IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

JAMES J. HYATT, II,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 00-613-JJF
	:	
UNUM LIFE INSURANCE COMPANY OF AMERICA,	:	
	:	
Defendant.	:	

Ben T. Castle, Esquire of YOUNG CONAWAY STARGATT & TAYLOR, LLP, Wilmington, Delaware.
Attorney for Plaintiff.

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Attorney for Defendant.

MEMORANDUM OPINION

July 11, 2001
Wilmington, Delaware

FARNAN, District Judge.

Presently before the Court is Defendant UNUM Life Insurance Company of America's Motion for Summary Judgment (D.I. 28). For the reasons stated below, the Court will grant the motion.

BACKGROUND

On October 16, 1998, Plaintiff James J. Hyatt, II ("Plaintiff") was involved in a non-work related biking accident in which he suffered a fractured right femur in his hip joint.[1] At the time of the accident, Plaintiff was employed by The Pep Boys as a loss prevention supervisor, and was eligible for short and long term disability benefits under the benefits plan ("the Policy") issued to The Pep Boys by Defendant UNUM Life Insurance Company of America ("Defendant"). Plaintiff received short term disability ("STD") benefits for a six month period from October 16, 1998 through April 15, 1999, even though Plaintiff was terminated from his employment with The Pep Boys on February 16, 1999. (D.I. 30 at 000557).

When Plaintiff's entitlement to STD benefits under the Policy expired on April 15, 1999, Plaintiff's claim was forwarded to Defendant's long term disability ("LTD") section. On May 4, 1999, Defendant learned from Plaintiff's treating physician, Dr. Kamali, that Plaintiff had been cleared for full-time employment on April 26, 1999. Based on this information, Defendant's LTD section determined that Plaintiff should receive LTD benefits from April 15, 1999 until April 25, 1999, totaling $466.75. Defendant's representative, Holly Bawlick, informed Plaintiff of this decision in a telephone

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[1] Plaintiff was twenty-seven years old at the time of the accident.

conversation on May 10, 1999 and in a letter dated May 11, 1999.

Plaintiff spoke with a representative of Defendant, Mark Halton, on November 24, 1999, in an attempt to reopen his claim for LTD benefits. Plaintiff informed Mr. Halton that he had consulted a new doctor in October 1999, who had diagnosed Plaintiff as having Reflex Sympathetic Dystrophy ("RSD"). Mr. Halton told Plaintiff that his eligibility for LTD benefits had expired when he did not return to work on April 26, 1999, the date that he had been cleared to work full-time, but Mr. Halton nonetheless encouraged Plaintiff to submit additional medical records. Plaintiff had Dr. Kamali submit updated medical records on January 11, 2000, and after reviewing these records, Defendant denied Plaintiff's claim for LTD benefits on January 18, 2000, because, according to Defendant, there were "no treatment records from April 26, 1999 to the present that support your inability to work." (D.I. 30 at 000432).

On February 10, 2000, Plaintiff's counsel wrote Defendant in order to initiate an appeal of the denial of benefits. On March 30, 2000, Defendant's disability claims specialist assigned to Plaintiff's appeal concluded that the denial of benefits was proper because Plaintiff never submitted documents indicating that he had been continuously disabled from April 26, 1999 to the present. Plaintiff filed this lawsuit on June 27, 2000, claiming that Defendant's decision denying Plaintiff of LTD benefits violated the Employee Retirement Income Security Act ("ERISA") (D.I. 1). After the completion of discovery, Defendant filed the instant motion for summary judgment. (D.I. 28).

STANDARD OF REVIEW

Rule 56(c) of the Federal Rules of Civil Procedure provides that a party is entitled to summary

judgment if a court determines from its examination of "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any," that there are no genuine issues of material fact and that the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). In determining whether there is a triable dispute of material fact, a court must review all of the evidence and construe all inferences in the light most favorable to the non-moving party. Goodman v. Mead Johnson & Co., 534 F.2d 566, 573 (3d Cir. 1976). However, a court should not make credibility determinations or weigh the evidence.[2] Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133, 150 (2000). To defeat a motion for summary judgment, Rule 56(c) requires the non-moving party to:

> do more than simply show that there is some metaphysical doubt as to the material facts. . . . In the language of the Rule, the non-moving party must come forward with "specific facts showing that there is a genuine issue for trial." . . . Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is "no genuine issue for trial."

Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp., 475 U.S. 574, 586-87 (1986). Thus, a mere scintilla of evidence in support of the non-moving party is insufficient for a court to deny the motion. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252 (1986).

DISCUSSION

A. Heightened Arbitrary and Capricious Standard

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[2] To properly consider all of the evidence without making credibility determinations or weighing the evidence, a "court should give credence to the evidence favoring the [non-movant] as well as that 'evidence supporting the moving party that is uncontradicted and unimpeached, at least to the extent that that evidence comes from disinterested witnesses.'" Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133, 151 (2000).

When a benefits plan provides that the plan administrator has discretion to interpret an applicant's eligibility for benefits under the plan, a reviewing court can overturn the plan administrator's decision only if said decision was "arbitrary and capricious." Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagon of Am., Inc., 222 F.3d 123, 129 (3d Cir. 2000). A plan administrator's decision is deemed "arbitrary and capricious" only if it is "clearly not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan." Id. (citations omitted). This means that the reviewing court should not substitute its own judgment for that of the plan administrator, but rather, should be deferential to the plan administrator's judgment. Id.

However, when an insurance company "both funds and administers benefits" under a plan, as Defendant does in the instant case, "it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 2000). Under this standard, a reviewing court must implement a sliding scale approach to the facts of each case, in that, the greater the plan administrator's conflict of interest, the less deference that will be afforded to the plan administrator's decision. Id. at 391-92. In doing so, the court must assess the substance of the decision as well as the process used to obtain the decision.[3] Id.

[3] Pinto also listed a number of factors for a court to consider, including: (1) the sophistication of the parties, (2) the information available to the parties, (3) the financial arrangement between the employer and the insurance company, and (4) the current status of the plan administrator. Id. at 392. As one court has noted, however, the Pinto decision is perplexing because the decision does not analyze any of these factors, but rather, automatically applied a heightened arbitrary and capricious standard simply because an insurance company administered and funded the plan. Cimino v. Reliance

at 393. See also Goldstein v. Johnson & Johnson, 2001 WL 567719, at *7 (3d Cir. May 25, 2001). A plan administrator does not have an affirmative duty to conduct a "good faith reasonable investigation" when assessing a particular claim; therefore, the reviewing court simply applies the heightened arbitrary and capricious standard "given the information available" to the plan administrator at the time the decision to deny benefits was made. Pinto, 214 F.3d at 394 n.8; Lasser v. Reliance Standard Life Ins. Co., 130 F. Supp. 2d 616, 628 (D.N.J. Feb. 8, 2001).[4] The Policy in the instant case states in relevant part that: "[i]n making any benefits determination under [the Policy], [Defendant] shall have the discretionary authority both to determine an employee's eligibility for benefits and to construe the terms of [the Policy]." (D.I. 30 at 000630).

In sum, when reviewing an insurer's decision to deny benefits where, as here, the insurer funds and administers the plan and has discretion to interpret the provisions of the plan, a reviewing court should only be "deferential" under the heightened arbitrary and capricious standard of review, not extremely deferential. Pinto, 214 F.3d at 393.

Standard Life Ins. Co., 2001 WL 253791, at *3 (E.D. Pa. Mar. 12, 2001). The Cimino court concluded that, since no evidence relevant to these factors had been presented to the court, the safe approach would be to "automatically" apply the heightened arbitrary and capricious standard when analyzing the decision and the process used to reach that decision. Id. In the instant case, little or no evidence has been adduced relevant to the above four factors, and the Court therefore concludes that the approach taken in Cimino is appropriate here. Accordingly, it will apply the heightened arbitrary and capricious standard when analyzing the substance of Defendant's decision and the procedure used to reach that decision.

[4] Pinto and Lasser refute the relevance of Plaintiff's argument that, under state contract law, an insurer has a duty to conduct a reasonable good-faith investigation and to assist a claimant in bringing a claim. (D.I. 33 at 5)(citing Tackett v. State Farm Fire & Cas. Inc., 653 A.2d 254 (Del. 1995); Ace v. Aetna Life Ins. Co., 139 F.3d 1241 (9th Cir. 1998)).

B. Application of the Heightened Arbitrary and Capricious Standard

Under the terms of the Policy, an employee is "disabled" only if he cannot "perform each of the material duties of his regular occupation." (D.I. 30 at 000636). Moreover, an employee's entitlement to LTD benefits ceases under the Policy on the date of his or her termination from employment, except that the employee remains eligible for LTD benefits after his termination during (i) the elimination period, or (ii) while benefits are being paid. (D.I. 30 at 000646).

