United States District Court
For the Northern District of California

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

PATRICIA FORTLAGE,

Plaintiff,

v.

HELLER EHRMAN LLP,

Defendant.
_______________________________/

No. C-08-3406 VRW (EMC)

REPORT AND RECOMMENDATION RE PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

This is an Employee Retirement Insurance Security Act ("ERISA") case. Plaintiff Patricia Fortlage contends that she is disabled as a result of various medical impairments, including ocular myasthenia gravis[1] or a left cranial nerve palsy (a visual impairment), neurocardiogenic syncope[2] (a heart condition), and Sjogren's disease[3] (an autoimmune disorder). Ms. Fortlage filed suit against Defendant the Heller Ehrman Long-Term Disability Plan on the basis that the administrator of the

[1] Myasthenia gravis is "a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at neuromuscular junctions." http://www.merriam-webster.com/medical/myasthenia%20gravis (last visited 11/5/2009).

[2] Neurocardiogenic syncope, also called vasovagal syncope, is "a usually transitory condition that is marked especially by fainting associated with hypotension [low blood pressure], peripheral vasodilation [widening of the lumen of blood vessels], and bradycardia [slow heart action] resulting from increased stimulation of the vagus nerve." http://www.merriam-webster.com/medical/vasovagal+syncope (last visited 11/3/2009).

[3] Sjogren's disease is "a chronic inflammatory autoimmune disease that affects especially older women, that is characterized by dryness of mucous membranes especially of the eyes and mouth and by infiltration of the affected tissues by lymphocytes, and that is often associated with rheumatoid arthritis." http://www.merriam-webster.com/medical/sjogren%27s (last visited 11/5/2009).

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plan, Unum Life Insurance Company of America ("Unum Life"), improperly denied her disability benefits.

Chief Judge Walker, the assigned judge in this case, referred the matter to the undersigned with the instruction that this Court prepare proposed findings of fact and recommendations. *See* Docket No. 72 (order, filed on 9/21/2009). Pursuant to that referral, this Court conducted a hearing, nominally a bench trial, on November 17, 2009. *See* Docket No. 76 (civil minutes). The parties agreed that no evidentiary hearing was required as all of the relevant evidence was in the record before this Court. At the hearing, Ms. Fortlage clarified that she believes Sjogren's to be the unifying diagnosis for all of her symptoms, including the visual and heart problems and fatigue. Having considered the arguments of the parties at the hearing, and having reviewed the parties' submissions and all other evidence of record, the Court hereby recommends that judgment be entered in favor of Defendant.

I. FACTUAL FINDINGS

In December 2004, Ms. Fortlage was hired by the law firm Heller Ehrman LLP as its Human Resources Director. *See* AR 37 (employment statement, dated 3/27/2006).

Heller Ehrman had a group disability plan for its eligible employees. There is no dispute that Ms. Fortlage was an eligible employee covered by the plan.

Heller Ehrman's group disability plan was insured by Unum Life ("Unum Life"). *See* AR 151 *et seq.* (policy). Under the policy, Unum Life was not only the insurer but also the administrator of the plan. The policy specified that, as the administrator, Unum Life was given "discretionary authority to determine [a claimant's] eligibility for benefits and to interpret the terms and provisions of the policy." AR 160; *see also* AR 187 (providing that "[b]enefits under this Plan will be paid only if the Plan Administrator or its designee (including Unum [Life]) decides in its discretion that the applicant is entitled to them").

Disability under the policy was defined in relevant part as follows.

> You are disabled when Unum [Life] determines that:
>
> – you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and

> – you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.
>
> After 21 months of payments, you are disabled when Unum [Life] determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

AR 164.

The policy provided that certain disabilities were not covered under the plan. For example, pre-existing conditions were not covered. *See* AR 174. A pre-existing condition was described in the policy as follows:

> You have a pre-existing condition if:
>
> – you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
>
> – the disability begins in the first 12 months after your effective date of coverage.

AR 174.

There is no dispute that Ms. Fortlage's effective date of coverage for long-term disability benefits was April 1, 2005, *see also* AR 37 (employment statement, dated 3/27/2006), and that the "pre-ex period" (also referred to as the "look back period") was therefore January 1-March 31, 2005.

On February 23, 2006, Ms. Fortlage was walking to BART after work when she experienced a sensation of motion or loss of balance which caused her to fall to the ground. She was taken to and treated at California Pacific Medical Center. *See* AR 236 (CPMC ER record).

Subsequently, on March 10, 2006, because of symptoms of chest pain and lightheadedness, Ms. Fortlage was treated at Seton Medical Center. *See* AR 489 (Seton ER record).

On March 16, 2006, Ms. Fortlage filed a disability claim with Unum Life. *See* AR 35 (disability claim). In the claim, she stated that she had stopped working as of March 10 because of "[d]izziness, disorientation, overall weakness, pain in chest, [and] difficulty breathing." AR 35.

In support of her claim, Ms. Fortlage submitted a statement from her treating physician, Dr. Penrose. Dr. Penrose described Ms. Fortlage's symptoms as dizziness and chest pain and stated that

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her primary diagnosis was syncope[4] and chest pain. *See* AR 33 (attending physician statement, dated 3/17/2006).

On June 6, 2006, Unum Life informed Ms. Fortlage that it would be "conduct[ing] a pre-existing condition evaluation because your effective date of coverage was April 1, 2005 and your disability began within 12 months of your coverage date." AR 520 (letter).

Several Unum Life medical consultants reviewed Ms. Fortlage's records as part of the pre-existing condition evaluation. *See* AR 902 (review by RN McCollum, dated 7/7/2006); AR 911-12 (review by Dr. Hayes, dated 7/11/2006); AR 919-24 (review by Dr. Kile, dated 7/17/2006).

Based on these reviews, Unum Life indicated to Ms. Fortlage that it believed that her symptoms were related to a pre-existing condition – *i.e.*, anxiety. Ms. Fortlage disputed such. *See* AR 925 (Unum Life file notes, dated 7/24/2006).

After obtaining additional information from Ms. Fortlage's treating physicians, *see* AR 952 (letter from Dr. Gravina, dated 7/25/2006); AR 268 (letter from Dr. Penrose, dated 7/25/2006); AR 992 (letter from Dr. Gradman, dated 8/2/2006), Unum Life decided to approve Ms. Fortlage's request for disability benefits under a reservation of rights. Unum Life explained as follows in its letter of August 15, 2006, to Ms. Fortlage: "We have not completed the review of your claim but as a customer service we are issuing benefits due to the length of time to process your claim. A pre-existing condition review is still being completed along with evaluating if you meet the definition of disability." AR 1029 (letter, dated 8/15/2006).

Thereafter, Unum Life received additional information from Ms. Fortlage's treating physicians, including various doctors from Stanford.

The medical records reflected that, in August 2006, two treating physicians diagnosed Ms. Fortlage with having myasthenia gravis . *See* AR 1515 (Dr. Dubey's notes, dated 8/14/2006); AR 1521 (Dr. Schwartz's notes, dated 8/15/2006). However, antibody testing for the disorder came back negative, as both physicians acknowledged. *See* AR 1514 (Dr. Dubey's notes, dated 8/14/2006) (stating that "[m]yasthenia antibodies were also sent and were fine normal as an

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[4] Syncope is "loss of consciousness resulting from insufficient blood flow to the brain." http://www.merriam-webster.com/medical/syncope (last visited 11/19/2009).

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outpatient"); AR 1519 (Dr. Schwartz's notes, dated 8/15/2006) (noting that neurologist had done a fairly thorough workup for myasthenia gravis, including an antibody test which was negative); *see also* AR 1565 (Dr. Cooper's notes, dated 8/18/2006) (noting that "acetylcholine receptor antibodies reported to patient as within normal limits").

The medical records also reflected that, in August and September 2006, several treating physicians concluded that there were no problems or at least no significant problems with Ms. Fortlage' s left eye. *See* AR 1520 (Dr. Schwartz's notes, dated 8/15/2006) (indicating that cranial nerves largely intact); AR 1570 (Dr. Dubey's notes, dated 8/18/2006) (noting that ophthalmologist "did not find anything significantly wrong with her left eye that was complaining of diplopia"); AR 1624 (Dr. Liao's notes, dated 9/7/2006) (indicating no left cranial nerve IV palsy but rather "a more generalized involvement of eye movement abnormality"). One physician, however, found to the contrary. *See* AR 1566 (Dr. Cooper's notes, dated 8/16/2006) (stating that "[t]he motility findings today are those of a left 4th cranial nerve palsy").

Finally, the medical records reflected that, in November 2006, Dr. Dubey, Ms. Fortlage's primary care doctor at Stanford, concluded that she was not suffering from Sjogren's disease or any other autoimmune disorder. *See* AR 1591 (noting that "Sjogren syndrome, she had a whole blood test done for autoimmune disorders, and they were essentially all negative"). Several months later, two other treating doctors concluded the same. *See* AR 1976 (Dr. Sharp and Dr. Holman's notes, dated 2/6/2007) (stating that "[w]e certainly do not think she has sicca symptoms with Sjogren syndrome or rheumatoid arthritis or any connective tissue disease"; adding that "[h]er laboratory tests have all been negative as well").

On January 2, 2007, Unum Life was informed that Dr. Dubey, Ms. Fortlage's treating physician at Stanford, had released Ms. Fortlage to fulltime work with no restrictions or limitations as of January 31, 2007. *See* AR 1325 (Unum Life file notes, dated 1/2/2007).

On January 10, 2007, Ms. Fortlage's treating cardiologist, Dr. Zei, noted that Ms. Fortlage had been diagnosed with neurocardiogenic syncope. Dr. Zei further noted that Ms. Fortlage's

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symptoms included fatigue and that she had episodes of bradycardia (*i.e.*, slow heart action[5]) which were significant. *See* AR 1636-39 (Dr. Zei's notes, dated 1/102/2007). Subsequently, however, Dr. Zei stated that a loop monitor that he had prescribed showed no significant bradycardia. *See* AR 1682-83 (Dr. Zei's notes, dated 3/27/2007).

On February 27, 2007, Unum Life's medical consultant, Dr. Kile reviewed Ms. Fortlage's file. 1655-63 (review by Dr. Kile). Dr. Kile noted that

> previously determined as PRE-EXISTING: anxiety, depression, bowel/anorectal symptoms, urinary urgency/frequency, and vaginal sxs. New information to my review ALSO indicates clmt received treatment for eye movement disorder/diplopia [double vision] – treated with yoked based up/down prism glasses for last 10-12 years . . . before, during and after the look back period of 1/1/05-3/31/05.

AR 1656.

Dr. Kile also stated that the "[e]ye condition and binocular vision deficit would appear to be a pre-existing disorder for which clmt received treatment with prisms during the look back period without evidence for new or separate problem which might warrant R&Ls [restrictions and limitations]." AR 1657.

Ultimately, Dr. Kile concluded as follows:

> Complex case with multiple physical symptoms. Weight of evidence suggests significant psychological overlay or psych underpinnings. There is no convincing objective evidence or clear medical opinion for significant organic pathophysiology which would explain constellation of symptoms or cause significant on-going functional loss (in absence of psych disturbance) during period under review.
>
> . . . .
>
> However, before final determination . . . will contact PCP [primary care provider] Dr. Dubey and Cardiologist Dr. Zei to clarify their opinions regarding primary problem, etiopathology, R&L's, etc.

