IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

MICHELLE WILLIAMS,

Plaintiff,

vs.

Case No. C2-08-128
Judge Edmund A. Sargus, Jr.
Magistrate Judge Terence P. Kemp

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY,

Defendant.

OPINION AND ORDER

This case, arising under the Employee Retirement Income Security Act of 1974, 28 U.S.C. § 1001 *et seq.* ("ERISA"), is before the Court for consideration of the Cross Motions for Judgment on the Administrative Record filed by Plaintiff, Michelle Williams, and Defendant, Hartford Life and Accident Insurance Company ("Hartford"). Plaintiff maintains that she is entitled to long-term disability benefits under her employer's ERISA plan. Defendant contends that it properly determined that Plaintiff was not disabled from "Any Occupation" pursuant to the terms of the ERISA-qualified plan. For the reasons that follow, Defendant's Motion for Judgment on the Administrative Record is **DENIED**. Plaintiff's Motion for Judgment on the Administrative Record is **GRANTED**.

I.

A. Plaintiff's Occupation

Plaintiff, Michelle Williams, is a forty-five year old high school graduate with some college education. She was employed by Countrywide Financial Corporation ("Countrywide") as an External Home Loan Consultant for six years. (HLI00334-336.[1]) As a consultant, Plaintiff traveled often and was responsible for sales and customer service, generating new business, originating loans and building and maintaining customer relationships. Her work on any given day could have required her to travel to clients' homes or places of employment. Plaintiff was also expected to attend weekly realtor association meetings in addition to meeting with partners and clients throughout the day. Plaintiff's work schedule was erratic and not often a rigid eight hour day. In addition to these duties, she was often required to travel to out of the city or state for training sessions.

B. The ERISA Plan

Plaintiff participated in Countrywide's Group Long Term Disability ("LTD") plan ("Plan") which is governed by ERISA. Countrywide employees were potentially eligible to receive LTD benefits pursuant to the terms of the Plan, issued by Continental Casualty Company ("Continental"), but presently underwritten by Hartford. Under the terms of the Plan, during the first twenty-four (24) months of disability, referred to as the "Elimination Period," "disability" is defined as follows:

> *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
>
> 1. Continuously unable to perform the *Material and Substantive Duties of Your Regular Occupation*; and

[1] This Court adopts this reference to the supporting document within the administrative record, which reflects Hartford's Bates stamp number affixed to the particular page.

2. Not working for wages in any occupation for which *You* are or become qualified by education, training or experience. (HLI00017.)

After the Monthly Benefits have been paid for 24 months, "disability" is then defined as:

> *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
> 1. Continuously unable to engage in any occupation for which *You* are or become qualified by education, training or experience; and
> 2. Not working for wages in any occupation for which *You* are or become qualified by education, training or experience. (*Id.*)[2]

C. Plaintiff's Disability and Application for Benefits

In 2003, Plaintiff began experiencing headaches and back pain. In fall of 2003, Plaintiff began experience back pain to such a degree that it began to affect her ability to work. Because of the pain, Plaintiff reduced her workload and began working part time on April 22, 2004. Plaintiff worked part time until June 1, 2004. Ultimately, Plaintiff was diagnosed with spina bifida occulta,[3] arachnoiditis[4] and diastenatomyelia[5] secondary to a tethered spinal cord.[6]

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[2] Plaintiff also asserts that she was "disabled," as that term is defined, under "Earnings Qualifier" provision of the Policy:

> You may be considered Disabled during and after the Elimination Period in any Month in which You are Gainfully Employed, if an Injury or Sickness is causing physical or mental impairment to such a degree of severity that You are unable to earn more than 80% of Your Monthly Earnings in any occupation for which You are qualified by education, training or experience. . . (HLI00017)

Plaintiff indicates that she was making $10,333 per month ($124,000 annually) at the time of her disability, and contends that provision means that she is "disabled" unless she is "employable" in a job that pays her at least $99,200 per year. This interpretation of the Policy, however, is mistaken. By its terms, the Earnings Qualifier provision applies only when a covered employee is "Gainfully Employed," defined later in the Policy as "performance of any occupation for the Employer, another Employer or You . . . ." (HLI00026) Here, Plaintiff never returned to her job or any other employment. The Earnings Qualifier definition of disability, therefore, does not apply in this case.

[3] Spina bifida occulta results from a congenital "spinal deformity and is associated with abnormal development of the spinal nerve roots and spinal cord. " (HLI00668.) The condition is the mildest form of spina bifida, but the severity of the condition varies from person to person. Plaintiff reports that she always has back stiffness and pain, sometimes suffers from incontinence, foot deformities, lower limb weakness, occasional loss of reflexes and numbness in her legs. (*Id.*)

[4] "Arachnoiditis is a chronic, insidious condition that causes debilitating, intractable pain and a range of other neurological problems. (HLI00585.) "Arachnoiditis is chronic inflammation inside the . . . arachnoid layer" of the system of membranes that envelops the central nervous system. (*Id.*)

Plaintiff filed for LTD benefits under the "Regular Occupation" standard of the Plan. After the twenty-four month Elimination Period, Plaintiff was required to demonstrate that she was disabled from "Any Occupation" in order to continue receiving benefits.