Defendant contends that summary judgment is warranted because no reasonable jury could conclude that Plaintiff was continuously disabled beginning on April 26, 1999. (D.I. 29 at 16-17)(citing Redden v. UNUM Life Ins. Co. of Am., 2000 WL 135137 (D. Del. Jan. 18, 2000). In particular, Defendant contends that it was informed in early May 1999 that Plaintiff was capable of full-time employment as of April 26, 1999 by a handwritten note from Plaintiff's treating physician, Dr. Kamali, and through a telephone conversation with a receptionist from Dr. Kamali's office, (D.I. 30 at 000118; D.I. 30 at 000557), and that Plaintiff never produced any medical records to refute this evidence. (D.I. 29 at 16-17). Accordingly, Defendant contends that Plaintiff ceased being disabled on April 26, 1999, and thus, lost his entitlement to LTD benefits. (D.I. 29 at 16-17). In response, Plaintiff cites to facts that allegedly establish that Defendant's decision was arbitrary and capricious. (D.I. 33 at 6-14).

1. Substance of Defendant's Decision

In an attempt to prove that the substance of Defendant's decision to deny Plaintiff LTD benefits was arbitrary and capricious, Plaintiff primarily contends that he suffered from RSD on April 26, 1999, but that he was not diagnosed with RSD until he consulted a second orthopedic surgeon in October

1999. (D.I. 33 at 6; D.I. 33, Exh. A at ¶ 8-9). Plaintiff further contends that he was unable to work in any capacity on April 26, 1999 or anytime thereafter, as a result of this ailment and that Defendant knew that he had not returned to work. (D.I. 33, Exh. A at ¶ 2-7). Based on the evidence in the record at this juncture, the Court concludes that there is no medical evidence asserted by Plaintiff that in any way reasonably contradicts that Plaintiff was able to perform his job, as of April 26, 1999, as Dr. Kamali indicated.

Plaintiff also cites to medical records submitted by Dr. Kamali, dated November 29, 1999, stating that Plaintiff: "is still unable to return to his regular work, but may return to light duty job of walking no more than 1-1½ hours a day." (D.I. 30 at 000531; D.I. 33, Exh. B at 26). Plaintiff contends that Defendant completely ignored this note and continued to rely on the note clearing Plaintiff for full-time work on April 26, 1999. Plaintiff argues that Defendant's failure to contradict this medical information establishes that Defendant's denial of LTD benefits to Plaintiff was arbitrary and capricious. (D.I. 33 at 8-10). The Court looks to the time frame when Plaintiff was first eligible for LTD benefits in order to determine whether Defendant was arbitrary and capricious. In this regard, the Court observes that Defendant has repeatedly maintained that the November 29, 1999 record had little or no significance in its decision to deny LTD benefits because the November information does not support Plaintiff's assertion that he suffered from RSD or that he was disabled in April 1999. (D.I. 34 at 8-9; D.I. 33, Exh. B at 26; D.I. 30 at 000414[5]). Moreover, earlier medical records submitted by Dr.

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[5] Plaintiff contends that this handwritten note of Defendant's claims reviewer, (D.I. 30 at 000414), which states that "[a]ll medical evidence establishes [Plaintiff] has RSD. Medical evidence

Kamali support a reasonable inference that Plaintiff's condition deteriorated in the fall of 1999. Specifically, an August 27, 1999 entry states that Plaintiff was "doing much better, walking with little or no limp. Range of hip motion is full and painless. . . . He is back to school and he is doing well." (D.I. 30 at 000533). Therefore, the Court concludes that Plaintiff has failed to meet his burden of proving that Defendant acted in an arbitrary and capricious manner.[6]

Next, Plaintiff cites to several notes written by Dr. Alex Bodenstab, dated October 14, 1999 and November 23, 1999, in support of his claim that he was disabled in April 1999. (D.I. 33 at 9-10)(citing D.I. 30 at 000004; D.I. 30 at 000472). Although these notes discuss the severity of Plaintiff's symptoms, and the November 23, 1999 note indicates that Plaintiff was unable to work at that time, they do not contradict Dr. Kamali's note which cleared Plaintiff to return to full-time work on April 26, 1999. Without some evidence that Dr. Kamali's medical opinion in April 1999 was erroneous, the evidence adduced by Plaintiff is consistent with the conclusion that Plaintiff's condition