AR 1660.

Dr. Kile also noted that, based on his records, Dr. Zei "[n]o longer opines bradycardia or fatigue as the issue but rather dizziness." AR 1663.

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[5] *See* http://www.merriam-webster.com/dictionary/bradycardia (last visited Dec. 14, 2009).

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Subsequently, Dr. Kile had oral conversations with Dr. Zei and Dr. Dubey. *See* AR 1688-89 (notes by Dr. Kile, dated 3/19/09); AR 1720-22 (notes by Dr. Kile, dated 4/28/2007). In the conversations, Dr. Kile discussed with both doctors restrictions and limitations that Ms. Fortlage had.

Dr. Kile then followed up with each physician by sending a letter summarizing the conversation and asking the doctor to sign the letter if he or she agreed with the summary. Both doctors signed off on the letters, which included a discussion of Ms. Fortlage's restrictions and limitations.

In the letter to Dr. Zei, Dr. Kile had stated, *inter alia*, that

> Dr. Zei clarifies that from a cardiovascular standpoint for her dizziness and pre-syncope with suspected neurocardiogenic syncope or dysautonomia, he agrees with reasonable restrictions and limitations of no rapid position changes, no prolonged fixed positions, no frequent bending below waist, opportunity to wear compression stockings, regular access to fluids (every 2 - 2 ½ hours) and avoiding driving and unprotected heights when feeling dizzy or lightheaded.

AR 1701 (letter, dated 3/23/2007, and sign-off, dated 3/29/2007).

In the letter to Dr. Dubey, Dr. Kile had stated that, *inter alia*,

> Dr. Dubey clarifies that she has not seen Ms. Fortlage since January 2007[[6]] and does not yet have a follow-up appointment scheduled.
>
> . . . .
>
> I discussed the clinical impressions and recommendations by Dr. Zei related to Ms. Fortlage's dizziness and pre-syncope . . . .
>
> Dr. Dubey indicated she would call patient back in to see her but states the restrictions and limitations of no heavy lifting, no rapid position changes, no prolonged fixed positions, no frequent bending below waist, opportunity to wear compression stockings, regular access to fluids (every 2 - 2 ½ hours), avoiding driving and unprotected heights if feeling dizzy or lightheaded, and regular access to restroom facilities, seem very reasonable. MD indicated she agreed from information available, Ms. Fortlage's condition would allow her to do at least sedentary level work activities with the above restrictions and limitations with further evaluation and management running concurrent with work.

[6] Dr. Dubey made a correction to the date in her sign-off – *i.e.*, February 2007 instead of January 2007. *See* AR 1732 (letter, dated 5/1/2007, and sign-off, dated 5/10/2007).

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> Dr. Dubey stated she can release Ms. Fortlage back to work however noted if the patient disagrees with this assessment; she would very likely refer her to their Occupational Medicine department for formal functional capacity evaluation to more objectively define her abilities.

AR 1732.

Subsequently, on June 14, 2007, Dr. Kile supplemented her review of Ms. Fortlage's file based on new information provided by Ms. Fortlage – *i.e.*, information from a new treating physician, an ophthalmologist, who was treating her diplopia (double vision)[7]. Dr. Kile noted that the physician, Dr. Ziffer, "confirms for her eye disorder strabismus[[8]] /diplopia she has work prism glasses essentially all her life." AR 1783 (review by Dr. Kile, dated 6/14/2007). Dr. Kile concluded:

> The weight of the evidence supports that the eye condition/eye complaints/diplopia for which the clmt is now seeing Dr. Ziffer (and has seen other eye specialists) is a pre-existing condition for which clmt received treatment (with prism glasses) before, during and after the look back period of 1/1/05-3/31/05. To my review there is no evidence for a separate or new eye disorder or an unrelated eye condition which would preclude return to usual work.

AR 1784.

On July 10, 2007, Ms. Fortlage informed Unum Life that her treating physicians, Dr. Dubey and Dr. Ziffer, had referred her to a neurologist. *See* AR 1811 (Unum Life file notes, dated 7/10/2007).

In his notes, the neurologist stated that Ms. Fortlage's neurological examination was "quite normal" as were the electrodiagnostic studies. AR 2097 (letter). The neurologist, Dr. McQuillen, also noted that, "[i]n the results of her blood work, there was no evidence for myasthenia, thyroid dysfunction, elevated creatine kinase, or any other abnormality." AR 2097; *see also* AR 1936 (Dr. McQuillen's notes, dated 5/24/2007) (stating that, "[i]f there is a neurological disease at present, it

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[7] *See* http://www.merriam-webster.com/dictionary/diplopia (last visited Dec. 14, 2009).

[8] Strabismus is "inability of one eye to attain binocular vision with the other because of imbalance of the muscles of the eyeball." http://www.merriam-webster.com/dictionary/strabismus (last visited 11/19/2009). As a child, Ms. Fortlage had surgery in her right eye to address the strabismus.

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certainly looks like myasthenia; however, sutides for that disorder apparently have been negative," including repetitive stimulation on EMG).

On August 22, 2007, Unum Life issued its decision on Ms. Fortlage's disability claim. It denied the claim on the basis that her condition was pre-existing. *See* AR 1850 (initial denial).

In the denial, Unum Life noted that,

> [i]n our initial medical review of your medical records on file, it appeared that there was no objective evidence for significant physiologic cause but appeared that anxiety and panic attacks were the ongoing problem.
>
> It appeared that you have a history of psychiatric treatment for depression and anxiety . . . . The conditions of depression and anxiety would be pre-existing and not be covered under this policy.

AR 1851.

Unum Life went on to state that, after this initial medical review, it received more information from Ms. Fortlage's treating physicians.

> Unum conducted a review of all the additional medical information. Our onsite physician had noted that the new information also reveals that you received treatment for eye movement disorder/diplopia during the pre-existing look back period. The records from Stanford Hospital dated August 15, 2006, indicate that you had eye problems since the fifth grade and had noted strabismus. At that time you were noted to have surgery done removing part of your right eye. Dr. Ziffer, your ophthalmologist since January 2007, states that you had worn prism glasses all your adult life. The records indicate that you were asymptomatic for many years treated with prism glasses for last 10-12 years which would have been before, during and after the look back period of January 1, 2005 through March 31, 2005. In our conversation on July 10, 2007, you indicated that you had worn the prism glasses for the past 4 to 5 years.

AR 1853.

As for the chest pain and syncope, Unum Life noted that its medical consulted had contacted both Dr. Zei and Dr. Dubey to evaluate any impairment. "A letter was went to both doctors to confirm any restrictions you may have. Both Dr. Zei and Dr. Dubey signed the letter and agreed that you may return to work with [certain] restrictions and limitations . . . ." AR 1853.

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Unum Life concluded that, "[a]s your conditions are either pre-existing or would not preclude you from your own occupation, no more benefits will be paid and your claim will be closed effective August 12, 2007." AR 1854.

Unum Life added that Ms. Fortlage could appeal the denial, providing any "additional information to support your request for disability benefits." AR 1854.

After the denial, Ms. Fortlage continued to seek treatment from various physicians, including physicians at Stanford, the Mayo Clinic, CPMC, and Pacific Eye Associates

Objective testing conducted by one of the CPMC doctors in late 2007 and again in January 2008 indicated that Ms. Fortlage did not suffer from myasthenia gravis. *See* AR 2292 (Dr. Miller's notes, dated 10/9/2007) (noting that repetitive stimulation did not result in abnormal increment or decrement); AR 2284 (Dr. Miller's notes, dated 1/2/2008) (noting repetitive nerve stimulation in right phrenic nerve with no abnormal increment or decrement).

In contrast, in November 2007, an objective test (a single-fiber EMG) conducted by a Mayo Clinic doctor indicated compatibility with myasthenia gravis. However, that doctor also made note that antibody testing for the condition was negative. *See* AR 2211 (Dr. Goodman's notes, dated 11/6/2007). Moreover, a CPMC doctor specifically questioned the single-fiber study because "it was a forehead muscle and not truly an ocular muscle, so it is difficult to interpret." AR 2282 (Dr. Katz's notes, dated 1/16/2008).

That same CPMC doctor ultimately concluded in early 2008 that Ms. Fortlage did not have myasthenia gravis based on the following facts: that the onset of the symptoms was relatively acute, that the antibody testing was negative, that there was a lack of response to prednisone, and that the tendency on the part of Ms. Fortlage was to fall or be off balance. *See* AR 2278, 2280-81 (Dr. Katz's notes, dated 2/8/2008 and 3/11/2008). But, at about the same time period, two other treating physicians, Dr. Paul and Dr. Reader, found to the contrary. *See* AR 2442 (Dr. Paul's notes, dated 3/25/2008) (concurring with diagnosis of myasthenia gravis); AR 2440 (Dr. Reader's notes, dated 4/5/2008) (concluding that Ms. Fortlage has "upgaze paresis most likely due to ocular myasthenia with the possibility of a vasculitic component being present").

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As for a left cranial nerve palsy, doctors at Stanford, CPMC, and the Mayo Clinic indicated that there did not appear to be any problem. *See* AR 2108 (Dr. So's notes, dated 9/26/2007) (indicating that cranial nerve exam largely normal); AR 2292 (Dr. Miller's notes, dated 10/9/2007) (stating cranial nerves normal); AR 2224 (Dr. Goodman's notes, dated 10/30/2007)) (noting that "[e]xtraocular movements in the left eye appeared quite normal"). However, one treating physician, Dr. Reader (a neuro-ophthalmologist), found to the contrary. *See* AR 2437 (letter from Dr. Reader, dated 4/21/2008) (diagnosing an acute left trochlear nerve palsy).

As for Ms. Fortlage's heart condition, one of the doctors at the Mayo Clinic diagnosed neurocardiogenic syncope in November 2007. *See* AR 2026 (Dr. Srivathsan's notes, dated 11/21/2007).

Finally, in early 2008, another treating doctor, Dr. Carteron (a rheumatologist), ruled out an autoimmune process as a basis for Ms. Fortlage's symptoms. *See* AR 2317 (Dr. Carteron's notes, dated 2/29/2008).

On April 15, 2008, Ms. Fortlage submitted her appeal. *See* AR 2025 *et seq.* (initial appeal). In the appeal, Ms. Fortlage argued that the medical evidence she was now providing, which included her Stanford and Mayo Clinic records as well as records from treating physicians Dr. Katz, Dr. Miller, and Dr. Carteron, "conclusively demonstrates that [her] vision problems are entirely the result of a new condition, never diagnosed or treated during the pre-existing period, of Ocular Myasthenia Gravis." AR 2026. Ms. Fortlage also argued that her "symptoms of chest pain, shortness of breath, and fatigue are also traceable to her neurocardiogenic syncope, also never diagnosed or treated during the pre-existing period." AR 2026. According to Ms. Fortlage, these conditions – both alone and in combination – precluded her from working in any occupation. *See* AR 2026.

Ms. Fortlage added that, because of circumstances beyond her control, she was not able to provide a "central medical report" and a functional capacity evaluation as part of her appeal. AR 2025. Ms. Fortlage therefore reserved the right to supplement the appeal once she received those documents. *See* AR 2025.