D. Initial Medical Evidence

When Plaintiff began to experience serious back pain, she sought treatment from her primary care physician, Michael D. Conaway, M.D. of Riverside Internal Medicine. He noted an interpretation of a March 30, 2004 MRI as suggestive of "an element arachnoiditis." In response to these finding Dr. Conaway, referred Plaintiff to a neurosurgeon, Dr. Michael Meagher, M.D., of Neurological Associates, for further evaluation of her back and bilateral leg pain. Dr. Meagher first evaluated Williams on April 28, 2004. In his evaluation he noted that "[Plaintiff] continues to have chronic neck pain, but for the last four months she has had fairly significant low back pain and has developed pain in both legs and both hips, and she says they feel like they are on fire at times." (HLI00957.)

Dr. Meagher observed that an MRI of her lumbar spine showed "evidence of some segmentation in the lumbar spine with associated spina bifida at what I am calling the L5 and S1 laminae." Dr Meagher also commented that there is "some question of low-lying conus with dorsal clumping of nerve roots suggesting the possibility of some tethering. Her plain lumbar spine x-rays reveal spina bifida at L5 and S1 and probably lumbarization of the first sacral

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[5] Diastematomyelia refers to "congenital division of all or part of the spinal cord." http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=diastematomyelia.

[6] "Tethered spinal cord" refers to

> any condition in which the spinal cord is attached to an immovable structure. Normally the bottom of the spinal cord, called the conus medullaris, floats freely within a pool of spinal fluid. There are, however, an array of pathologic conditions that cause tethering of the cord. This leads to abnormal stretching with growth and movement, which over time can lead to the characteristic symptoms of tethered spinal cord, including muscle weakness, sensory loss, change in bowel or bladder control, and orthopedic deformity.

http://www.boston-neurosurg.org/publications/faq/tethered_cord_MP.shtml

segment." (*Id.*) Dr. Meagher opined that "there is probably nothing surgical to be done in her case." He scheduled a CT scan of Plaintiff's lumbar spine, and referred her to Dr. Scott Elton for further evaluation. (*Id.*)

The CT scan took place on May 18, 2004. Dr. Meagher reviewed the films with Dr. Elton. Dr. Meagher believed that Plaintiff's CT scan was compatible with diastematomyelia, associated with tethered cord and some clumping of nerve roots compatible with arachnoiditis. (HLI01065.) The report on the CT scan also noted small broad-based bulging at nearly every other point along the lumbar spine.

Dr. Elton examined Williams on June 9, 2004. Dr. Elton reported that, on examination, "Michelle clearly has leg length and size discrepancy from right to left. The right leg is much smaller that the left. Both limbs are slightly cooler then her upper extremities." Dr. Elton also reviewed Plaintiff's MRI and CT scans that revealed "a diastematomyelia with tethered spinal cord," which he termed "unusual." Later, Dr. Elton expanded his diagnosis to be "Diastematomyelia with leg length discrepancy, hyperreflexia, and bilateral dysesthesia." (HLI00822.)

Dr. Conaway wrote a letter on September 26, 2005, indicating that he believed it was not possible for Plaintiff to drive due to her narcotic pain medication. (HLI00650.) He also indicated that, due to the nature of her spina bifida occulta, Plaintiff was unable to sit for extended periods of time. Dr. Meagher on the wrote in a letter on October 5, 2005, that Plaintiff had been treated with extensive medications, including Neurotin, OxyContin, Vicodin, and Skelaxin but continued to be in intractable pain. Dr. Meager indicated that, in his medical opinion as a board-

certified neurological surgeon, that Plaintiff was totally disabled from gainful employment due to her severe and chronic pain. (HLI00624.)[7]

E. Termination of Plaintiff's LTD Benefits and Reinstatement

As part of its investigation, Hartford referred Plaintiff's file to two physicians, Dr. Eric Hermansen and Dr. Randal King, for evaluations of Plaintiff's functional limitations and restrictions. Both doctors reviewed only records. Dr. Hermansen observed that Plaintiff had spina bifida occulta with diastematomyelia with a tethered spinal cord, but opined that there was "no evidence of progression of any neurological abnormalities." (HLI000671-78.) He concluded that Plaintiff's complaints of back pain were purely subjective and that she is able to work a full-time occupation with some restrictions and accommodations. In Dr. Hermansen's opinion, Plaintiff could work full time if she was allowed to adjust her position while sitting, avoided repetitive bending at the waist and was limited in the amount of weight she lifted to 10 pounds frequently and 20 points occasionally. (*Id.*) He also suggested that Plaintiff could drive with periodic breaks. Similarly, Dr. King reviewed Plaintiff's medical records and found that, despite her back conditions of spina bifida occulta and tethered spinal cord, her neurological findings were normal. He opined that "it is unlikely that she has arachnoidtis," and that "it does not appear that she has a physiological basis for her pain." (HLI00561-570.) He noted, however, that due to the narcotics Plaintiff took for her pain, she could not drive a car. (HLI00569.)

