UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BRIAN HAGERTY, Plaintiff(s), v. AMERICAN AIRLINES LONG TERM DISABILITY PLAN, Defendant(s).	No. C09-3299 BZ **ORDER DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT**

Plaintiff Brian Hagerty filed this action claiming that defendant American Airlines Long Term Disability Plan ("The Plan") violated his rights under ERISA by wrongfully denying him long term disability benefits. The Plan now moves for summary judgment that it did not violate ERISA and that it is entitled to judgment as a matter of law. For the following reasons, The Plan's motion is **DENIED**.[1]

Plaintiff worked as a flight attendant for American

[1] All parties have consented to my jurisdiction, including entry of final judgment, pursuant to 28 U.S.C. § 636(c) for all proceedings.

Airlines, Inc. for over 30 years.[2] Around 1984, plaintiff contracted HIV which required him to take several medications. He continued to work as a flight attendant, until November 15, 2004. He then filed a claim for long term disability benefits with The Plan, claiming that his HIV, Hepatitis C, and other conditions prevented him from working. Plaintiff has suffered from a number of conditions, with several persisting to this day including chronic hepatitis C, skin lesions, colonic diverticulosis, gastroesophageal reflux disease, recurrent dysphagia, a hiatal hernia, schatzki's ring, a thyroid condition, and a heart murmur.

The Plan is administered by MetLife, whose compensation is not tied to the payment or denial of claims. The Plan is funded entirely through employee contributions. Under the terms of The Plan, during the first 24 months of disability, an employee is considered disabled if he or she is unemployed and unable to perform the major and substantial duties of a Flight Attendant because of sickness or injury. After the initial 24 month period, an employee is considered totally disabled if he or she is unemployed and unable to perform the major and substantial duties of any occupation for which the employee has become reasonably qualified.

Plaintiff received disability payments from March 15, 2005 through April 14, 2008. From January 17, 2007 until April 14, 2008, MetLife determined that plaintiff was disabled

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[2] The parties did not submit a joint statement of undisputed facts. However, the Court has only relied on facts which the parties do not dispute, unless otherwise noted.

from working in any capacity. AR 189. On April 14, 2008, MetLife terminated Plaintiff's disability benefits based on its on-going review of plaintiff's condition. MetLife found that the medical information it reviewed did not substantiate plaintiff's claim that he was unable to work in any occupation for which he was qualified and that plaintiff would be able to work as a sales attendant, appointment clerk, or cashier. MetLife conducted another review of plaintiff's file which upheld the prior decision. In connection with this review, MetLife had plaintiff's claim reviewed by Medical Consultants Network. Dr. Gerstenblitt of Medical Consultants Network found that plaintiff did not sufficiently establish that he was disabled, in part because he had provided no objective medical evidence of his fatigue claims. Plaintiff then appealed this decision to the Pension Benefits Administration Committee ("PBAC"). In his appeal, plaintiff provided a list of his doctors, health care providers, and prior correspondence with MetLife. He did not enclose any additional medical reports, diagnosis, or test results. The PBAC analyst requested an independent review, which was performed by Network Medical Review. Network had a Gastroenterologist, a Cardiologist, and an Endocrinologist review plaintiff's file and render an opinion whether plaintiff was totally disabled from performing the major job duties of any occupation for which he was qualified as of April 11, 2008. The reviewing doctors all concluded that from their standpoints, plaintiff had not submitted sufficient proof that he was disabled. Plaintiff filed this lawsuit

following the final review of his file by Network.

The Plan first argues that this case should be subject to an abuse of discretion standard, which plaintiff does not contest. The Plan next argues that there are no triable issues of material fact regarding the disposition of plaintiff's claims and that The Plan did not abuse its discretion.

The Plan contends that it appropriately determined plaintiff's eligibility for two reasons. First, plaintiff made several comments that he was retired and that he had no interest in returning to work. Second, The Plan contends that the final review conducted by Network was accurately and fairly carried out. In response, plaintiff contends that the plan abused its discretion by denying his first appeal, conducting the final appeal without the necessary records, failing to determine the limiting effects of plaintiff's HIV status, and failing to consider plaintiff's SSDI benefits.

Bias

As an initial matter, plaintiff claims that Dr. Gerstenblitt and Network were biased and did not render independent opinions. In support, he cites to a number of rulings in other cases which found that evidence presented in those cases supported a charge of bias. No such evidence was developed in this case. The Court will only examine National's and Dr. Gerstenblitt's behavior as documented within the administrative record in determining whether they acted appropriately in determining that plaintiff was not

disabled.[3] Administrative Record ("AR") 134-38. However, given that MetLife owes the plan participants a "special standard of care," its decision to continue to use Dr. Gerstenblitt and Network in light of the opinions cited by plaintiff is curious.

First Appeal/Failure to Document Fatigue

Plaintiff complains Dr. Gerstenblitt committed error by requiring objective proof or documentation of plaintiff's complaints of fatigue. Plaintiff cited several cases where courts found it error to require objective medical evidence of complaints that are inherently subjective in nature. See e.g. Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 635 (9th Cir. 2009) ("unreasonable for Hartford to require Montour to produce objective proof of his pain level"); Cook v. Liberty Life Assur. Co. of Boston, 320 F.3d 11, 21 (1st Cir. 2003) (requiring objective documentation of Chronic Fatigue Syndrome is unreasonable); Mitchell v. Eastman Kodak Co., 113 F.3d 433 (3rd Cir. 1997) (same). Since defendant did not respond to this argument and the cited cases, I find that requiring objective medical evidence of fatigue, when The Plan documents do not expressly require such proof, is a factor suggesting The Plan abused its discretion.

