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

DAVID MOORMAN	:	CIVIL ACTION
	:	
vs.	:	
	:	NO. 04-CV-3689
ROHM AND HAAS LONG TERM	:	
DISABILITY PLAN, and LIBERTY	:	
LIFE ASSURANCE COMPANY OF BOSTON	:	

MEMORANDUM AND ORDER

JOYNER, J. **April 20, 2006**

This civil action has been brought before the Court on cross-motions of the parties for summary judgment. For the reasons set forth in the following paragraphs, the plaintiff's motion is denied, the defendants' motion is granted and judgment is entered in favor of the defendants and against the plaintiff as a matter of law.

History of the Case

Plaintiff, David Moorman, was first hired by the Rohm and Haas Company as a contract lab technician at its facility in Deer Park, Texas in 1985. In 1988, Plaintiff became a full-time employee of Rohm and Haas, (hereafter "R & H") covered under the Rohm and Haas Company Health and Welfare Plan, which provides, *inter alia*, life insurance, health care, and long and short-term disability benefits. Such plans are employee welfare benefit

plans within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, *et. seq.* See Generally, 29 U.S.C. §1002(1).

Plaintiff alleges that, as part of his job duties at R & H, he was required to handle mercury thermometers on a regular basis and that he handled those thermometers both under and out from under a protective vent hood. Because R & H failed to provide sufficient thermometers to the plaintiff and other employees, they were purportedly required to "hoard" them in desk drawers. According to the plaintiff, the thermometers would break from time to time in the drawers and during experiments and he was exposed to the dangerous and toxic vapors from elemental mercury.

On October 6, 1998, Plaintiff reported to a Rohm and Haas doctor with complaints of work-related stress, fatigue, insomnia, weight loss, poor appetite, the feeling that he couldn't go on anymore and with reports of hearing voices, conversations and musical notes. Mr. Moorman was directed to consult his primary care physician, have a psychiatric evaluation and to refrain from working for six weeks. Shortly thereafter, Mr. Moorman was diagnosed as suffering from multiple chemical sensitivities and began undergoing a program of detoxification and chelation therapy. He never returned to work and began collecting short term disability benefits under the R & H short term disability plan shortly thereafter. In May, 1999, plaintiff began receiving

long term disability benefits and on June 3, 2002, he was adjudicated to be disabled within the meaning of and entitled to disability benefits under the Social Security Act.

The R & H Disability Program's Summary Plan Description ("SPD") provides, *inter alia*:

> LTD coverage is designed to ensure that you receive a level of income replacement in case you become totally disabled for an extended period of time. To qualify for benefits, you must:
>
> - exhaust STD benefits in order to receive LTD benefits;
> - Meet the requirements, as illustrated in this summary plan description and the relevant contract; and
> - Receive regular care from a licensed physician (other than you, any family member or your domestic partner).
>
> To continue receiving LTD benefits, you must be able to prove your continued disability at your own expense.

(Volume I of Defendant's Appendix of Exhibits, at D72).

Under the heading "How Long You Can Receive Benefits," the SPD further states:

> Your LTD benefits will continue unless one of the following events occurs:
>
> - You refuse to be examined or evaluated at reasonable intervals;
> - You refuse to receive appropriate available treatment;
> - You refuse a job for which the Company has made modifications or accommodations that allow you to perform most of your job duties or other duties associated with another Rohm and Haas job;
> - You are able to work in your own occupation for 24 months or, after that time, in another available job occupation on at least a part-time basis, but choose

not to do so;

- You are no longer partially or totally disabled, as defined under this Program;
- You are working for another employer;
- Your partial disability earnings are equal to or greater than 80 percent of your basic monthly earnings;
- You are not under the regular care of a licensed doctor (other than you, any family member or domestic partner) or fail to provide any required proof of your continuing disability;
- You reach the maximum LTD benefits period shown in the chart on page 9;
- Your doctor does not provide proof of your continued disability;
- You retire;
- You die; or
- Your employment is terminated.

If you meet any of the above criteria, your disability payments may be suspended. In cases of fraud or similar circumstances, the Company may terminate your benefits and/or terminate your employment.

(Defendants' Appendix Volume I at D73).