In August 2005, Hartford terminated Plaintiff's LTD benefits. Plaintiff appealed, submitting additional medical evidence including a letter from Dr. Conaway. Responding to

[7] Plaintiff also submitted letters from four lay witnesses who described a once energetic and vibrant woman who, due to her pain had been "forced to sleep in a recliner in the basement," (HLI00628), "hardly gets dressed. . . is lucky if she showers successfully a few times a week. . . ." (HLI00633.)

Hartford's conclusion that Plaintiff could work with certain accommodations, Dr. Conaway wrote:

> I disagree with this finding. Michelle has been advised not to drive a motor vehicle due to the nature of her treatment with narcotic analgesics. Therefore, your recommendation of taking periodic breaks while driving is not appropriate, when I have recommended that she not drive while under the influence of these medications. Also due to the nature of her spina bifida occulta, she is unable to sit on her sacrum/coccyx for extended periods of time and she must be able to recline in order to achieve this.
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> You also did not make mention of [Plaintiff's] diagnosis of arachnoiditis secondary to the diastematomyelia and tethered spinal cord. This inflammation plays an important role in relation to her pain. I anticipate that her pain will be a chronic issue for the rest of her life and unfortunately we have been unable to relieve the pain in any way other than through narcotic analgesics.

(HLI00650). Dr. Meagher provided his opinion:

> I am writing this letter on behalf of Michelle Miller whom I have seen in the past for neurosurgical consultation. She has, as you know, been found to have diastenatomyelia, a tethered spinal cord, and arachnoiditis. This condition has resulted in severe and chronic pain in both lower extremities which definitely interferes with her ability to be gainfully employed. She has been treated with extensive medications including narcotics, Neurontin, OxyContin, Vicodin, and Skelaxin and continues to be bothered by intractable pain.
>
> I continue to feel as a board-certified neurological surgeon that Ms. Michelle Miller remains totally disabled from gainful employment and would formally request that you appeal your previous decision.

(HLI00624.)

On January 10, 2006, Hartford reinstated Plaintiff's LTD benefits. Hartford agreed that driving was an integral part of her particular job, and accepted Dr. Conaway's statement that Plaintiff's narcotic pain medication prevented her from driving.

F. Change in Definition of Disability - Any Occupation

Defendant sent Plaintiff a letter on July 25, 2006, informing her that, as of October 22. 2006, in order to continue to meet the definition of Disability, she must be continuously unable

to engage in any occupation for which she is qualified by education, training or experience. Hartford required Plaintiff to submit additional information regarding her medical treatment and medications, as well as a self-assessment describing how her condition disabled her. (HLI00767-770.)

In her responses to the self-assessment questionnaire, Plaintiff reported that she had good days and bad days, sometimes needed help when dressing and frequently needed assistance in the shower, such as handrails and a shower seat. She answered that her husband did almost all of the cooking. She indicated that she could take short walks with her husband as support, but used a rolling walker or motorized scooter for longer walks. She reported that she could not sleep in a bed, but instead slept in a recliner. (HKI00505-506).

On October 17, 2006, Hartford's Rehabilitation Case Manager performed an Assessment of Employability Report for Plaintiff. Hartford classified Plaintiff as possessing the skills required to perform alternative sedentary skilled occupations using the Occupational Access System (OASYS). This program is a computerized job matching system that cross references an individual's qualifications with over 12,000 occupations classified by the U.S. Department of Labor in the 1991 Dictionary of Occupational Titles ("DOT"). (HLI00444-488.) The Rehabilitation Case Manager used OASYS and took into account the plaintiff's medical restrictions, as well as Plaintiff's education, training and experience. The report identified four jobs that the plaintiff was capable of performing. These consisted of jobs as Benefits Manager, Chamber of Commerce Division Manager, Federal Aid Coordinator and Chief Dispatcher II. (HLI00444-480)

After receiving the Employability Report, Hartford advised Plaintiff that it had determined she no longer met the definition of Disability beyond October 21, 2006. Hartford

reviewed Plaintiff's file, including primarily the two medical reports written by Drs. Hermansen and King. Based on the level of functionality described by Dr. King, as well as Plaintiff's vocational background, Hartford determined that Plaintiff was able to perform gainful, alternative occupations such as those indentified in the Employability Report.

Plaintiff appealed Hartford's decision and provided additional information, including medical reports from Dr. Conaway covering his treatment of her from January 5, 2006 through March 22, 2007. In addition, an MRI of Plaintiff's lower back in April 2007 noted a shallow protruding disc, some disc displacement and narrowing of the nerve passages. (HLI00373.) The MRI also indicated that Plaintiff's "distal cord and conus appear unremarkable." (Id.)

Dr. Conaway also supplemented the medical reports with a letter dated April 16, 2007, noting that he had been Plaintiff's treating physician for approximately four years. He noted the large quantities of medication Plaintiff was required to take to minimize her chronic, persistent pain, severe depression, bladder/bowel dysfunction and other psychological conditions. Dr. Conaway reported that, in addition, Plaintiff's motor functions were weak and affected by cramps, spasms, and numbness in her legs while sitting or walking longer than 15 minutes. He concluded "to a medical certainty that [Plaintiff] is not able to engage in any occupation that will exacerbate her debilitating medical conditions now or in the foreseeable future." (HLI00379.)