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On May 2, 2008, Ms. Fortlage sent to Unum Life her supplemental appeal. Ms. Fortlage provided a "central medical report" – a letter from Dr. Reader in which he stated that Ms. Fortlage has an acute left trochlear nerve palsy and that this condition was unrelated to Ms. Fortlage's childhood strabismus (which affected her right eye, not her left). *See* note 8, *supra*. She also provided a functional capacity evaluation (also called a "FCE"). *See* AR 2341 (supplemental appeal); AR 2437 (letter from Dr. Reader, dated 4/21/2008). As in her initial appeal, Ms. Fortlage argued that the medical evidence demonstrated that she was disabled from any gainful employment because of ocular myasthenia gravis and neurocardiogenic syncope. *See* AR 2341.

On the last page of the supplemental appeal, Ms. Fortlage asked Unum Life for the opportunity to review and respond to any medical evaluation of the evidence that Unum Life might obtain before it issued a decision on the appeal. *See* AR 2436.

On April 16, 2008, Unum Life began its review of the appeal. *See* AR 2022 (letter, dated 4/17/2008) (stating that "[w]e will begin our review of the file at this time").

On May 7, 2008, Unum Life sent a letter to Ms. Fortlage, noting that the documents reviewed indicated that she had been approved for Social Security disability benefits. Unum Life asked that Ms. Fortlage submit a copy of the Social Security decision by May 23, 2008. *See* AR 2512 (letter, dated 5/7/2008).

On May 8, 2008, Unum Life had a medical consultant, RN Murphy, review Ms. Fortlage's file. *See* AR 2515-51 (review by RN Murphy). RN Murphy summarized the extensive medical evidence that had been provided. She also took into consideration additional information that had been submitted, including declarations from Ms. Fortlage and her friends and family and the functional capacity evaluation. *See* AR 2540-41. RN Murphy noted that, as reflected in the records, Ms. Fortlage's activities seemed

> inconsistent with the myriad of complaints, severity, intensity and impact on daily functioning. For example, she has reported that she drives, does household chores, gardens, reads, uses the computer and has been documented as having researched various conditions that she feels she might have, exercises at the gym, using treadmill/elliptical machine, does scrapbooking and beading. She has taken trips such as the Caribbean where she went scuba diving, Hawaii where she reportedly experienced an episode where her heart stopped but she didn't seek medical attention. Cardiac stress testing and ECHO have

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> revealed no abnormalities and the claimant was able to exercise to a minimum of 10 METS, stopping only due to fatigue. This would be equivalent to the capacity for performing activities within the moderate/medium demand level.

AR 2550.

RN Murphy, however, did not reach any final conclusions and instead referred the case out for additional review. *See* AR 2547.

Two reviews followed, one conducted by Dr. Doane, *see* AR 2614-23 (review by Dr. Doane, dated 5/22/2008), and the other by Dr. Zimmerman. *See* AR 2594-602 (review by Dr. Zimmerman, dated 5/21/2008).

In his review, Dr. Doane concluded that certain restrictions and limitations were appropriate. *See* AR 2621. However, he emphasized that

> the available medical evidence does not support a local or systemic disease of the cardiovascular, neuromuscular, immunologic or vestibular systems that would result in the claimant's symptom complex. . . . Anxiety was clearly noted by most examiners with indication that the anxiety played a significant role in symptom complex and concern for symptoms. . . . Long present IBS [irritable bowel syndrome] and neurocardiogenic presyncope/syncope in an underweight individual have been confirmed. The PVCs [heart contractions] are benign and do not warrant treatment. The diplopia, with a reasonable degree of medical certainty is a result of the effect of aging, anxiety and the residual effects of childhood strabismus surgery.

AR 2620. Dr. Doane concluded by recommending an ophthalmologist review "to determine if the exotropia/hypertropia findings are consistent with residual effects of prior childhood strabismus or represent a new onset left third nerve palsy." AR 2621.

In her review, Dr. Zimmerman stated that her "review of the medical records was consistent with Dr. Doane's in that the available medical records (1990s through 2007) revealed a longstanding pattern of the physiological and cognitive symptoms of anxiety and pain, somatizing, and episodic depression." AR 2597; *see also* AR 2601 (stating that "the available medical documentation provided compelling evidence of a longstanding anxiety disorder with somatic focus for those symptoms not explained by strabismus as discussed with Dr. Doane").

On May 15, 2008, Unum Life sent another letter to Ms. Fortlage in which it noted that her file was with the medical department for review which it expected to be completed "within the next

few weeks." AR 2586 (letter, dated 5/15/2008). Unum Life added that it was "still waiting for a copy of Ms. Fortlage's fully favorable decision from Social Security" and asked again that the information be provided by May 23, 2008. AR 2586.

On May 15, 2008, Ms. Fortlage responded to Unum Life's May 7 letter. She did not provide a copy of the actual decision but did provide a copy of the SSA notice, which stated her benefit amount for 2008. Ms. Fortlage explained that she had "applied for [Social Security disability] benefits by telephone in November 2007 and was approved immediately, apparently as a continuation of her 2002 Award based on PTSD. That, of course, is not the basis for her disability since 2006." AR 2590 (letter, dated 5/15/2008).

That same day, Unum Life sent a reply. Because it was not clear what was the basis for the Social Security award, Unum Life forwarded to Ms. Fortlage "an authorization to release information form required by the Social Security Administration." AR 2582 (letter, dated 5/15/2008). Unum Life asked that the authorization be returned by May 30, 2008. *See* AR 2582.

On May 22, 2008, Ms. Fortlage provided Unum Life with a copy of the authorization executed by her, which would allow Unum Life to obtain a copy of her Social Security disability claim file (from January 2006 to the present). *See* AR 2610 (letter, dated 5/22/2008). .

On May 23, 2008, Unum Life informed Ms. Fortlage by letter that it would need an extension of up to 45 days to make a decision. Unum Life added, however, that the "extension will begin only after we receive Ms. Fortlage's Social Security file." AR 2625 (letter, dated 5/23/2008). "[I]f we do not receive Ms. Fortlage's Social Security file within 45 days, we will have to make a decision on Ms. Fortlage's appeal based on the information we have at that time." AR 2625.

On June 9, 2008, Ms. Fortlage sent to Unum Life a second report from her treating rheumatologist, Dr. Carteron. That report was dated June 5, 2008. *See* AR 2632-34 (letter, enclosing Dr. Carteron's June 2008 report). In the report, Dr. Carteron diagnosed, *inter alia*, a multi-system inflammatory autoimmune disorder, which was responsible for, *inter alia*, the cardiogenic syncopy. *See* AR 2633. The report also noted that Dr. Carteron had ordered a salivary gland biopsy, which led in part to Dr. Carteron diagnosing Sjogren's some five months later in

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November 2008 – after the denial of the appeal was issued. *See* White Decl., Ex. 2 (Dr. Carteron's November 2008 report).

The Unum Life adjuster working on the appeal, Ms. Tetrault, did not provide a copy of Dr. Carteron's June 2008 report to Unum Life's medical consultants for review. Her file notes state: "The report from Dr. Carteron dated 6/5/08 that we received on 6/9/08 will not be referred to our medical dept. for review as the time period in question is the claimant's condition as of 6/06, approximately two years prior to this first visit with Dr. Carteron."[9] AR 2635 (Unum Life file notes, dated 6/17/2008).

On June 23, 2008, Unum Life sent a letter to Ms. Fortlage, noting that it still had not received her Social Security file. "Therefore, we are continuing to toll Ms. Fortlage's appeal while we await receipt of her file." AR 2637 (letter, dated 6/23/2008).

By letters dated July 15 and 17, 2008, Ms. Fortlage responded to Unum Life's statement that it was waiting for the Social Security decision. More specifically, on July 15, Ms. Fortlage provided to Unum Life a notice from the SSA that it had reviewed the evidence in her Social Security disability claim and determined that her disability was still continuing. Ms. Fortlage noted: "Because Unum is required to give [the Social Security] decision significant weight, Unum can no longer delay its decision and should release Ms. Fortlage's benefits immediately." AR 2649 (letter, dated 7/15/2008).

On July 17, Ms. Fortlage sent another letter to Unum Life. In this letter, Ms. Fortlage acknowledged Unum Life's request (made by telephone) that she agree to continued tolling until Unum Life reviewed the complete Social Security file. Ms. Fortlage refused to agree, noting, *inter alia*, that she had provided "a complete package of medical and functional evidence in [her] appeal in April, 2008" as well as "all documents [she was] able to obtain from Social Security to date. We

[9] The adjuster incorrectly stated that this was Ms. Fortlage's first visit with Dr. Carteron. In fact, Ms. Fortlage had seen Dr. Carteron prior to June 2008. Unum Life should have known of this fact since Ms. Fortlage had provided medical records from Dr. Carteron, including a report dated February 2008, as part of her initial appeal in April 2008. *See* AR 2027 (initial appeal) (referring to Dr. Carteron's medical records); AR 2303-71 (Dr. Carteron's medical records). As Ms. Fortlage points out, it does not appear that the appeals adjuster rejected the February 2008 report from Dr. Carteron, even though it was only a few months older than the June 2008 report.

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have no control over when or if any additional documents may be received from Social Security." AR 2644 (letter, dated 7/17/2008). Her letter concluded: "We believe that Unum has more than sufficient information to require that Ms. Fortlage's LTD benefits be reinstated immediately." AR 2645.

On July 22, 2008, Unum Life acknowledged that Ms. Fortlage did not want it to wait for the Social Security file. "Therefore, we are proceeding with an expedited ophthalmologist review of Ms. Fortlage's claim as recommended by our medical consultant [Dr. Doane]." AR 2660 (letter). Ms. Fortlage did not respond to this letter.

The ophthalmologist review was conducted by Dr. Berman. Unum Life was given a copy of Dr. Berman's report on August 12, 2008. *See* AR 2693-95 (Dr. Berman's report). In his report, Dr. Berman expressed his "strong[] belie[f]" that Ms. Fortlage's "intermittent diplopia is more likely related to her childhood strabismus and prior surgery," and was not the result of any ocular myasthenia gravis. AR 2695. He also stated that "[i]t should be possible to address [Ms. Fortlage's] intermittent diplopia and residual strabismus with prism or additional surgery. She could also occlude one eye to alleviate any double vision." AR 2695.

On August 18, 2008, Unum Life's adjuster asked for another medical consultation in order "to clarify my understanding of Dr. Berman's review." AR 2720 (Unum Life file notes, dated 8/18/2008). Dr. Doane responded two days later. *See* AR 2720. He noted that Dr. Berman's report "confirms the diplopia is a result of lifelong strabismus and post-strabismus surgery for which the claimant has worn/had prescribed prism glasses before, during and since the look back period. . . . [Dr. Berman] found no evidence to support an isolated ocular muscle Myesthenia [sic] gravis or isolated left 3rd, nerve palsy." AR 2720.

Thereafter, on August 22, 2008, Unum Life sent to Mr. Fortlage a letter updating her on the status of the appeal. Unum Life stated: "We are in the process of completing our review of Ms. Fortlage's appeal. When we have completed our review we will send you our final determination in writing." AR 2724 (letter, dated 8/22/2008). Ms. Fortlage did not respond to this letter.