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establishes he suffers from disabling condition," is sufficient evidence to defeat Defendant's motion. (D.I. 33 at 13). However, Defendant contends that this note is a summary of Plaintiff's counsel's letter to Defendant. (D.I. 34 at 10)(citing D.I. 30 at 000412-000414, 000410, 000425-000426). After reviewing the cited documents, the Court concludes that the handwritten note is consistent with Defendant's interpretation. Moreover, this handwritten note was prepared in February 2000, so even if Defendant's claims reviewer had concluded that Plaintiff was disabled at the time this entry was made, it does not support the conclusion that Plaintiff was disabled in April 1999.

[6] Plaintiff also cites to a November 1999 record from St. Francis Pain Center to prove that he suffered from "right anterolateral thigh pain" since his October 1998 injury. (D.I. 33 at 9)(citing D.I. 30 at 000085). However, this record specifically notes that this pain "has essentially gotten worse over the last 3-4 months." (D.I. 30 at 000085). This record therefore supports the conclusion that Plaintiff's condition was not sufficiently severe for him to be considered "disabled" until sometime after April 1999.

deteriorated after April 1999, and that, therefore, Plaintiff was not "disabled" until sometime after April 1999. Thus, the Court concludes that Plaintiff has failed to establish that Defendant's decision violated the heightened arbitrary and capricious standard. See Redden, 2000 WL 135137, at *6 (holding that proof that claimant was disabled in October 1996 and in January 1997 does not prove that claimant was disabled "on every day in between").[7]

2. Procedure in Making the Decision

Plaintiff also contends that the procedure used by Defendant in reaching its decision was improper. Specifically, Plaintiff contends that Defendant failed to conduct an independent medical examination at any time, and that it failed to seek an in-house medical review of Plaintiff's appeal file in order to evaluate Plaintiff's RSD claim. (D.I. 33 at ¶ 5, 8). However, as discussed above, Defendant did not have to conduct an investigation in an attempt to verify Plaintiff's claim. Thus, the Court concludes that any lack of investigation by Defendant is not relevant to the instant analysis. Additionally, the evidence demonstrates Defendant's willingness to accept new information provided by Plaintiff and reconsider its May 1999 decision. (D.I. 30 at 000540, 000538, 000537). This conclusion is supported by Plaintiff's own statement that: "[a]s late as January and February, 2000, [Defendant] was conducting medical reviews of [Plaintiff's] file." (D.I. 33 at 9). Based on the record

[7] Plaintiff also offers testimony of Dr. William Feist, a former vice president and medical director of "UNUM-Provident," that was adduced during unrelated litigation, establishing that "UNUM-Provident" put into place new procedures in 1993 in order to deny legitimate disability claims. (D.I. 33 at 14). In light of the evidence adduced by Defendant that: (1) Dr. Feist worked for "Provident Life and Accident," which did not merge with Defendant until June 30, 1999, and (2) Dr. Feist ceased working for Provident Life and Accident in February 1996, the Court concludes that Dr. Feist's testimony is irrelevant to the instant dispute. (D.I. 34, Exh. B; D.I. 33, Exh. D at 12).

to this point, the Court concludes that there were no procedural abnormalities in the handling of Plaintiff's claim for LTD benefits that would warrant overturning Defendant's decision to deny Plaintiff's claim. See, e.g., Pinto, 214 F.3d at 393-94 (describing procedural abnormalities that are arguably arbitrary and capricious).

CONCLUSION

In sum, the Court concludes that Defendant's motion for summary judgment (D.I. 28) must be granted.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

JAMES J. HYATT, II,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 00-613-JJF
	:	
UNUM LIFE INSURANCE COMPANY OF AMERICA,	:	
	:	
Defendant.	:	

FINAL ORDER

At Wilmington this 11 day of July, 2001, for the reasons set forth in the Memorandum Opinion issued this date;

IT IS HEREBY ORDERED that Defendant UNUM Life Insurance Company of America's Motion for Summary Judgment (D.I. 28) is **GRANTED**, and therefore, judgment is entered in favor of Defendant and against Plaintiff on all counts.

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UNITED STATES DISTRICT JUDGE