Hartford obtained independent medical reviews of her records to determine whether Plaintiff met the requirements required for the Plan. Hartford retained three physicians to conduct reviews of Plaintiff's medical records: Dr. Albert C. Fuchs, who is Board Certified in Internal Medicine; Dr. Douglas T. Brown, who is Board Certified in Neurology; and Dr. Robert N. Polsky, who is Board Certified in Psychiatry.

Both Dr. Fuchs and Dr. Brown found that Plaintiff had no physical restrictions or limitations that would preclude her from performing sedentary-level work on a full time basis if she were permitted the ability to occasionally alternate positions. Dr. Fuchs noted Plaintiff's essentially normal MRI and questioned whether Plaintiff had a tethered spinal cord. Dr. Fuchs also believed Plaintiff exhibited no cognitive functional impairment from the use of her prescribed medications. (HLI00340-51.)

Dr. Brown discussed Plaintiff's case wither her treating physician, Dr. Conaway. Dr. Brown opined that Plaintiff's medical records contained "no consistent objective evidence of neurological abnormality or other functional impairment." (HLI00350.) He noted that the degenerative disc changes in the MRI were mild and would not be expected to cause an impairment of function. Dr. Brown concluded that "there is no objective evidence of any impairment of function from a physical or neurological perspective that would preclude sedentary work activities as described." (HLI00350.) He also found that there was "no evidence of a cognitive functional impairment based on the use of these medications as prescribed." (HLI00351.)

Based on a file review and his discussions with Dr. Conaway, Dr. Polsky, a psychiatrist, opined that Plaintiff had no psychiatric restriction of limitations on her ability to perform sedentary full-time work. He also conclude that there was "no evidence of a cognitive functional impairment" based on the use of the psychotropic medications prescribed. (HLI00346)

Based on its review, Hartford upheld its prior decision to terminate Plaintiff's LTD benefits. Hartford informed Plaintiff of its decision in a letter dated June 29, 2007:

> [Hartford] acknowledges that [Plaintiff] has medical conditions and symptoms which may require ongoing treatment. However, the presence of a condition, symptom or treatment of such does not determine a disability. The medical findings provided do not support that your client's conditions and symptoms,

> either alone or in combination, are such severity that she is rendered incapacitated and unable to perform the duties of any occupation as required by the policy after 10/21/06.

(HLI00132.) This lawsuit followed.

II.

The Court of Appeals for the Sixth Circuit has held that traditional summary judgment concepts are "inapposite to the adjudication of an ERISA action for benefits, brought under 29 U.S.C. § 1132(a)(1)(B), because the district court is limited to the evidence before the plan administrator at the time of its decision, and therefore, the court does not adjudicate an ERISA action as it would other federal civil litigation." *Buchanan v. Aetna Life Ins. Co.*, 179 Fed. Appx. 304, 306 (6th 2006)(citing *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 617-19 (6th Cir. 1998)). Under ERISA, 29 U.S.C § 1132(a)(1)(B), a civil action may be brought by a participant or beneficiary "to recover benefits due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

At the outset, the parties dispute what level of deference this Court should afford Hartford's decision to terminate Plaintiff's LTD benefits. In reviewing a denial of benefits under an ERISA-governed plan, the district court applies a *de novo* standard unless the plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe terms of the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan grants the administrator discretionary authority to determine benefit eligibility, however, the district court examines those determinations under the arbitrary-and-capricious standard of review. *Calvert v. Firestar Fin. Inc.*, 409 F.3d 286, 291-92 (6th Cir. 2005). Because the arbitrary and capricious standard is the exception and not the standard rule, the plan at issue must

contain a clear grant of discretionary authority to determine benefits and interpret the plan. *Wintermute v. The Guardian*, 524 F. Supp. 2d 954, 959 (S.D. Ohio 2007). When determining whether a plan contains a clear grant of discretion, courts look to the governing language in the documents that were actually provided to the employee, such as a plan summary. *Willis v. ITT Educ. Servs.*, 254 F. Supp. 2d 926, 933 (S.D. Ohio 2003).

Plaintiff contends that this Court should apply a *de novo* standard of review, while the Defendant asserts that the deferential arbitrary and capricious standard is appropriate. The Plan at issue in this case provides that Countrywide is the Plan Sponsor and Administrator. Countrywide, as the Plan Administrator, clearly has discretionary authority to determine a participant's eligibility and entitlement to benefits. (HLI00028, HLI00029.) Under the terms of this Plan, however, "[t]he plan administrator has delegated sole discretionary authority to *Continental Casualty Company* [("Continental")] to determine [a participant's] eligibility for benefits and to interpret the terms and provisions of the Policy." (HLI00028)(emphasis added); see also HLI00029.)[8] The parties do not dispute that this language in the Policy effectively delegated discretionary authority to Continental. Continental, however, sold its assets to Hartford in 2003.

Plaintiff maintains that Continental alone, and not Hartford, has discretionary authority to interpret the Plan and to make eligibility determinations. According to Plaintiff, because the Plan grants no discretionary authority to Hartford, the company that ultimately reviewed her claim and terminated her LTD benefits, the Court must review the determination using the *de novo* standard of review. Hartford counters that it purchased Continental in 2003, expressly assumed all responsibilities under its policies and, as the successor in interest, stepped into the

[8] Continental issued the insurance contract to Countrywide and is also the claims administrator.

role as designee of the discretionary authority granted under the terms of all of Continental's policies, including the Plan at issue in this case.