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Approximately a month later, on September 19, 2008, Unum Life denied Ms. Fortlage's appeal. *See* AR 2755 (denial of appeal). The denial of the appeal was consistent with the initial denial, stating that

> the visual and neurocardiogenic conditions for which [Ms. Fortlage] is claiming disability are considered pre-existing. In addition, even if these conditions were not considered pre-existing, the restrictions and limitations given by our consultant of the use of prism glasses as needed and caution in sudden position changes would not prevent her from performing her own sedentary occupation. Further, the restrictions and limitations that Dr. Zei gave on March 29, 2007 of no rapid position changes, no prolonged fixed positions, no frequent bending below waist, the opportunity to wear compression stockings, regular access to fluids and avoid driving and unprotected heights when feeling dizzy or lightheaded also would not preclude Ms. Fortlage from performing her own occupation.

AR 2759.

Shortly thereafter, Ms. Fortlage protested the denial and submitted additional information showing the most recent test results obtained from Dr. Carteron, her treating rheumatologist. Dr. Carteron's testing indicated that Ms. Fortlage suffered from the autoimmune disorder Sjogren's disease. *See* White Decl., Ex. 1 (letter, dated 9/29/2008); *see also* White Decl., Ex. 2 (Dr. Carteron's November 2008 report) (diagnosing Sjogren's).

Defense counsel of record responded to the letter since, by that time, Ms. Fortlage had initiated the instant lawsuit. *See* White Decl., Ex. 1 (letter, dated 10/9/2008); Docket No. 1 (complaint, filed on 7/15/2008). In the letter, counsel stated that the evidence submitted would not be added to the administrative record because the record closed as of September 19, 2008 (*i.e.*, with the denial of the appeal). *See* White Decl., Ex. 1.

II. RECOMMENDATIONS

A. Standard of Review

Defendant argues that the standard of review to be applied in the instant case is abuse of discretion. Ms. Fortlage asserts that *de novo* review is required. The Court agrees with Defendant.

"To assess the applicable standard of review, the starting point is the wording of the plan." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 962-63 (9th Cir. 2006). If "a plan does not confer discretion on the administrator 'to determine eligibility for benefits or to construe the terms of

the plan,' a court must review the denial of benefits de novo." *Id.* at 963. "But if the plan does confer discretionary authority as a matter of contractual agreement, then the standard of review shifts to abuse of discretion." *Id.*

As noted above, in the instant case, the disability policy was issued by Unum Life Insurance Company of America ("Unum Life") to Heller Ehrman. *See* AR 151 (policy). Under the policy, Unum Life was given "discretionary authority to determine [a claimant's] eligibility for benefits and to interpret the terms and provisions of the policy." AR 160; *see also* AR 187 (providing that "[b]enefits under this Plan will be paid only if the Plan Administrator or its designee (including Unum [Life]) decides in its discretion that the applicant is entitled to them"). This language establishes that Unum Life was given sufficient discretion to shift the standard of review to abuse of discretion. *Compare Abatie*, 458 F.3d at 963 (emphasizing that the Ninth Circuit has "repeatedly held that similar plan wording – granting the power to interpret plan terms and to make final benefits determinations – confers discretion on the plan administrator").

Ms. Fortlage argues that, even though Unum Life was given discretion under the plan, *de novo* review is still proper for three reasons. First, she contends that the benefits decision in her case was not actually made by Unum Life but rather by another Unum entity and therefore the benefits decision in her case is not entitled to any deference. Second, she asserts that, even if Unum Life made the benefits decision in her case, it failed to comply with procedural requirements under ERISA, and this failure was so flagrant and substantial that the standard of review should be altered from abuse of discretion to *de novo*. Finally, she argues that *de novo* review is proper because, once she filed the instant action, the substantive relationship between the parties changed, thus giving rise to *de novo* review. Each argument is addressed below.

1. Entity Making Benefits Decision

As noted above, Ms. Fortlage argues first that there must be *de novo* review because in her case the benefits decision was not made by Unum Life but rather by another Unum entity. Ms. Fortlage claims that this other Unum entity was Unum Life's parent, which she calls Unum. *See* Docket No. 38 (Pl.'s Mot. at 14). The main case on which Ms. Fortlage relies in support of this

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argument is *Anderson v. Life Insurance Company of America*, 414 F. Supp. 2d 1079 (M.D. Ala. 2006).

In *Anderson*, the plan at issue gave Unum Life discretionary authority to make benefits decisions and to interpret the plan. *See id.* at 1086. However, Unum Life then had a General Services Agreement with its parent UnumProvident, which provided that UnumProvident would make benefits decisions. *See id.* at 1086-87. Notably, the General Services Agreement between Unum Life and Unum Provident specified that UnumProvident was engaged as an independent contractor and not as an employee, partner, or agent of Unum Life. *See id.* at 1087. Furthermore, under the General Services Agreement, UnumProvident maintained the exclusive right to exercise discretion and control over associates performing services for Unum Life, and the individuals who made the actual benefits decision in the case identified themselves as UnumProvident employees. *See id.*

The court in *Anderson* concluded that all of the evidence in the record pointed to UnumProvident as the entity that made the benefits decision, not Unum Life. As noted above, the General Services Agreement specified that UnumProvident would be making the benefits decisions, and the individuals who made the benefits decision in the actual case identified themselves as employees of UnumProvident. This was borne out by the correspondence they sent, which bore a UnumProvident letterhead. The *Anderson* court also took note that there was no evidence in the record suggesting that Unum Life had control over the individuals who made the benefits decision. Finally, it was significant that the plaintiff was directed to send her appeal to UnumProvident, not Unum Life. *See id.* at 1098-99.

The court acknowledged that a deferential standard of review could still apply even though it was UnumProvident, and not Unum Life, who made the benefits decision – more specifically, if the plan allowed Unum Life to delegate its discretionary authority to a third party. *See id.* at 1099-110 (emphasizing that "[t]he plan documents . . . must in the first instance give Unum the power to delegate those duties before Unum can invoke the arbitrary and capricious standard of review"); *see also Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1284-85 (9th Cir. 1990) (applying abuse of discretion review to findings by third party to which authority had

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properly been delegated in plan documents). However, the court did not find – and the parties did not point to any – language in the policy which gave Unum Life the authority to delegate its discretionary authority to a third party. *See Anderson*, 414 F. Supp. 2d at 1099.

The *Anderson* court thus held that Unum Life had failed to meet its burden of proving that the arbitrary and capricious (*i.e.*, abuse of discretion) standard should apply. *See id.* at 1095 (noting that, "[w]hile ERISA places the burden upon [the plaintiff] to prove an entitlement to disability benefits under the policy, Unum [Life] bears the burden of proving that the arbitrary and capricious standard of review applies").

While *Anderson* does support the general principle that a deferential standard of review is appropriate only where the party making the benefits decision has actually been given discretion or where that party has appropriately delegated that discretion pursuant to the plan, the facts underlying the result in *Anderson* are distinguishable from the instant case. Unlike *Anderson*, the evidence here establishes that the decisions were made by the administrator, Unum Life.

In the case at bar, the initial benefits decision was made by Philip Popovich. The letter in which Mr. Popovich conveyed the benefits decision did bear the UnumProvident logo at the top but also contained at the bottom contact information for Unum Life. *See* AR 1850 (initial denial, dated 8/22/2007). At the end of the letter, Mr. Popovich identified himself as an employee or agent of Unum Life, *see* AR 1856, as he had in other correspondence related to Ms. Fortlage's claim. *See, e.g.*, AR 523 (letter, dated 5/19/2006).

On appeal, Ms. Fortlage's claim was first handled by Kathleen Reid. In her initial correspondence with counsel for Ms. Fortlage, Ms. Reid identified herself as an employee or agent of Unum Life. The correspondence had a Unum logo at the top (different from the UnumProvident logo), but at the bottom of the letter there is the statement that "UNUM IS A REGISTERED TRADEMARK AND MARKETING BRAND OF UNUM GROUP AND ITS INSURING SUBSIDIARIES." AR 1998 (letter, dated 2/15/2008). Also, the letter provided contact information for Unum Life. *See* AR 1998; *see also* AR 2019 (letter, dated 3/19/2008). In subsequent correspondence, Ms. Reid did not specifically identify herself as a Unum Life employee or agent, and the letters did not contain contact information for Unum Life specifically but rather referred to

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Unum generally. *See, e.g.*, AR 2022 (letter, dated 4/17/2008). Similarly, the appeals consultant who took over after Ms. Reid – *i.e.*, Patricia Tetrault – did not specifically identify herself as a Unum Life employee or agent, and her letters did not contain contact information for Unum Life specifically but rather referred to Unum generally. *See, e.g.*, AR 2605 (letter, dated 5/22/2008). However, these facts are not material because (1) as noted above, Unum appears to be a registered trademark and marketing brand of Unum Group *and* its insuring subsidiaries, which would presumably include Unum Life, and (2) the address listed for Unum was the same as the address previously listed for Unum Life. Finally, it is worth noting that Ms. Tetrault's denial of the appeal specifically stated that the decision was being made by Unum Life. *See* AR 2755 (denial of appeal).

Ms. Fortlage argues that an Unum entity other than Unum Life decided her disability claim because, *e.g.*, medical reviewers identified themselves as working for Unum generally rather than Unum Life specifically. *See* Docket No. 51 (Reply at 7) (citing AR 2553, 2584, 2607, 2720). The mere use of the name Unum, however, is not dispositive because, as noted above, it is a trademark for the Unum group and its insuring subsidiaries. While Ms. Fortlage correctly notes that Dr. Berman, one of the medical reviewers, directed his report to UnumProvident rather than Unum or Unum Life, *see* AR 2693 (Dr. Berman report, dated 8/12/2008), the record clearly reflects that Ms. Tetrault asked for the consultation with Dr. Berman. *See* AR 2660 (letter, dated 7/22/2008). As noted above, Ms. Tetrault appears to be an employee of Unum Life. Furthermore, while Dr. Berman's report does identify UnumProvident as the recipient, the fax cover sheet indicates that the report was sent to Brandi Warren of Unum, and Ms. Warren appears to have been the recipient only because she was delegated this task by Ms. Tetrault, as reflected by an e-mail exchange involving Ms. Tetrault and Ms. Warren. *See* AR 2689-90 (e-mail exchange, dated 7/31 and 8/1/2008).

As a final argument, Ms. Fortlage contends that it must have been another Unum entity that made the decision on her disability claim because Unum Life has never denied the existence of a General Services Agreement with UnumProvident. But a General Services Agreement has not been offered to the Court as evidence. Ms. Fortlage claims that Unum Life refused to disclose the agreement, but she cites no evidence to support this contention (*e.g.*, there is no declaration from counsel). Moreover, if Unum Life refused, she could have moved to compel production of the

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agreement, particularly since she could have argued that this discovery was relevant to the standard of review. *See, e.g.*, *Duran v. Cisco Sys.*, 258 F.R.D. 375, 380 (C.D. Cal. 2009) (stating that discovery related to the proper standard of review is appropriate). Evidently, she brought no such motion.

In sum, the evidence in this case – unlike the evidence in *Anderson* – all points to a benefits decision being made by Unum Life, and not UnumProvident or any other Unum entity. The case cited by Unum Life in its papers, *see Zurndorder v. Unum Life Ins. Co. of Am.*, 543 F. Supp. 2d 242 (S.D.N.Y. 2008), supports this conclusion. In that case, the court specifically found that, in contrast to *Anderson*, it was "beyond dispute" that the individuals who made benefits decision were "authorized agents of Unum [Life], whatever their other roles within UnumProvident structure." *Id.* at 256-57. The evidence establishes the same conclusion in the instant case.