On November 8, 2002, the Plan's Claims Administrator, Liberty Life Assurance Company of Boston ("Liberty"), sent Plaintiff a letter with enclosed forms requesting updated information on Plaintiff's current medical condition and employment status. (Defendants' Appendix, Volume II, at D788). As he did not immediately respond, Liberty sent a second letter dated December 9, 2002, reminding Mr. Moorman that he was

required by the LTD policy to submit periodic updates regarding his claim in order to continue receiving LTD benefits and requesting a response by January 8, 2003. (Defendants' Appendix, Volume II, at D785). Plaintiff returned the enclosed forms via letter dated January 8, 2003 and also provided his own narrative version of his "Medical Treatment Plan" for 2003. (Defendants' Appendix Volume II, at D781-784).

In July, 2003, Liberty again wrote to Plaintiff to request current medical information in the form of actual medical records and proof of ongoing disability. (Defendants' Appendix Volume II, at D773). In response, Plaintiff forwarded medical notes and reports from two of his treating physicians reflecting follow-up visits in November, 2002 and February, 2003. (Defendants' Appendix, Vol. II, at D766-772). Because that information was more than six months old, via letter dated August 22, 2003, Liberty requested that Plaintiff supply it with his medical records from June, 2003 to the present along with proof of ongoing disability within 30 days or his benefits would be suspended. (Defendants' Appendix, Vol. II, at D764-765).

Although several of the plaintiffs' treating doctors forwarded updated information in response to his request therefor, Liberty's review of those records revealed that there was little medical support for continued disability. It therefore referred Mr. Moorman's file to its consulting

physicians for review and suspended his benefits effective September 22, 2003. (Defendants' Appendix, Vol. II, at D756, 761-763). On October 2, 2003, the consulting physician, John Holbrook, M.D., issued a lengthy report detailing his review of the records and in which he concluded, *inter alia*, that the diagnoses of mercury poisoning, immune deficiency and multiple chemical sensitivity "has not been established in the case of the claimant and is unlikely," "[t]he neuropsychiatric status of the claimant is uncertain; current impairment on a neuropsychiatric basis is uncertain," and "[t]here are significant gaps in the clinical notes available in the medical file; obtaining at least the most recent clinical records of the claimant may be useful in understanding the presence or absence of impairment..." (Defendants' Appendix, Vol. II, at D665). Dr. Holbrook further found that:

> (1) the plaintiff's medical file did not include clinical notes from many treating physicians and diagnostic studies that were referenced in his medical history and that the current statement from his attending physician was "not accompanied by any clinical notes or observations to support or explain the insured's claimed multiple chemical sensitivity, chronic fatigue, PTSD, or major depression...,"
>
> (2) [t]here is no evidence that the claimant currently suffers from mercury toxicity...,"
>
> (3) "[t]he most recent [neuropsychiatric] evaluation...is dated 3/12/2002. However, that evaluation is not sufficiently recent to provide a current estimate of the claimant's functional capacity..."
>
> (4) "No evidence is presented in the medical file that the claimant suffers from any medical or organic diagnosis...Dr.

> Rea, the environmental specialist, opined in March, 2002 that exposure to toxic agents may impair the claimant's physical functioning. However, he specifically notes that he did not evaluate the claimant's physical functioning, and did not opine that in fact the claimant's physical functioning was impaired by exposure to toxic agents..."
>
> (5) "The restrictions and limitations suggested in the claimant's APS are either unreasonable or too vague to be useful in understanding the claimant's ability to reenter the workforce..."
>
> (6) "The medical file does not document or precisely describe the claimant's limitations or impairments..."

(Defendants' Appendix, Vol. II, at D665-667). Based in large part upon Dr. Holbrook's findings, Liberty denied Plaintiff's claim for further benefits consideration and closed out his claim as of October 23, 2003. (Defendants' Appendix, Vol. II, at D. 630-633). Plaintiff then appealed the denial of his benefits to Rohm and Haas, which upheld Liberty's decision on February 11, 2004. (Defendants' Appendix, Vol. II, at D550-551). Plaintiff thereafter commenced this lawsuit on August 2, 2004.