In support of her position, Plaintiff relies chiefly on the recent decision in the case of *Weidauer v. Broadspire Servs, Inc.*, 2009 WL 152501 (S.D. Ohio 2009). In *Weidauer* the ERISA plan contained a clear grant of discretionary authority to Kemper National Services. Kemper asserted, without evidentiary support, that it subsequently sold its assets and obligations to Broadspire which thereafter transferred the assets and liabilities to Aetna. The Court concluded that the "sale or transfer of obligations does not necessarily include a clear grant of discretionary decision making authority" under an ERISA plan. *Id.* at *10. Thus, the Court concluded that the plan provisions in that case did not show that the administrator had authority to delegate its fiduciary duties. As such, the Court found that Broadspire and Aetna had no discretion to interpret the Plan, and a *de novo* standard of review was appropriate.

Weidauer, however, is distinguishable on at least two bases. First, the administrative record contained no evidence that either Broadspire or Aetna was given a clear grant of discretion because the parties did not provide proof that all of Kemper's assets and obligations were transferred to these subsequent corporations. *See Weidauer v. Broadspire Servs., Inc.*, Case No. C-3-07-097, (S.D. Ohio Oct. 27, 2008), Order (Doc. 28), at p. 18. Second, and more significantly, the language of the ERISA plan in *Weidauer* differs substantially from the provision at issue here with regard to the procedures for delegating fiduciary responsibilities.

In this case, Hartford provided to the Court an Amended and Restated Purchase Agreement dated November 30, 2003.[9] The Agreement evidences Hartford's purchase of 100% of the issued and outstanding stock of Continental in 2003. Furthermore, several courts have

[9] Because the Agreement contains confidential information relating to the parties' business practices, Hartford filed the document under seal.

recognized Hartford's role as successor in interest to the Continental policies and specifically noted the transfer of assets and liabilities to Hartford, including the discretionary authority to interpret the terms of Continental's policies.[10]

Moreover, in *Weidauer*, the defendants asserted that the following language in the ERISA plan provided discretionary authority to the successor administrators and thus triggered the arbitrary and capricious standard of review: "In all circumstances related to any claim or appeal for benefits under any plan, the plan administrator or claim administrator responsible for making a determination on the claim or appeal shall have discretionary authority in making such determinations . . . ." *Weidauer*, 2009 WL 152501 at *2. The court noted that this language granted discretionary authority over any claim, but not to any plan or claim administrator, and that the plan otherwise contained no provision permitting delegation of fiduciary responsibilities.[11] *Id.* at *3. By contrast, the Plan at issue in this case provides that "[t]he plan administrator and other plan fiduciaries have discretionary authority to determine *Your* eligibility for entitlement to benefits. . . The plan administrator has delegated sole discretionary authority to Continental . . . ." (HLI00028.) Thus, the Plan at issue here has, at least, initial enabling language to permit delegation of the fiduciary duties.

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[10] *Barnes v. Hartford Life and Acc. Ins. Co.*, 2008 WL 4298466, *2, n. 1 (E.D. Mich. Sept. 18, 2008) (noting that the plan invests discretionary authority for determining eligibility for benefits to Continental; parties agreed that Hartford assumed the discretionary authority by virtue of the 2003 purchased of Continental stock); *McBride v. CNA Ins. Co. a/k/a Continental Cas. Co.*, 463 F. Supp. 2d 613, 615, n.4 (S.D. Miss 2006) (noting that "although Continental issued the Policy ... Harford subsequently assumed all responsibilities and obligations under the Policy, including the processing and payment of eligible claims."); *Beamish v. Hartford/The Hartford Fin. Servs. Group Inc.*, 487 F. Supp. 2d 1196, 1197, n.1 (W.D. Wash 2007); *Loughray v. Hartford Group Life Ins. Co.*, 2007 U.S. LEXIS 24390, *2, n. 1 (D. Colo. April 2, 2007).

[11] The provision in the ERISA statute at issue in these cases provides that "[t]he instrument under which a plan is maintained may provide for procedures (A) for allocating responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than the named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan." 29 U.S.C. § 1105(c)(1).