2. Failure to Comply with Procedural Requirements Under ERISA

As noted above, Ms. Fortlage's second argument is that, even if Unum Life made the benefits decision, *de novo* review is still appropriate because it flagrantly failed to comply with procedural requirements under ERISA.

In *Abatie*, the Ninth Circuit held that, "when a decision by an administrator utterly fails to follow applicable procedures, the administrator is not, in fact, exercising discretionary powers under the plan, and its decision should be subject to de novo review." *Abatie*, 458 F.3d at 959; *see also id.* at 971-72 (noting that, "[b]ecause an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority"). The court emphasized, however, that "an administrator's failure to comply with such procedural requirements ordinarily does not alter the standard of review"; it is only where the procedural irregularities are "substantial" – *i.e.*, "so flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm" – that the standard of review is changed. *Id.* at 971. "Lesser irregularities . . . do not remove the decision from abuse of discretion review, but rather should be factored into the calculus of whether the administrator abused its discretion." *Id.* at 959.

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As an example of a flagrant procedural violation that required alteration of the standard of review, *Abatie* pointed to an earlier decision where "the administrator had kept the policy details secret from the employees, offered them no claims procedure, and did not provide them in writing the relevant plan information; in other words, the administrator 'failed to comply with virtually every applicable mandate of ERISA.'" *Id.* at 971. In contrast, "[w]hen an administrator can show that it has engaged in an ongoing, good faith exchange of information between the administrator and the claimant, the court should give the administrator's decision broad deference notwithstanding a minor irregularity." *Id.* at 972 (internal quotation marks omitted).

In the instant case, Ms. Fortlage contends that Unum Life flagrantly violated ERISA's procedural requirements by not ruling on her appeal for more than five months. According to Ms. Fortlage, she submitted her initial appeal on or about April 16, 2008, *see* AR 2022 (letter, dated 4/17/2008) (acknowledging receipt of information on April 16, 2008, and stating that "[w]e will begin our review of the file at this time"), but ultimately no decision was made on the appeal until September 19, 2008. *See* AR 2755 (denial of appeal). Ms. Fortlage argues that, in taking so long to decide the appeal, Unum Life violated the procedural requirement in ERISA that an appeal in a disability case be decided in 90 days.

Title 29 C.F.R. § 2560.503-1(i)(1) and (3) provides that, for a disability claim, the plan administrator shall notify a claimant of the plan's benefit determination on review within

> a reasonable period time of time, but not later than [45] days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim.

29 C.F.R. § 2560.503-1(i)(1), (3). The extension cannot "exceed a period of [45] days from the end of the initial period." *Id.* Thus, as Ms. Fortlage asserts, typically, an appeal in a disability case must be decided in 90 days.

Section 2560.503-1(i)(4), however, has a tolling provision. It states as follows:

> [T]he period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is

> extended as permitted pursuant to paragraph (i)(1) . . . or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Id. § 2560.503-1(i)(4). The Department of Labor has noted that "[t]his tolling period ends on the date on which the plan receives the claimant's response to the notice, *without regard to whether the claimant's response supplies all of the information necessary to decide the claim*." 65 Fed. Reg. 70246, 70250 n.21 (2000) (emphasis added); *see also McDowell v. Standard Ins. Co.*, 555 F. Supp. 2d 1361, 1369 (N.D. Ga. 2008) (rejecting defendant's contention that the tolling provision allows a plan administrator to "hold the claims process in abeyance until plaintiff produce[s] the requested information"; citing in support both the language of § 2560.503-1(i)(4) as well as 65 Fed. Reg. 70246).

In the instant case, the relevant history regarding tolling is as follows.

As noted above, on April 16, 2008, Unum Life began its review of the appeal immediately after Ms. Fortlage submitted her initial appeal on April 15. *See* AR 2022 (letter, dated 4/17/2008) (stating that "[w]e will begin our review of the file at this time"). Under § 2560.503-1(i)(1) and (3), Unum Life had 45 days to render a decision on the appeal, absent an extension based on special circumstances. *See* AR 2022 (acknowledging that "[w]e hope to make a determination on your client's claim within 45 days, unless special circumstances extend the time needed to make the determination," in which case "we are committed to making a determination no later than 90 days from April 16, 2008"). In other words, Unum Life had until May 31, 2008 (a Saturday), to decide the appeal.[10]

On May 7, 2008, Unum Life sent a letter to Ms. Fortlage, noting that the documents reviewed indicated that she had been approved for Social Security disability benefits. Unum Life asked that Ms. Fortlage submit a copy of the Social Security decision by May 23, 2008 – *i.e.*,

[10] It is not clear whether Unum Life should have been held to the Saturday date or whether the following Monday – *i.e.*, June 2, 2008 – would be the date by which the decision on the appeal had to be made.

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1 approximately a week before Unum Life had to make a decision on her appeal. *See* AR 2512 (letter,
2 dated 5/7/2008). On May 15, 2008, Unum Life sent another letter to Ms. Fortlage in which it
3 noted that her file was with the medical department for review which it expected to be completed
4 "within the next few weeks." AR 2586 (letter, dated 5/15/2008). Unum Life added that it was "still
5 waiting for a copy of Ms. Fortlage's fully favorable decision from Social Security" and asked again
6 that the information be provided by May 23, 2008. AR 2586.

7 On May 15, 2008, Ms. Fortlage responded to Unum Life's May 7 letter. She did not provide
8 a copy of the actual decision but did provide a copy of the SSA notice, which stated her benefit
9 amount for 2008. Ms. Fortlage explained that she had "applied for [Social Security disability]
10 benefits by telephone in November 2007 and was approved immediately, apparently as a
11 continuation of her 2002 Award based on PTSD. That, of course, is not the basis for her disability
12 since 2006."[11] AR 2590 (letter, dated 5/15/2008).

13 That same day, Unum Life sent a reply. Because it was not clear what was the basis for the
14 Social Security award, Unum Life forwarded to Ms. Fortlage "an authorization to release
15 information form required by the Social Security Administration." AR 2582 (letter, dated
16 5/15/2008). Unum Life asked that the authorization be returned by May 30, 2008. *See* AR 2582.

17 On May 22, 2008, Ms. Fortlage provided Unum Life with a copy of the authorization
18 executed by her, which would allow Unum Life to obtain a copy of her Social Security disability
19 claim file (from January 2006 to the present). *See* AR 2610 (letter, dated 5/22/2008). At this point,
20 Unum Life had only another week or so to render a decision on the appeal.

21 Accordingly, the next day – May 23, 2008 – Unum Life informed Ms. Fortlage by letter that
22 it would need an extension of up to 45 days to make a decision. Unum Life added, however, that the
23 "extension will begin only after we receive Ms. Fortlage's Social Security file." AR 2625 (letter,
24 dated 5/23/2008). "[I]f we do not receive Ms. Fortlage's Social Security file within 45 days, we will
25

26 [11] In her papers, Ms. Fortlage suggests that, once she made this response to Unum Life's request
27 for Social Security information, tolling of the time period to make a decision on the appeal ended. *See*
Docket No. 38 (Pl.'s Mot. at 12). The problem with this argument is that tolling does not begin under
28 § 2560.503-1(i)(4) unless there has first been an extension of time. Here, Unum Life did not make a
request for an extension of time until later – *i.e.*, until May 23, 2008. *See infra*.

have to make a decision on Ms. Fortlage's appeal based on the information we have at that time."[12] AR 2625. Thus, Unum Life was indicating to Ms. Fortlage that it was tolling the time for it to make a decision pursuant to § 2560.503-1(i)(4). *See* 29 C.F.R. § 2560.503-1(i)(4) (providing that, "[i]n the event that a period of time is extended as permitted pursuant to paragraph (i)(1) . . . or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information").

On June 23, 2008, Unum Life sent a letter to Ms. Fortlage, noting that it still had not received her Social Security file. "Therefore, we are continuing to toll Ms. Fortlage's appeal while we await receipt of her file." AR 2637 (letter, dated 6/23/2008). By letters dated July 15 and 17, 2008, Ms. Fortlage responded to Unum Life's statement that it was waiting for the Social Security decision. More specifically, on July 15, Ms. Fortlage provided to Unum Life a notice from the SSA that it had reviewed the evidence in her Social Security disability claim and determined that her disability was still continuing. Ms. Fortlage noted: "Because Unum is required to give [the Social Security] decision significant weight, Unum can no longer delay its decision and should release Ms. Fortlage's benefits immediately." AR 2649 (letter, dated 7/15/2008). On July 17, Ms. Fortlage sent another letter to Unum Life. In this letter, Ms. Fortlage acknowledged Unum Life's request (made by telephone) that she agree to continued tolling until Unum Life reviewed the complete Social Security file. Ms. Fortlage refused to agree, noting, *inter alia*, that she had provided "a complete package of medical and functional evidence in [her] appeal in April, 2008" as well as "all documents [she was] able to obtain from Social Security to date. We have no control over when or if any additional documents may be received from Social Security." AR 2644 (letter, dated 7/17/2008).

[12] In her papers, Ms. Fortlage notes that Unum Life did not make a decision on the appeal within 45 days of the May 23 letter. This is true. However, the tolling provision in § 2560.503-1(i)(4) does not limit tolling to 45 days. *See* 29 C.F.R. § 2560.503-1(i)(4) (allowing for tolling "until the date on which the claimant responds to the request for additional information"). Accordingly, Unum Life's failure to make a decision within 45 days of the May 23 letter did not violate the federal regulations. Moreover, as described below, on June 23, 2008 – *i.e.*, before the 45 days expired – Unum Life stated that it would continue to toll the appeal until it received the Social Security file.

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Her letter concluded: "We believe that Unum has more than sufficient information to require that Ms. Fortlage's LTD benefits be reinstated immediately." AR 2645.

Because Ms. Fortlage had responded to Unum Life's request for the Social Security decision – even if she did not provide the decision itself – the tolling under § 2560.503-1(i)(4) ended. *See* 65 Fed. Reg. 70246, 70250 n.21 (2000) (stating that "[t]his tolling period ends on the date on which the plan receives the claimant's response to the notice, *without regard to whether the claimant's response supplies all of the information necessary to decide the claim*") (emphasis added). Accordingly, Unum Life had only 45 days (the extension) to decide Ms. Fortlage's appeal – *i.e.*, until August 29, 2008 (based on the July 15 letter), or August 31, 2008 (based on the July 17 letter). Unum Life, however, did not decide the appeal until September 19, 2008. *See* AR 2755 (denial of appeal). Because Unum Life did not timely decide Ms. Fortlage's appeal, it did commit a procedural violation of ERISA.

Defendant argues there was no procedural violation. It contends that Unum Life did timely decide the appeal in compliance with ERISA, but this argument is based on the faulty premise that "the initial period for Unum [Life] to decide [the] appeal did not commence until July 2008." Docket No. 47 (Opp'n at 13). As noted above, on April 16, 2008, Unum Life began its review of the appeal. *See* AR 2022 (letter, dated 4/17/2008) (stating that "[w]e will begin our review of the file at this time"; also acknowledging that "[w]e hope to make a determination on your client's claim within 45 days, unless special circumstances extend the time needed to make the determination," and that, "[i]f there are special circumstances, we are committed to making a determination no later than 90 days from April 16, 2008"). It is true that, back on April 15, 2008, Ms. Fortlage stated to Unum Life that she would agree "that [its] time to begin reviewing this matter does not commence until the supplementary evidence and comment [*i.e.*, a medical report and functional capacity/vocational evaluation] has been submitted," AR 2025 (letter, dated 4/15/2008), but Unum Life did not take Ms. Fortlage up on that offer. Instead, it expressly stated that it was beginning its review of her appeal as of April 16, 2008. *See* AR 2022 (letter, dated 4/17/2008).