Further, Dr. Gerstenblitt declined to analyze the objective medical effects of the myriad medications plaintiff took which caused drowsiness or fatigue. For example, during

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[3] Defendant's objections to plaintiff's evidence of bias against Dr. Gerstenblitt and Network (Reply p. 7) are well taken. However, plaintiff's bias allegations play no role in the disposition of this motion.

the time surrounding Dr. Gerstenblitt's review, plaintiff regularly took Lexiva, Ziagen, and Lisinopril, all of which are known to cause fatigue.[4] AR 108. Dr. Gerstenblitt opined that there was no medical documentation of fatigue, yet he ignored the medications which commonly cause fatigue.

Failure to Obtain Records

Plaintiff contends that Network's failure to obtain medical records referenced, but not attached to plaintiff's second level appeal constituted an abuse of discretion. In support, plaintiff cited Booton v. Lockheed Medical Ben. Plan, 110 F.3d 1461, 1465 (9th Cir. 1997) which states that "to deny the claim without explanation and without obtaining relevant information is an abuse of discretion." Booton is based on the numerous requirements in ERISA that a Plan provide a claimant with detailed information of why a claim was denied, including: "iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary . . . ." 29 C.F.R. § 2560.503-1. Once again, The Plan declined to respond to this authority which seems to be fairly applicable to this case. In Booton, as here, "[l]acking necessary-and easily obtainable-information, [the defendant] made its decision blindfolded." See Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990)

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[4] The Court takes judicial notice of information posted on websites such as that of the Department of Veteran Affairs, http://www.va.gov/, and http://www.drugs.com, regarding the most common side effects of medications. Further, defendant does not dispute plaintiff's assertion that these medications commonly cause fatigue.

(burden is on plan to obtain adequate information to make decision). Here, three physicians rendered an opinion without consulting with plaintiff's treating physicians or reviewing at least some of plaintiff's relevant medical files. Plaintiff listed his medical care providers in his appeal to the PBAC and had provided at least some authorization to obtain records. Nevertheless, Network did not contact plaintiff's cardiologist, gastroenterologist, or his endocrinologist despite reviewing plaintiff's file for cardiac, gastroenterologic, and endocrine related disability.

Defendant's sole response to this argument is that the appeals process required plaintiff to submit all appropriate documentation and plaintiff's failure to do so should countenance the review of an otherwise incomplete file. However, under ERISA, if defendant believed that plaintiff had not attached adequate information, it should have informed plaintiff that his submission was inadequate. Deciding this case on an admittedly incomplete file without notifying plaintiff of what additional records it needed is another fact suggesting an abuse of discretion.

Moreover, plaintiff asserted at argument and defendant did not dispute, that The Plan's practice was to require a claimant to initiate a claim by completing a form and signing a medical authorization so The Plan could get the records necessary to review a claim. Because of this practice plaintiff believed he had done all that was necessary when he updated his long list of doctors.

Failure to Determine HIV effects

Plaintiff also argues that Network should have evaluated whether plaintiff's HIV status affected his ability to perform any occupation. None of the Network doctors ever evaluated whether plaintiff's HIV status affected his ability to work. Defendant does not contest this statement or the import of it.

SSDI

While it is true that there are differences between disability determinations in Social Security and ERISA settings, "complete disregard for a contrary conclusion without so much as an explanation raises questions about whether an adverse benefits determination was the product of a principled and deliberative reasoning process." Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 635 (9th Cir. 2009). Here, The Plan never obtained plaintiff's Social Security file, and never addressed the different results it found by drawing an opposite conclusion, even though it encouraged him to apply for Social Security.

Plaintiff's Remarks

Defendant heavily relies on several statements that plaintiff made which purportedly show that plaintiff willingly chose not to work despite being physically capable. In 2006, plaintiff said "I could be considered well enough to take on new training for another job." AR 74. In 2006, plaintiff also stated "I can't return to airline or union work, and I am too OLD to retrain." AR 81. Dr. Ollife, plaintiff's attending physician, stated that "patient [plaintiff] has chosen to retire due to intermittent fatigue & physical

limitations" and that plaintiff could work a few hours per day. AR 102. Defendant contends that these statements prove that plaintiff was not physically disabled and instead simply chose not to return to work.

However, considering the full context of plaintiff's comments, they do not prove that plaintiff was physically able to return to work. Plaintiff also stated that "I retired early due to my interferon treatments" for HIV and that "I can't & won't return to work." AR 109. Plaintiff further stated that "I had hopes of returning to work after the [interferon] treatment was over, but during the course of the year it became apparent that I was getting older and was becoming fatigued very easily, and that didn't stop after my treatment ended in 2006 . . . . My decision [to retire] was made at least in part, due to my physical disability to do that job." AR 132. When read in context, plaintiff's comments demonstrate his subjective belief that he was unable to work at least in part due to disability.

Conclusion

There are a number of factors present here that prevent me from finding that The Plan did not abuse its discretion in determining plaintiff's eligibility for long term disability benefits. Therefore, **IT IS ORDERED** that defendant's motion for summary judgment is **DENIED**.

Dated: September 3, 2010

Bernard Zimmerman
United States Magistrate Judge

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