A district court in California addressed the identical issue in a case involving these precise insurers and this stock purchase agreement between Continental and Hartford. In *Simonia v. Hartford Ins. Co.*, 606 F. Supp. 2d 1091, 1096-96 (C.D. Cal. 2009), the plaintiff asserted that a *de novo* review was appropriate because the ERISA plan gave full discretion to Continental, not Hartford, to interpret its terms. The district court held that, as a result of Hartford's purchase of Continental's stock in 2003, Hartford became the sole surviving entity and stepped into the shoes of Continental. The court found that Hartford obtained all the powers that the plan had conferred on Continental, including the discretionary authority to determine eligibility of benefits. *Id.* at 1096. According to the court, the case did not implicate an improper delegation by the fiduciary. Rather, the court concluded that when Hartford purchased the contracts, any discretionary authority Continental negotiated in its policies transferred to Hartford. *Id.* (citing *Giannone v. Metropolitan Life Ins. Co.*, 311 F.Supp.2d 168, 175 (D. Mass. 2004)(concluding "when Met Life . . . acquired all of the assets and liabilities of Gen Am, it stepped into Gen Am's shoes, and in so doing acquired all of the powers conferred by the Plan on Gen Am, including the discretionary authority to make benefits decisions."); *Stewart v. Continental Casualty Co.*, No. CV-08-919-RGK (C.D. Ca. December 13, 2006 ("Upon assumption of this business, Hartford stepped into the shoes of CNA and assumed the rights and obligations attached to its business ... included among the assumed rights and obligations are CNA's fiduciary obligations created by the discretionary authority to determine eligibility of benefits ... Therefore, when Hartford purchased the insurance contract from CNA, discretionary authority transferred from CNA to Hartford.")

The Court finds these cases to be persuasive. Further, both Plaintiff and Defendant agree that Hartford, not Continental, is the real party in interest. Indeed, Hartford made all of the

factual findings and interpretations of the Plan in this case. When Hartford purchased Continental's stock, it became the successor in interest and assumed the discretionary authority to make eligibility determinations under Continental's policies, including the Plan applicable to Plaintiff's claim for LTD benefits. Under these circumstances, the Court concludes that the arbitrary and capricious standard applies to Hartford's review of Plaintiff's claim.

The arbitrary and capricious standard is the least demanding form of judicial review of an administrative action. *See Smith v. Continental Cas. Co.*, 450 F.3d 253, 259 (6th Cir. 2006). The plan administrator's decision will be upheld if it is the result of a deliberate, principled reasoning process and is rational in light of the plan's provisions. *Cooper v. Life Ins. Co. of N. Am.*, 486 F.3d 157, 165 (6th Cir. 2007). Although review of a matter before the court under the arbitrary and capricious standard is thus extremely deferential, "[i]t is not, however, without some teeth. . . 'Deferential review is not no review,' and 'deference need not be abject.'" *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003)(citations omitted).

Further, when determining whether a decision was arbitrary and capricious, the Court factors in whether a conflict of interest existed. *Metro. Life Ins. Co. v. Glenn*, --- U.S. ----, 128 S.Ct. 2343, 2351 (2008). An inherent conflict of interest exists when, as in this case, an insurance company is both the administrator rendering eligibility determinations and the insurer responsible for paying the benefits out of its own pocket. *Id.* at 2346. The Court in *Glenn* made clear that the significance of the conflict to that determination depends on the circumstances of each case. *Id.* at 2346. "[A]ny one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending on the tiebreaking factor's inherent or case-specific importance." *Id.* at 2351. A conflict of interest "should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it

affected the benefits decision" and "less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." *Id.*

The record contains no evidence to suggest that Hartford has a history of biased claims administration or that the conflict otherwise affected its benefits decisions in this case. Conversely, nothing in the record indicates that Hartford has taken steps to reduce the potential for bias or to promote accuracy. Accordingly, the Court gives Hartford's conflict of interest neither greater nor lesser weight and simply considers it as one factor in determining whether it arbitrarily and capriciously denied Plaintiff's claim for LTD benefits.

III.

Hartford denied Plaintiff's request for continued LTD benefits based its findings that Plaintiff was no longer "Disabled," as that term is defined in the Occupational Qualifier portion of the Plan, after the twenty-four month Elimination Period. After twenty-four months, Plaintiff is "Disabled" if an "injury" or "sickness" causes physical or mental impairment to such a degree that she is "continuously unable to engage in any occupation" for which she is or may become qualified by education, training or experience. (HLI00017.) Hartford asserts that its determination that Plaintiff is not disabled must be affirmed because it is supported by the opinions of the physicians who reviewed Plaintiff's medical records, all of whom agreed that no objective evidence supports Plaintiff's claim of disability from any occupation. Hartford also relies heavily on the results of an MRI, which Hartford asserts was essentially normal aside from

mild disc bulging, and an Assessment of Employability Report that identified a sample of four (4) occupations for which Plaintiff was qualified and capable of performing.

Plaintiff contends that her treating physician's opinion regarding her medical condition is entitled to deference because he is the only physician who actually examined her. Hartford maintains that a plan administrator is not required to give any special deference to a plaintiff's treating physician, and instead is free to prefer the opinions of doctors who review the medical records of a patient without conducting a physical examination. On that basis, Hartford contends that it need not give Dr. Conaway's opinion deference simply because he is the only physician to examine the Plaintiff.

ERISA does not compel a plan administrator to accord special deference to the opinions of treating physicians. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003). Nor does ERISA impose a "heightened burden of explanation on administrators when they reject a treating physician's opinion." *Id.* Nonetheless, plan administrators "may not arbitrarily refuse to credit a claimant's treating physician." *Id.* at 834. Plan administrators must give reasons for adopting an alternative opinion. *Evans v. UnumProvident Corp.*, 434 F.3d 866, 877 (6th Cir. 2006)(holding that a plan administrator may not arbitrarily disregard reliable medical evidence proffered by a claimant, including the opinions of a treating physician.)