That there was a procedural violation of ERISA is not itself dispositive to the standard of review. As noted above, under Ninth Circuit law, it is only where the procedural irregularities are

"substantial" – *i.e.*, "so flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm" – that the standard of review is changed from abuse of discretion to *de novo*. *Abatie*, 458 F.3d at 971. "When an administrator can show that it has engaged in an ongoing, good faith exchange of information between the administrator and the claimant, the court should give the administrator's decision broad deference notwithstanding a minor irregularity." *Id.* at 972 (internal quotation marks omitted).

In the instant case, Unum Life's decision on the appeal was untimely, but only by about three weeks. Altogether, the appeal took only five months, approximately 150 days. *See Gatti v. Reliance Standard Life Ins. Co.,* 415 F.3d 978, 985 (9th Cir. 2005) (reversing district court's application of de novo review because, even though the claims administrator issued its decision 279 days after the claimant submitted her request for administrative review, violations of time limits were not so "flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm"). Moreover, during the entire claim process – including but not limited to the appeal – Unum Life was regularly in contact with Ms. Fortlage, and Ms. Fortlage was given the opportunity to provide additional information in support of her disability claim. *See, e.g.*, AR 1755-57 (letter, dated 6/7/2007) (obtaining medical records from new physician, Dr. Ziffer); AR 2431-36 (letter, dated 5/2/2008) (supplementing appeal). Also, once Ms. Fortlage asserted that Unum Life could make a decision on her appeal without the Social Security information, Unum Life promptly acted by sending out her file for a medical review. *See* AR 2660 (letter, dated 7/22/2008) (noting that "you do not want us to wait to obtain Ms. Fortlage's SS claim file" and "[t]herefore, we are proceeding with an expedited opthalmologist review of Ms. Fortlage's claim file as recommended by our medical consultant").

Therefore, the procedural irregularity was minor. The delay was not extreme. More importantly, Unum Life engaged in an ongoing dialogue with Ms. Fortlage during the process and responded with reasonable diligence and good faith. As the Ninth Circuit held in *Lamantia v. Voluntary Plan Adm'rs, Inc.*, 401 F.3d 1114 (9th Cir. 2005), "[a] deferential standard may apply to 'an administrator engaged in genuine, productive, ongoing dialogue that substantially complies with a plan's and the regulations' timelines.'" *Id.* at 1122; *see also Dyer v. Metropolitan Life Ins. Co.*,

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No. CV 07-2085 R (AJWx), 2008 U.S. Dist. LEXIS 82617, at *16-17 (C.D. Cal. Aug. 18, 2008) (indicating that defendant engaged in an ongoing, good faith exchange of information with plaintiff); *Riffey v. Hewlett-Packard Co. Disability Plan*, No. CIV. S-05-1331 FCD/JFM, 2007 U.S. Dist. LEXIS 21847, at *41 (E.D. Cal. Mar. 27, 2007) (stating that, "[w]hile VPA overran the applicable time limits, it was regularly in contact with plaintiff during all relevant times and can only be described as engaging in an ongoing, good faith exchange of information between [administrator] and [claimant]'").

This case contrasts with the facts in *Jebian v. Hewlett-Packard Co. Emple. Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1107 (9th Cir. 2003) where the procedural violations "were far from 'inconsequential,' . . . and there was no such 'ongoing, good faith exchange'" – *e.g.*, administrator failed to decide appeal within 60 days, failed to inform claimant that because of special circumstances it needed an additional 60 days, and ultimately did not request any further information from claimant "until the 119th day, one day short of the 120-day." *Cf. Cushman v. Motor Car Dealers Servs.*, No. CV 08-5284 SVW (CTx)2009 U.S. Dist. LEXIS 66098, at *23 (C.D. Cal. July 27, 2009) (concluding that defendant did not engage in a good faith exchange of information with plaintiff as demonstrated by the fact that defendant failed to respond to multiple communications sent by plaintiff following the benefits termination decision and denied plaintiff the standard procedures for pursuing an administrative appeal; but still applying an abuse of discretion standard – "tempered by a large amount of skepticism" – in spite of these problems).

In sum, there was no material procedural violation of ERISA warranting *de novo* review.

3. Administrative Exhaustion and Filing of Lawsuit

Finally, Ms. Fortlage argues that *de novo* review is required because she had exhausted her administrative remedies when she filed the instant lawsuit and the suit altered the substantive relationship between the parties. In support of this argument, Ms. Fortlage relies solely on an unpublished memorandum decision of the Ninth Circuit in *Neathery v. Chevron Texaco Corp. Group*, No. 07-56325, 2008 U.S. App. LEXIS 26106 (9th Cir. 2008).

As such, *Neathery* is not binding. In any event, as Defendant argues, *Neathery* does not support Ms. Fortlage's position because, in the opinion, the Ninth Circuit never addresses the issue

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1 of the proper standard of review. Rather, the court was simply addressing whether or not a medical
2 consultant review should have been included as part of the administrative record. *See id.* at *2-3.
3 B. Abuse of Discretion Standard of Review
4 For the foregoing reasons, the Court concludes that the proper standard of review is abuse of
5 discretion. The question is how that standard should be applied in the instant case. To answer the
6 question, the Court must first take into account that Unum Life, in acting as both the insurer and the
7 administrator of the plan, had a structural conflict of interest. *See Metropolitan Life Ins. Co. v.*
8 *Glenn*, 128 S. Ct. 2343, 2348 (2008) (stating that "a plan administrator [that] both evaluates claims
9 for benefits and pays benefits claims creates [a] 'conflict of interest'").
10 The Ninth Circuit has stated that, "[i]n the absence of a conflict, judicial review of a plan
11 administrator's benefits determination involves a straightforward application of the abuse of
12 discretion standard. In these circumstances, the plan administrator's decision can be upheld if it is
13 'grounded on any reasonable basis.'" *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933,
14 938-39 (9th Cir. 2009). If there, is however, a conflict of interest, then there is a "more complex"
15 abuse-of-discretion analysis. *Id.* at 939. More specifically, a court must take into account the
16 administrator's conflict of interest as one factor in determining whether there was an abuse of
17 discretion. *See id.* That is, the abuse-of-discretion review conducted by a court must be "informed
18 by the nature, extent, and effect on the decision-making process of any conflict of interest that may
19 appear in the record." *Abatie*, 458 F.3d at 967. A conflict of interest is only one among many
20 factors that must be considered in reviewing a plan administrator's decision for abuse of discretion.
21 *See Metropolitan Life*, 128 S. Ct. at 2352 (stating that, "when judges review the lawfulness of
22 benefit denials, they will often take account of several different considerations of which a conflict of
23 interest is one"). Other factors that may be considered include, *e.g.*, whether the plan administrator
24 engaged in a selective review of the record (*i.e.*, emphasizing medical reports that favor a denial of
25 benefits); whether the plan administrator took doctors' statements out of context or distorted them to
26 support a denial of benefits; whether the plan administrator failed to provide its independent
27 vocational and medical experts with all of the relevant evidence; whether the plan administrator
28 failed to engage in a meaningful dialogue with the plaintiff in deciding whether to award benefits;

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and whether the plan administrator committed a procedural violation. *See id.*; *see also Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 873 (9th Cir. 2008); *Abatie*, 458 F.3d at 972.

With respect to the conflict of interest, *Abatie* teaches that

> [t]he level of skepticism with which a court views a conflicted administrator's decision may be low if a structural conflict of interest is unaccompanied, for example, by any evidence of malice, of self-dealing, or of a parsimonious claims-granting history. A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record.

Id. at 968-69.

1. History of Claims Payment

Ms. Fortlage argues that the Court should look with much skepticism at Unum Life's benefits decision because Unum Life has a history of parsimonious claims payment. In support of this assertion, Ms. Fortlage cites *Saffon,* 522 F.3d at 863. *Saffon*, however, did not actually involve Unum Life or any other Unum entity directly. Rather, the insurer and plan administrator in *Saffon* was MetLife. The plaintiff in *Saffon* had argued that the court should disregard MetLife's discretionary authority because, *inter alia*, several states, including California, had revoked its certificate of insurance for the policy that the plaintiff had and the National Association of Insurance Commissioners was encouraging other states to do the same. *See Saffon*, 522 F.3d at 867. The Ninth Circuit noted that

> [t]his nationwide vote of no confidence seems to have been precipitated by the cupidity of one particular insurer, UnumProvident Corp., which boosted its profits by repeatedly denying benefits claims it knew to be valid. UnumProvident's internal memos revealed that the company's senior officers relied on ERISA's deferential standard of review to avoid detection and liability. *See* John H. Langbein, Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, 101 Nw. U. L. Rev. 1315, 1317-21 (2007) (describing UnumProvident's behavior).

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Id. Based on the law review referenced by the *Saffon* court, it appears that the questionable practices of UnumProvident took place in period from the late 1990's to the early 2000's – prior to 2004. *See* Langbein, 101 N.W. U. L. Rev. 1318-20. It also appears that the questionable practices were tied to UnumProvident's being headed by Harold Chandler, who "instituted cost-containment measures that pressured claims-processing employees to deny valid claims" until he was dismissed in 2003. *Id.* at 1319. Here, the challenged denial of benefits took place in 2006 and thereafter. Thus, there is nothing in the record here indicating the denial of Ms. Fortlage's claim was part of the earlier problems referenced in *Saffon*.

2. Procedural Violations

Ms. Fortlage argues that, nevertheless, Unum Life's benefits decision should still be viewed with a great deal of skepticism because the structural conflict of interest is accompanied by numerous procedural violations by Unum Life. Under ERISA, certain procedural requirements are imposed on employee benefit plans to protect plan participants. The relevant statute is 29 U.S.C. § 1133. It provides as follows:

> In accordance with regulations of the Secretary, every employee benefit plan shall --
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. Title 29 C.F.R. § 2560.503-1 is the regulation that expounds on § 1133.

The alleged procedural violations in the instant case are discussed below. For the reasons discussed below, the Court finds that there is only one procedural violation. That violation is not so egregious so as to require giving Unum Life's structural conflict of interest significant weight. In spite of the structural conflict of interest, there is little to show that the conflict played a causative role in Unum Life's decision to deny Ms. Fortlage's benefits. Therefore, so long as there is substantial evidence to support Unum Life's decision, there is no abuse of discretion. *See Hobson v.*

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Metropolitan Life Ins. Co., 574 F.3d 75, 79 (2d Cir. 2009) (noting that plaintiff did not establish that defendant was influenced by its structural conflict of interest and concluding that defendant did not abuse its discretion since, *inter alia*, substantial evidence supported its denial of benefits claim).