Standards Governing Summary Judgment Motions

Summary judgment is appropriate where the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, reveal no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The district court's responsibility is not to resolve disputed issues of fact, but to determine whether any factual issues exist to be tried. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-49 (1986). The presence of "a mere

scintilla of evidence" in the non-movant's favor will not avoid summary judgment. Williams v. Borough of West Chester, 891 F.2d 458, 460 (3d Cir. 1989) (citing Anderson, 477 U.S. at 249). Rather, summary judgment will be granted unless "the evidence is such that a reasonable jury could return a verdict for the non-moving party." Anderson, 477 U.S. at 248. In making this determination, all of the facts must be viewed in the light most favorable to the non-moving party and all reasonable inferences must be drawn in favor of the non-moving party. Id. at 256. Once the moving party has met the initial burden of demonstrating the absence of a genuine issue of material fact, the non-moving party must establish the existence of each element of its case. J.F. Feeser, Inc. v. Serv A Portion, Inc., 909 F.2d 1524, 1531 (3d Cir. 1990)(citing Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986)).

Discussion

By his pleadings in this lawsuit, brought pursuant to Section 502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B), Plaintiff alleges that he is entitled to the reinstatement of his long term disability benefits under the Rohm and Haas Company Health and Welfare Plan. (Amended Complaint, ¶2).

ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Firestone Tire and Rubber Co.

v. Bruch, 489 U.S. 101, 113, 109 S.Ct. 948, 956, 103 L.Ed.2d 80 (1989), quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90, 103 S.Ct. 2890, 2896, 77 L.Ed.2d 490 (1983) and Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 148, 105 S.Ct. 3085, 3093, 87 L.Ed.2d 96 (1985). Indeed, Section 502 specifically empowers a plan participant or beneficiary to bring a civil action "to recover benefits due to 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." Id. A claim for wrongful denial of benefits may be brought against an ERISA plan itself or against the persons who are shown to have control over the plan in their fiduciary capacity. Rieser v. Standard Life Insurance Company, Civ. A. No. 03-5040, 2004 U.S. Dist. LEXIS 11556 at *16 (E.D.Pa. June 24, 2004); Edwards v. Continental Airlines, Civ. A. No. 98-6039, 1999 U.S. Dist. LEXIS 67 at *4 (E.D. Pa. Jan. 7, 1999), both citing Curcio v. Hancock Mutual Life Insurance Co., 33 F.3d 226, 233 (3d Cir. 1994).

However, "[a]lthough it is a comprehensive and reticulated statute, ERISA does not set out the appropriate standard of review for actions under §1132(a)(1)(B) challenging benefit eligibility determinations. Firestone, 489 U.S. at 108-109, 109 S.Ct. at 953. To fill this gap, the U.S. Supreme Court in Firestone decreed that:

> ...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...Thus, for purposes of actions under §1132(a)(1)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. 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 'factor in determining whether there is an abuse of discretion.'"

Firestone, 489 U.S. at 115, 109 S.Ct. at 956-957, quoting Restatement (Second) of Trusts §187, Comment *d* (1959).

Attempting to distill this directive into a workable standard, the Third Circuit has held that "when 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. Stratton v. E.I. DuPont DeNemours & Co., 363 F.3d 250, 254 (3d Cir. 2004), quoting Pinto v. Reliance Standard Life Insurance Co., 214 F.3d 377, 378 (3d Cir. 2000). This heightened form of review is to be formulated on a sliding scale basis, which enables the Court to review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of beneficiaries. Id., citing Pinto, 214 F.3d at 391. In employing the sliding scale approach, the following factors should be taken into account in deciding the severity of the conflict: (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 status of the fiduciary, as the company's financial or structural deterioration might negatively impact the presumed desire to maintain employee satisfaction. Id., citing Pinto, 214 F.3d at 392.[1] Indeed, the risk of a conflict of interest is decreased where the administrator and funder of the plan is the employer, rather than an insurance company, because the employer has "incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits," suggesting that there is at least some counter to the incentive not to pay claims. Smathers v. Multi-Tool, 298 F.3d at 197, quoting Nazay v. Miller, 949 F.2d 1323, 1335 (3d Cir. 1991).