The Court of Appeals for the Sixth Circuit has observed that an ERISA plan administrator, in choosing to employ independent experts who are paid to assess a claim, is operating under a conflict of interest that provides it with a "clear incentive to contract with individuals who were inclined to find in its favor that [a claimant] was not entitled to continued [disability] benefits." *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 292 (6th Cir. 2005). Thus,

although "routine deference to the opinion of a claimant's treating physician" is not warranted, a [court] may consider whether "a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled'" as a factor in determining whether the plan administrator acted arbitrarily and capriciously in deciding to credit the opinion of its paid, consulting physician. *Kalish v. Liberty Mut.*, 419 F.3d501, 508 (6th Cir. 2005)(citing *Nord*, 538 U.S. at 832.)

In its decision to affirm denial of Plaintiff's LTD benefits, Hartford references only in passing the opinions of Plaintiff's treating physician, Dr. Conaway, and the neurologist who examined her, Dr. Meagher. Instead, Hartford insists that Plaintiff's pain is merely "self-reported," without any clinical basis, and unsubstantiated by the medical records and examinations. Hartford, therefore, relied on the medical opinions of its hired consultants, to the exclusion of Plaintiff's treating physician's conclusions.

Each of the three medical experts Hartford hired was employed by the same company, MES Solutions. None of Hartford's hired consultants conducted a physical examination of Plaintiff. Hartford's decision to give more weight to a non-treating physician's opinion for no apparent reason lends force to the conclusion that Hartford's decision to deny Plaintiff's claim was arbitrary and capricious. *See Kalish,* 419 F.3d at 508. While Hartford had no duty to give deference to Plaintiff's treating physicians, as a fiduciary, it cannot simply disregard these findings for more favorable opinions of its paid consultants.

In the same way, Plaintiff asserts that that Hartford improperly relied upon a file review when the Plan permits Hartford to commission a physical examination.[12] The Court regards Hartford's decision to conduct a file review, rather than a physical examination, as another factor

[12] The Plan provides that, "At *Our* expense, *We* have the right to examine *Your* person as often as reasonably required during the pendency of *Your* claim." (HLI00023.)

in its assessment of whether Hartford acted arbitrarily and capriciously in terminating Plaintiff's LTD benefits. *Calvert*, 409 F.3d at 295.

Plaintiff points to a provision in the Plan that allows Hartford to have her physically examined any time during the pendency of her claim. Certainly, nothing in the Plan language prohibits a pure paper-file review of Plaintiff's medical records. Yet, an administrator's decision to conduct a file-only review "especially where the right to [conduct a physical examination] is specifically reserved in the plan-- may, in some cases, raise questions about the thoroughness and accuracy of the benefits determination." *Id.*

Here, over the course of her claim, Hartford hired five consultants to conduct file reviews of Plaintiff's claim and never once exercised its right to have Plaintiff examined. To be sure, the Court finds nothing intrinsically objectionable about a peer review by a qualified physician hired by an ERISA plan administrator to assist with its duty to make benefits determinations. *See Calvert*, 409 F.3d 296 (noting "nothing inherently objectionable" about a file review). In this case, however, all of Hartford's medical consultants, who were retained for the appeal process, disagreed with the finding of Dr. Conaway, Plaintiff's treating internist, as well as Dr. Meager, her treating neurosurgeon. Yet, Dr. Conaway conducted numerous physical examinations of Plaintiff and had repeated conversations with her regarding her continuing complaints of debilitating pain and physical limitations. He prescribed narcotic drugs to treat her chronic pain. Dr. Conaway referred Plaintiff to Dr. Meager and reviewed her CT-scans and other tests as part of his on-going treatment of her. These physical examinations, tests, consultations with other physicians and conversations with the Plaintiff herself, led Dr. Conaway to conclude that that in his medical opinion the Plaintiff is unable to work now or in the foreseeable future. (HLI00379.)

Dr. Meagher, a Board certified neurologist, concurred and found that Plaintiff remains totally disabled from gainful employment.

Despite these conclusions, Hartford denied Plaintiff benefits because it found no clinical evidence to support her subjective complaints. Hartford described all of Plaintiff's symptoms as self-reported and lacking of any clinical evidence. Hartford maintains that there was no objective data in the record to support the conclusion that Plaintiff suffered from her diagnoses or disability. In its June 29, 2007 letter conveying this conclusion, Hartford relied exclusively on the conclusions Drs. Fuchs, Polsky and Brown who developed their opinions after a file review.

In fact, both Drs. Conaway and Meager detailed a series of objective findings which corroborate Plaintiff's subjective complaints. These include (1) an MRI revealing evidence of segmentation in the lumbar spine with associated spina bifida; (2) a CAT scan evidencing small broad-based bulging at or near every point on the lumbar spine; (3) a CAT scan evidence compatible with diastematomyelia, associated with tethered cord; and (4) a CAT scan showing clumping of nerve roots compatible with arachnoiditis. Just as important are the physical findings reported by Dr. Elton, including a discrepancy in size between the left and right leg and a noted coolness in the legs compared with the rest of the body. Both of these findings are indicative of lumbar spinal injury, radiating into both legs, albeit in varying degrees. These findings could only be made by an examining physician. The doctors retained by Hartford did not address or explain Dr. Elton's findings.