In the instant case, Ms. Fortlage charges Unum Life with having violated ERISA's procedural requirements in the following ways: (a) by never stating what evidence she needed to provide to reverse the initial decision denying benefits; (b) by adding a new reason for denial in the denial of the appeal that was not mentioned in the initial denial; (c) by relying on a report of a medical consultant, Dr. Berman, who was not given critical medical records (*i.e.*, the medical records from Dr. Reader and Dr. Paul, two treating sources); (d) by refusing to give a critical medical report (*i.e.*, a report by Dr. Carteron, a treating source) to its medical consultants and not following up on the results of a test mentioned in that report; and (e) by not giving her an opportunity to respond to the medical review of Dr. Berman. Each of the alleged procedural violations is discussed below.

a. Evidence Needed to Reverse Initial Denial

The regulation implementing § 1133 – *i.e.*, 29 C.F.R. § 2560.503-1 – provides in relevant part that, when a plan administrator notifies a claimant of any adverse benefit determination, then the notification must set forth, *inter alia*, "[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(g)(1)(iii). According to Ms. Fortlage, Unum Life failed to comply with § 2560.503-1(g)(1)(iii) because all that Unum Life said in the initial denial was the following: "If you have additional information to support your request for disability benefits, it must be sent to my attention for further review at the address noted on this letterhead . . . ." AR 1854 (initial denial, dated 8/22/2007).

There is some authority to support Ms. Fortlage's position. For example, in *Tinker v. Versata, Inc.*, 566 F. Supp. 2d 1158 (E.D. Cal. 2008), a district court concluded that the plan administrator had failed to comply with the regulation because "the termination letter merely stated that if Tinker had 'additional medical information' not mentioned in the letter or wished Continental to reconsider its decision then she should submit a formal request for reconsideration in writing

within 60 days." *Id.* at 1163. Similarly, in *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685 (7th Cir. 1992), the Seventh Circuit stated that "a blanket request for 'additional medical information' would not [satisfy] the regulatory requirements" – "[a] letter would have to specify the kind of additional medical information needed." *Id.* at 691.

However, there is contrary authority interpreting § 2560.503-1(g)(1)(iii). Most notably, in *Terry v. Bayer Corp.*, 145 F.3d 28 (1st Cir. 1998), the First Circuit explained as follows:

> [T]he regulations mandate that the administrator describe what is required to "perfect the claim." Terry has not convinced us that "perfect the claim" is synonymous with "win the appeal." Indeed, it would seem to us that in the instant case, neither Northwestern nor Bayer contended that Terry's claim was *deficient*. The decision was simply that the lack of objective findings, together with the failure to participate more fully in the hardening program, did not support a finding of total disability.

Id. at 39 (emphasis added). Other courts have likewise held that the insurer need only identify material needed to perfect the claim. *See Eppler v. Hartford Life & Accident Ins. Co.*, No. C 07-04696 WHA, 2008 U.S. Dist. LEXIS 9866, at *23 (N.D. Cal. Feb. 11, 2008) (noting that, "[b]ecause plaintiff did not need to send any additional material or information in order to perfect his claim, Hartford did not need to explain what further information was needed"); *Hall v. Baptist Healthcare Sys.*, No. 3:07-CV-292, 2007 U.S. Dist. LEXIS 78243, at *9 (W.D. Ky. Oct. 22, 2007) (accepting defendant's argument that it did not request more information because none was needed); *Kaiser v. Standard Ins. Co.*, No. C-05-4284 SC, 2007 U.S. Dist. LEXIS 2239, at *16-17 (N.D. Cal. Jan. 11, 2007) (noting that "[t]he problem with Plaintiff's claim was not that he had failed to submit a key document to qualify for coverage or appeal, it was that he did not have sufficient evidence to convince Standard that he was disabled and could not return to work").

The Ninth Circuit has not expressly endorsed the latter approach. However, in *Booton v. Lockheed*, 110 F.3d 1461 (9th Cir. 1997), the Ninth Circuit commented:

> ERISA plan administrators do not have unbounded discretion. Under federal law, an ERISA plan "shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant: (1) The specific reason or reasons for the denial; (2) Specific reference to pertinent plan provisions on which the denial is based; (3) A description of any additional material or information necessary for the claimant *to perfect*

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> *the claim* and an explanation of why such material or information is necessary; and (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review." In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial; *if the plan administrators believe that more information is needed to make a reasoned decision*, they must ask for it. There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.

Id. at 1463 (emphasis added). *Booton* concluded that, under the facts of the case, the plan administrator had not complied with the regulation.

> Aetna's conduct in handling Booton's claim did not comply with this common sense standard; not close. Aetna's rejection letters . . . denied benefits without a rational explanation, without even acknowledging Booton's argument that her back teeth needed work on account of the injury to her front teeth. Worse, Dr. Herod [Aetna's consulting dentist] advised Aetna that more information (such as pre-accident X-rays) might help Booton substantiate her claim, but the plan administrator failed to ask for it. Dr. Herod also asserted that "none of the[] documents [forwarded by Booton's dentists] explains why Mrs. Booton's accident required treatment to her back teeth." The record shows that plaintiff's dentists were ready and able to explain their work but no one at Aetna sought their explanations.
>
> Lacking necessary -- and easily obtainable -- information, Aetna made its decision blindfolded.
>
> . . . .
>
> Had Aetna requested the needed information and offered a rational reason for its denial, it would be entitled to substantial deference. But to deny the claim without explanation and without obtaining relevant information is an abuse of discretion.

Id. at 1463-64; *see also Montour*, 582 F.3d at 946 (noting that "regulations promulgated by the Secretary of Labor authorize, if not require, plan administrators working with an apparently deficient administrative record to inform claimants of the deficiency and to provide them with an opportunity to resolve the problem by furnishing the missing information").

Consistent with *Terry*, *Booton* suggests that if there is information the insurer needs from the claimant to "perfect the claim" or which the insurer knows is needed to make a reasoned decision, it must so inform the claimant. Under this approach, it does not appear that, in the instant case, there was any information that Unum Life believed was missing in order to perfect the claim or for it to

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make a reasoned decision. Rather, Unum Life considered a large body of medical evidence submitted by Ms. Fortlage and generated by its medical review in reaching its conclusion that the medical conditions were either pre-existing or not disabling. *See* AR 1854 (initial denial, dated 8/22/2007). There is no indication that any particular additional information was needed to make a reasoned decision. Thus, Unum Life did not have to describe to Ms. Fortlage what additional information was needed. There was no violation of § 2560.503-1(g)(1)(iii).

Even if a more restrictive approach were applied and a violation of the regulation were found, substantial compliance with the regulation is all that is required. *See Chuck*, 455 F.3d at 1032. The critical issue in determining whether there is substantial compliance is whether the claimant had a sufficiently clear understanding of the administrator's position to permit effective review. *See Brogan v. Holland*, 105 F.3d 158, 165 (9th Cir. 1997); *Terry*, 145 F.3d at 39; *Gravelle v. Health Net Life Ins. Co.*, No. C 08-04653 MHP, 2009 U.S. Dist. LEXIS 4929, at *23 (N.D. Cal. Jan. 26, 2009). In *Terry*, the First Circuit concluded that the claimant did have a sufficiently clear understanding as reflected by the fact that "[h]e submitted additional medical and vocational information to the Benefit Committee which directly addressed the question whether he was disabled from performing 'any' job. His actions demonstrate that he was well aware of the reasons for the decision, and was submitting additional evidence on the crucial point." *Terry*, 145 F.3d at 39.

As in *Terry*, Ms. Fortlage's own actions establish that she had a sufficiently clear understanding of Unum Life's position to permit an effective review. In her initial appeal, Ms. Fortlage acknowledged that, in its termination letter, "Unum [Life] essentially claimed that [she] was either disabled from a pre-existing condition, or that her condition was not disabling at all." AR 2025 (letter, dated 4/15/2008); *see also* AR 1854 (initial denial) (stating that, "[a]s your conditions are either pre-existing or would not preclude you from your own occupation, no more benefits will be paid and your claim will be closed effective August 12, "). She also acknowledged that the purported pre-existing conditions were "her childhood strabismus surgery, anxiety or panic attacks and irritable bowel syndrome." AR 2026. So informed, she was afforded a full opportunity to respond and seek to supplement the record through the administrative process.

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Accordingly, the Court concludes that no procedural violation occurred with respect to § 2650.503-1(g)(1)(iii).

b. New Reason for Denial

The Ninth Circuit has specifically held that a procedural violation takes place when a plan "administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level." *Abatie*, 458 F.3d at 974; *see also Burke v. Pitney Bowes Inc. Long-Term Disability Plan*, 544 F.3d 1016, 1028 (9th Cir. 2008) (noting that "there is some evidence of procedural irregularities, as the Committee considered a basis for terminating her benefits on appeal that was not part of the Plan's initial decision to terminate her benefits"). According to Ms. Fortlage, that is what happened in the instant case. More specifically, Ms. Fortlage claims that, in its initial denial, Unum Life concluded that she did have neurocardiogenic syncope but found that it was not disabling; in its denial of the appeal, Unum Life "changed its position and had a new in-house medical reviewer, Dr. Doane, opine that [her] Neurocardiogenic Syncope was a 'pre-existing' condition." Docket No. 38 (Pl.'s Mot. at 17).

The Court must examine what was stated in the initial denial. In the initial denial, Unum Life did not address the specific impairment of neurocardiogenic syncope. It did state, however, as follows:

- "In Dr. Penrose's attending physician's statement dated March 17, 2006, she had provided a diagnosis of *Syncope and Chest Pain*." AR 1850 (initial denial, dated 8/22/2007) (emphasis added).
- "In our initial medical review of your medical records on file, it appears that there was no objective evidence for significant physiologic cause but appeared that *anxiety and panic attacks were the ongoing problem*. It appears that you have a history of psychiatric treatment for depression and anxiety . . . . The conditions of depression and anxiety would be pre-existing and not be covered under this policy." AR 1851 (emphasis added).
- "We had talked on February 28, 2007 stating that you may require a pacemaker and were referred to a cardiologist, Dr. Paul Zei, due to lesions in your heart. You had also notified us that you were seeing a Dr. Dubey at Stanford Hospital for celiac disease [intestinal disorder].

[¶] Our onsite physician contacted both Dr. Zei and Dr. Dubey to further evaluate any impairment there may be from these conditions. A letter was sent to both doctors to confirm any restrictions you may have. *Both Dr. Zei and Dr. Dubey signed the letter and agreed that you may return to work with [certain] restrictions and limitations* . . . ." AR 1853 (emphasis added).

- "Note that the conditions of bowel, anorectal symptoms, urinary urgency/frequency, vaginal symptoms, anxiety, depression, and diplopia are pre-existing conditions and not covered under your policy. Your doctors had released you to return to work with restrictions that would not preclude you from your occupation for any cardiac condition or celiac disease." AR 1854 (emphasis added).
- "As your conditions are either pre-existing *or* would not preclude you from your own occupation no more benefits will be paid and your claim will be closed effective August 12, 2007." AR 1854 (emphasis added).

In sum, the initial denial did indicate that any syncope was not disabling because the treating doctors had stated that she could return to work with certain restrictions or limitations. The initial denial also concluded that the syncope was pre-existing, noting that the initial medical review indicated that the syncope was related to Ms. Fortlage's anxiety which was pre-existing. Furthermore, the concluding sentence, as noted above, was that Ms. Fortlage's conditions were either pre-existing *or* not disabling.

