 2 F.3d at 45. The only evidence Dr. Cohan and Dr. Goldberg cited for their conclusions Levesque was not disabled was his continued work. The Third Circuit has held "[a] claimant's return to work is not dispositive of his or her disability." *Lasser*, 344 F.3d at 392. It would be error to require an employee to prove economic necessity drove him to work even though disabled; a desire to work, as evidenced here, may be as compelling. In this case, Levesque's treating physicians unanimously and without reservation stated Levesque would never be able to work.

Applying a slightly heightened level of scrutiny, I find Kemper was arbitrary and capricious in its denial of short-term disability benefits to Levesque under the Agere Plan without substantial

evidence.[11] Levesque met the definition of totally disabled in the Plan because he could "not perform any of the substantial and material duties of the job" and he was "unable to be accommodated at another job within the company." I find Kemper's decision to deny Levesque short-term disability benefits was not supported by substantial evidence and was, therefore, arbitrary and capricious. For that reason, I will grant Levesque's motion for summary judgment and deny Agere's.

Levesque's Complaint includes demands for the amount he would have received under the short-term disability plan, costs and attorney fees under 29 U.S.C. § 1132(g)(1), and statutory damages under 29 U.S.C. §§ 1132(c)(1)(B) and (g)(1). The amount of the award will be determined upon motion of the Plaintiff and response. An appropriate order follows.

[11]Further evidence Kemper acted arbitrarily and capriciously in reviewing Levesque's claim is its disagreement with the findings of the Social Security Administration. *Dorsey v. Provident Life & Acc. Ins. Co.*, 167 F. Supp. 2d 846, 856 n.11 (E.D. Pa. 2001) (collecting cases). Levesque notified Kemper on February 3, 2003, the Social Security Administration found him disabled on January 27, 2003. Failure to follow a Social Security Administration finding is not a procedural anomaly which would heighten the scrutiny, but it is evidence which a Plan administrator may only disregard with reason. *Id.*

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KEMPER NATIONAL SERVICES, INC., AGERE SYSTEMS INC. SHORT TERM DISABILITY PLAN and AGERE SYSTEMS INC.	:	

ORDER

And now this 6th day of February, 2006, upon suggestion of death, Constance G. Levesque, personal representative of the Estate of Daniel R. Levesque, shall be substituted as Plaintiff. Plaintiff's Motion for Summary Judgment (Document 29) is GRANTED, and Defendant's Motion for Summary Judgment (Document 23) is DENIED. Judgment is ENTERED in favor of Plaintiff, Constance G. Levesque, personal representative of the Estate of Daniel R. Levesque, and against Agere Systems Inc. Short Term Disability Plan. Damages, attorney fees and costs will be determined on motion.

BY THE COURT:

\s\ Juan R.Sánchez
Juan R. Sánchez, J.