Of course, where the plan gives the administrator discretionary authority, the administrator's exercise of that

[1] It should be noted that in Pinto's wake, the Third Circuit has not been hesitant to apply a heightened standard of review to an employer who both funds and administers its ERISA plan where the evidence demonstrates a reason to question the employer's impartiality. Hunter v. Federal Express Corporation, No. 04-3563, 2006 U.S. App. LEXIS 4259 at *13 (3d Cir. Feb. 26, 2006). Such reasons to question have been found where the employer would sustain direct financial harm if the claim was paid or if there is a "demonstrated procedural irregularity, bias or unfairness in the review of the claimant's application for benefits." Id., citing Kosiba v. Merck & Company, 384 F.3d 58 (3d Cir. 2004) and Smathers v. Multi-Tool, Inc., 298 F.3d 191 (3d Cir. 2002). Other examples of procedural bias include: failing to follow a plan's notification provisions and conducting self-serving paper reviews of medical files, relying on favorable parts while discarding unfavorable parts in a medical report, denying benefits based on inadequate information and lax investigatory procedures, and ignoring the recommendations of an insurance company's own employees that benefits should be reinstated. Addis v. The Limited Long Term Disability Program, Civ. A. No. 05-357, 2006 U.S. Dist. LEXIS 15325 at *11 (E.D.Pa. March 30, 2006).

authority is reviewed under an ordinary "arbitrary and capricious" standard, and the administrator's decision will be overturned only if it is without reason, clearly not supported by the evidence in the record, the administrator has failed to comply with the procedures required by the plan, or erroneous as a matter of law. Vitale v. Latrobe Area Hospital, 420 F.3d 278, 282 (3d Cir. 2005), citing Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am., Inc., 222 F.3d 123, 129 (3d Cir. 2000); Mitchell v. Eastman Kodak Company, 113 F.3d 433, 439 (3d Cir. 1997). "This scope of review is narrow and the court is not free to substitute its own judgment for that of the administrator in determining eligibility for plan benefits." Mitchell, supra, quoting Abnathya v. Hoffman LaRoche, Inc., 2 F.3d 40, 45 (3d Cir. 1993).

Applying these standards to the case at hand, we first observe that under the Summary Plan Description, Rohm and Haas Company is designated as the Plan Administrator and Liberty Life Assurance Company of Boston is named as the Claims Administrator. The SPD further provides, in relevant part:

> Benefits under the Program will be paid only if the Plan Administrator or the Claims Administrator decides in its discretion that you are entitled to them. The Plan Administrator or the Claims Administrator, as applicable, shall make, in its sole discretion, all determinations arising in the administration, construction or interpretation of the Program, including the right to construe disputed or doubtful Plan and Program terms and provisions, and any such determination shall be conclusive and binding on all persons, to the maximum extent permitted

by law.

(Defendant's Appendix of Exhibits, Vol. I, at D91). Thus, the administrators having been granted discretionary authority under the Plan, we would be compelled to apply the arbitrary and capricious standard of review to Liberty Mutual's decision to rescind Plaintiff's benefits as of October, 2003. As the record reflects, the Rohm and Haas LTD Plan is a self-insured disability policy with all benefit monies actually coming from the Rohm and Haas Company rather than Liberty Mutual, and hence as the employer we find that Rohm and Haas has "incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits." (See, Defendants' Appendix of Exhibits, Vol. II, at D861-862; D983-984). We therefore conclude that the arbitrary and capricious standard is the appropriate standard of review to be applied in this case. In any event and regardless of whether the heightened standard or the ordinary standard of arbitrary and capricious review is applied, however, we discern no error.

For one, we note that the plaintiff was represented throughout these proceedings by counsel and thus we find that the parties are on relatively equal footing insofar as sophistication is concerned. Second, there is no evidence on this record that R & H's financial or structural condition was in any way precarious such as might override its incentive to maintain high morale

among its employees.

Furthermore, the Plan language is clear and unequivocal: “To continue receiving LTD benefits, you must be able to prove your continued disability at your own expense.” (Volume I of Defendant’s Appendix of Exhibits, at D72). Thus, the impetus to demonstrate *continuing and current disability* falls on the plaintiff.