The Court concludes that Hartford's benefits determination was not based on a reasoned or rational reading of the record and was arbitrary and capricious in light of the actual record evidence. The three consultants who the reviewed Plaintiff's file during her appeal process

rejected her treating-physicians' opinions. Drs. Fuchs, Polsky, and Brown all opined the Plaintiff was capable of performing sedentary work. All three doctors acknowledge Dr. Conaway's opinions, and then reject them. Plaintiff has been diagnosed as suffering from spina bifida occulta, arachnoiditis and diastenatomyelia secondary to a tethered spinal cord. These diagnoses are supported by clinical evidence of record. Yet, Dr. Fuchs relies on a single MRI scan as proof that these diagnoses and all of Dr. Conaway's opinions are unsupported by the medical evidence. He does not refer to the other MRIs, CTs, X-Rays and myelograms that show significant degenerative and congenital conditions related to Plaintiff's spine. Dr. Polsky and Dr. Brown do not suggest any specific reason for disagreeing with Dr. Conaway and simply discount the validity of his opinions. Hartford's decision to rely on these doctors' peer review reports, to the exclusion of any analysis of Plaintiff's treating physician's opinion, as well as the opinions of Dr. Meager and the findings of Dr. Elton, was arbitrary and capricious in light of the actual record evidence. *See Calvert*, 409 F.3d at 296 (finding reviewing physician's report to be inadequate because, even though the reviewing physician "does mention [the claimant's doctors] by name, he does not explain why their conclusions . . . were rejected out-of-hand"); *see also McDonald*, 347 F.3d at 170 ("The evidence presented in the administrative record did not support the denial of benefits when only [the administrator]'s physicians, who had not examined [the claimant], disagreed with the treating physicians.").

All three medical consultants' opinions are approximately one page in length, including the questions posed to them by Hartford. In contrast, the summary of Plaintiff's medical history in his report is over four pages long. Only Dr. Fuchs refers to any specific medical test, namely the single MRI which he uses to discredit every evaluation that Dr. Conaway has performed on

the Plaintiff.[13] Dr. Brown, on the other hand, who is the neurologist retained by Hartford, does not refer to a single piece of medical evidence, physician report or medical test to arrive at his conclusory opinion that Plaintiff is not disabled and is able to return to gainful employment. Dr. Brown also provides limited commentary and injects the same boilerplate language to many of his responses to Hartford's inquiries regarding Plaintiff's functionality and impairments.

This Court must determine whether Hartford acted arbitrarily and capriciously in denying further disability benefits to Plaintiff based on the record as a whole, taking all aspects of this case into account, including Hartford's conflicts of interest. Considering the conclusory medical-records reviews performed by Hartford's paid consultants, the decisions of these physicians to dismiss outright Plaintiff's treating physicians' opinions and other objective medical evidence, together with Hartford's failure to commission a physical exam, the Court concludes that Hartford acted arbitrarily and capriciously and that its decision denying long-term disability benefits to Plaintiff must be reversed.

Furthermore, the Court finds that the record clearly establishes that Plaintiff is disabled and that she is therefore entitled to judgment in her favor. "'[W]here the problem is with the integrity of the plan's decision-making process, rather than that a claimant was denied benefits to which [s]he was clearly entitled,'" remand to the plan administrator is the appropriate remedy. *Cooper v. Life Ins. Co. of N. Am.*, 486 F.3d 157, 171 (6th Cir. 2007) (quoting *Elliott v. Metro. Life Ins. Co.*, 473 F.3d 613, 622 (6th Cir. 2006)). Although the Court questions the integrity of

[13] Hartford makes much of the fact that its consultants confirmed conversations with Drs. Conaway and Meagher in letters to them which specifically invited the doctors to make changes, comments or additions to the summaries contained therein. These letters informed Drs. Conaway and Meagher that "[i]f [they] failed to respond the insurer may rely on the summary in its current form." (HLI00572; 00575.) The fact that Drs. Conaway and Meagher did not sign and return the letters is not tantamount, as Hartford suggests, to agreeing that the summaries memorialized the conversations accurately, or that the doctors concurred and opted not to make any changes.

the decision-making process here, the record clearly establishes that Plaintiff is entitled to benefits. Plaintiffs' treating physicians based their opinions on objective medical evidence. The contrary opinions of the physicians whom Hartford hired to review Plaintiff's records are not entitled to countervailing weight for the reasons set forth above. *Cooper*, 486 F.3d 157, 172-73; *Kalish*, 419 F.3d at 513 (concluding that the appropriate remedy was an immediate award of benefits rather than a remand to allow the plan administrator to consider evidence that it had previously ignored).

IV.

For the foregoing reasons, Defendant's Motion for Judgment on the Administrative Record is **DENIED**. Plaintiff's Motion for Judgment on the Administrative Record is **GRANTED**. Hartford is directed to award LTD benefits retroactive to the date on which Plaintiff's benefits ceased.

IT IS SO ORDERED.

9-24-2009
DATED

EDMUND A. SARGUS, JR.
UNITED STATES DISTRICT JUDGE