In this case, our review of the record evidence reveals that the materials submitted by Mr. Moorman and his treating physicians simply did not satisfy his burden of proof. Although there are numerous copies of medical reports from a number of doctors with whom Plaintiff treated, many of these reports are duplicates and those that supported a finding of disability were dated between 1998 and 2001. In fact, in his letter report of March 6, 2002 and in response to a request for an estimated return to work date, one of Plaintiff’s doctors, (Dr. Howe) related that “[w]ith continued appropriate treatment and a compatible work environment this [return to work] could be accomplished in 2002.” (Defendants’ Appendix, Vol. II, at D 737-738).

In addition, all of the medical records provided from the latter part of 2002 and 2003 reflected normal or near-normal levels of metals in Plaintiff’s system and his urine and blood work was normal with the exception of high cholesterol, high

monocytes and an elevated PSA reading. (Defendants' Appendix, Vol. II, at D741-753). Although on September 3, 2003, Plaintiff's new primary care doctor in Hawaii, Clif Arrington, M.D., did address a note regarding Plaintiff "To Whom It May Concern" and observing that "[h]e is totally disabled for work," it appears from that note that at the time of that writing Dr. Arrington may not have yet seen Mr. Moorman and that he would merely be coordinating his care by referring him to specialist physicians for treatment. That note, which was not accompanied by any other medical records, documents or test results, read as follows:

> I am a physician in Hawaii and I have agreed to accept the above person for medical care under my supervision. David suffers from Multiple Chemical Sensitivity, Chronic Fatigue, PTSD and Major Depression. He is totally disabled for work.
>
> My function will be to coordinate his care by making the appropriate referrals for special treatment. Presently his condition is unchanged and his disability will continue for at least one year from now or longer.

(Defendants' Appendix, Vol. II, at D761). Dr. Arrington's notation is the most recent declaration of Plaintiff's disability contained in the plaintiff's file materials. In as much as Dr. Arrington's statement was silent as to what Mr. Moorman's level of current functioning was, whether and why Mr. Moorman is presently disabled from *all* employment or just from his former position as a laboratory technician and was unsupported by any other medically objective records, Liberty Mutual referred Mr.

Moorman's case first to its Nurse reviewer and subsequently to a Consulting Physician for full review. (Defendants' Appendix, Vol. II, at D644-650). It was only after the Consulting Physician, Dr. Holbrook likewise found that there was no evidence in the file that the plaintiff was *currently* suffering from mercury toxicity and that his current level of impairment was uncertain that Liberty terminated Plaintiff's benefits. Plaintiff appealed and Rohm and Haas then referred the case to two of its Consulting Physicians, Dr. Jeffrey Erinoff and Dr. Eileen Bonner for further review and subsequently upheld Liberty's denial. Given that our review of these same materials and other evidence of record likewise reveals that while Plaintiff was apparently disabled from working as a laboratory technician due to mercury toxicity, depression, chronic fatigue, and immune deficiency up through the late 2001 to early 2002 time frame and that while he still appeared to be suffering from some residual effects of metals toxicity and chemical sensitivity, there is nothing in the record to indicate any connection between those residual effects and his alleged inability to work or that demonstrates that Plaintiff was completely disabled from *any and all* work as of October, 2003. Accordingly, we cannot find that even under the heightened arbitrary and capricious standard of review, that the decisions by both Liberty Mutual and Rohm and Haas to terminate Mr. Moorman's long term disability benefits

were in any way improper, without reason, unsupported by the evidence or erroneous in any other respect. We are therefore compelled to deny the plaintiff's motion for summary judgment and grant that of the defendants.

An order follows.

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

DAVID MOORMAN	:	CIVIL ACTION
	:	
vs.	:	
	:	NO. 04-CV-3689
ROHM AND HAAS LONG TERM	:	
DISABILITY PLAN, and LIBERTY	:	
LIFE ASSURANCE COMPANY OF BOSTON	:	

ORDER

AND NOW, this 20th day of April, 2006, upon consideration of the Cross-Motions of Plaintiff and Defendants for Summary Judgment, it is hereby ORDERED that the Defendants' Motion is GRANTED, the Plaintiff's Motion is DENIED and Judgment is hereby entered in favor of the Defendants and against the Plaintiff as a matter of law for the reasons set forth in the preceding Memorandum Opinion.

BY THE COURT:

s/J. Curtis Joyner
J. CURTIS JOYNER, J.