The denial of the appeal was consistent with the initial denial. It stated that

> the visual and neurocardiogenic conditions for which [Ms. Fortlage] is claiming disability are considered pre-existing. In addition, even if these conditions were not considered pre-existing, the restrictions and limitations given by our consultant of the use of prism glasses as needed and caution in sudden position changes would not prevent her from performing her own sedentary occupation. Further, the restrictions and limitations that Dr. Zei gave on March 29, 2007 of no rapid position changes, no prolonged fixed positions, no frequent bending below waist, the opportunity to wear compression stockings, regular access to fluids and avoid driving and unprotected heights when feeling dizzy or lightheaded also would not preclude Ms. Fortlage from performing her own occupation.

AR 2759 (denial of appeal, dated 9/19/2008).

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Hence, both the initial denial and denial of the appeal concluded her conditions were either pre-existing or not disabling. Because there is no inconsistency between the initial denial and the denial of the appeal, the Court rejects Ms. Fortlage's contention that Unum Life, in the denial of the appeal, tacked on a new reason for denial. To the extent Ms. Fortlage argues that the reasons for the initial denial were not sufficiently clear, this argument should also be rejected. While the initial denial was not the model of clarity, the reasons for denial were reasonably clear. *See Booton*, 110 F.3d at 1463 (stating that, "[i]f benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language").

c. Whether Dr. Berman Was Furnished with Medical Records From Dr. Reader and Dr. Paul

As noted above, § 1133(2) requires that a participant in an employee benefit plan be given a full and fair review. *See* 28 U.S.C. § 1133(2). Ms. Fortlage asserts that she denied a full and fair review because Unum Life's medical consultant, Dr. Berman, was not given critical medical records – namely, the medical records from Dr. Reader and Dr. Paul, two of her treating sources. The problem with this contention is that Dr. Berman's own report reflects that he was given these very records. *See* AR 2694 (Dr. Berman's report) (listing records from both Dr. Reader and Dr. Paul). Accordingly, there was no procedural violation here.

d. Consideration of Dr. Carteron's June 2008 Report

Ms. Fortlage argues that she was denied a full and fair review as required by § 1133(2) because Unum Life's appeals adjuster made the decision that she would not provide a copy of a critical medical report to Unum Life's medical department for review. The report at issue is a reported dated June 2008 and written by Dr. Carteron.

Dr. Carteron is a physician certified in rheumatology and internal medicine. *See* AR 2633 (Dr. Carteron's June 2008 report). In June 2008, she prepared a report based on a physical evaluation of Ms. Fortlage. It appears that Dr. Carteron evaluated Ms. Fortlage pursuant to a referral by another doctor (Dr. Reader). *See* AR 2633. In the report, Dr. Carteron diagnosed, *inter alia*, multi-system inflammatory autoimmune disorder and ocular myasthenia gravis. *See* AR 2633.

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Ms. Fortlage submitted Dr. Carteron's report to Unum Life in June 2008 while her appeal was pending. However, the adjuster working on the appeal, Ms. Tetrault, did not provide a copy of the report to Unum Life's medical consultants for review. Her file notes state: "The report from Dr. Carteron dated 6/5/08 that we received on 6/9/08 will not be referred to our medical dept. for review as the time period in question is the claimant's condition as of 6/06, approximately two years prior to this first visit with Dr. Carteron."[13] AR 2635 (Unum file notes, dated 6/17/2008).

As Ms. Fortlage argues, the appeals adjuster's decision not to refer Dr. Carteron's report was a procedural violation. The determination of whether or not the report was relevant should have been made by a health care professional, not the adjuster. Section 2560.503-1(h)(3)(iii) provides that, as part of a full and fair review, the claims procedures of an employee benefit plan must

> [p]rovide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, . . . the appropriate named fiduciary shall consult with a *health care professional* who has appropriate training and experience in the field of medicine involved in the medical judgment.

29 C.F.R. § 2560.503-1(h)(3)(iii) (emphasis added).

Furthermore, case law in the Social Security as well as the ERISA context indicates that a retrospective diagnosis – even one made years after the onset of the alleged impairment – may be relevant. As the Ninth Circuit noted in *Smith v. Bowen*, 849 F.2d 1222 (9th Cir. 1988), "reports containing observations made after the period for disability are relevant to assess the claimant's disability[;] [i]t is obvious that medical reports are inevitably rendered retrospectively and should not be disregarded solely on that basis." *Id.* at 1225; *see also Boyd v. Heckler*, 704 F.2d 1207, 1211 (11th Cir. 1983) (concluding that, even though a doctor did not examine the claimant until two years after the expiration of her insured status and then rendered an opinion about an injury which occurred five years earlier, that did "render his medical opinion incompetent or irrelevant to the

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[13] The adjuster incorrectly stated that this was Ms. Fortlage's first visit with Dr. Carteron. In fact, Ms. Fortlage had submitted a report from Dr. Carteron as part of her initial appeal. *See* AR 2027 (letter, dated 4/15/2008) (referring to Dr. Carteron's medical records); AR 2303-71 (Dr. Carteron's medical records). That earlier report – dated February 2008 – indicated that Dr. Reader had referred Ms. Fortlage to Dr. Carteron "to exclude additional autoimmune dysfunction." AR 2317 (Dr. Carteron's February 2008 report). At that time, Dr. Carteron ruled out, *inter alia*, "other Autoimmune process." AR 2317. As Ms. Fortlage points out, it does not appear that the appeals adjuster rejected this report, even though it was only a few months older than the June 2008 report.

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decision in this case"), *superseded by statute on other grounds*, *Landry v. Heckler*, 782 F.2d 1551, 1553 (11th Cir. 1986); *Fontana v. Guardian Life Ins.*, No. C08-1231 CRB, 2009 U.S. Dist. LEXIS 3303, at *10 (N.D. Cal. Jan. 12, 2009) (stating that medical reports made after a period of disability may or may not be relevant to determine if the beneficiary was disabled at an earlier date but they are not irrelevant solely because of their date); *Allenby v. Westaff, Inc.*, No. C 04-2423 TEH, 2006 U.S. Dist. LEXIS 92568, at *11-12 (N.D. Cal. Dec. 12, 2006) (noting that defendants failed to cite authority for the proposition that a court must ignore later diagnosis because it was not contemporaneously made with the date of the claimed disability; such a rule would penalize anyone not properly diagnosed by the initial treating physician); *Thompson v. Standard Ins. Co.*, 167 F. Supp. 2d 1186, 1194 (D. Or. 2001) (stating that "'the fact that a diagnosis is not made contemporaneously within the period that a claimant is insured does not undercut the viability of a later diagnosis" and that "'[a] diagnosis of plaintiff's condition may properly be made several years subsequent to the onset of the disability'"), *overruled on other grounds*, *Disanto v. Wells Fargo & Co.*, No. 8:05-CV-1031-T-27MSS, 2007 U.S. Dist. LEXIS 62781, at *29-30 (M.D. Fla. Aug. 24, 2007). Thus, for example, if a doctor's report specifically states that a diagnosis is applicable to an earlier time period, or if a doctor's report refers to symptoms that also occurred during the earlier time period, the report is likely relevant. *See Fontana*, 2009 U.S. Dist. LEXIS 3303, at *10-11; *Gecevic v. Secretary of Health & Human Servs.*, 882 F. Supp. 278, 286-87 (E.D.N.Y. 1995). *See generally Aplet v. Secretary of Health & Hum. Servs.*, No. 92-1060, 1992 U.S. App. LEXIS 32086, at *9-10 (6th Cir. No. 24, 1992) (stating that "[e]vidence and diagnoses compiled years later are admissible and relevant to a determination of disability before the expiration of the individual's insured status if that evidence relates back to the relevant period.").

In the instant case, Dr. Carteron's June 2008 report did not expressly state that her diagnosis of, *inter alia*, multi-system inflammatory autoimmune disorder and ocular myasthenia gravis related back two years earlier to the alleged onset date of the disability. *See* AR 2633-34 (Dr. Carteron's June 2008 report). However, as far back as August 2006 (*i.e.*, close to the alleged onset date of the alleged disability), one of Ms. Fortlage's treating physicians speculated that myasthenia gravis was the problem. *See* AR 1514-55 (Dr. Dubey's notes, dated 8/14/2006). Thus, there was at least a

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plausible basis that Dr. Carteron's June 2008 report was relevant since it also addressed myasthenia gravis. Moreover, in her discussion of multi-inflammatory autoimmune disorder, Dr. Carteron referred to cardiogenic syncopy – one of the same symptoms that had occurred at the time of the alleged onset date of the asserted disability. This provided a further basis for relevance. At the very least, Unum Life could have solicited additional information from Dr. Carteron to determine how retrospective her diagnosis was. It is worth noting that Unum Life did not reject Dr. Carteron's earlier report of February 2008 (submitted as part of the initial appeal), even though it was only a few months older than the June 2008 report. There was no substantial basis for rejecting outright Dr. Carteron's June 2008 report.

In short, the Court concludes that there was a procedural violation because Unum Life's appeals adjuster decided not to pass on Dr. Carteron's June 2008 report to Unum Life's medical department for review.

e. Opportunity to Respond to Dr. Berman's Report

Finally, Ms. Fortlage asserts that Unum Life violated ERISA's procedural requirements by not giving her a copy of the report issued by Dr. Berman, Unum Life's medical consultant, thus also depriving her of the opportunity to respond to the report before her appeal was decided. (After the appeal was decided, Ms. Fortlage obtained a new diagnosis from Dr. Carteron – *i.e.*, a diagnosis of Sjogren's disease.) Ms. Fortlage points out that, under § 2560.503-1(h)(2)(iii), a claimant must be "provided, upon request . . . , reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." 29 C.F.R. § 2560.503-1(h)(2)(iii). Relevant information is defined in § 2560.503-1(m)(8) as, *inter alia*, information that "[w]as relied upon in making the benefit determination" or that "[w]as submitted, considered, or generated in the course of making the benefit determination." *Id.* § 2560.503-1(m)(8).

There are both legal and factual problems with Ms. Fortlage's position. With respect to the law, most courts have held that § 2560.503-1(h)(2)(iii) does not require a plan administrator to provide a medical review conducted as part of the appeal process prior to the administrator's final decision on appeal. For example, in *Metzger v. Unum Life Insurance Co. of America*, 476 F.3d 1161 (10th Cir. 2007), the plaintiff had, during the appeal, requested that the plan administrator provide

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copies of any new expert reports prior to its final decision on the appeal. The plan administrator did not do so, giving the medical reviews to the plaintiff only after it denied the appeal. *See id.* at 1164. The district court held that § 2560.503-1(h)(2)(iii) "requires a plan administrator to release only documents relied upon during the *initial benefit determination* prior to its final decision on the appeal. . . . [D]ocuments generated during the *appeal process itself* need be made available only after the decision on appeal." *Id.* at 1166 (emphasis in original). The Tenth Circuit agreed, explaining:

> Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal – even when those reports contain no new factual information and deny benefits on the same basis as the initial decision – would set up an unnecessary cycle of submission, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which, under the regulations, should normally be completed within 45 days.

Id.

The Tenth Circuit went on to note that its conclusion was also supported by the Department of Labor's description of the 2000 amendments to the regulation.

> In explaining its decision to adopt subsection (m)(8) [which defines what is relevant information], the Department stated that it "believes that this specification of the scope of the required disclosure of 'relevant' documents will serve the interests of both claimants and plans by providing clarity as to plans' disclosure obligations, *while providing claimants with adequate access to the information necessary to determine whether to pursue further appeal*." [Plaintiff's] position – that claimants be given pre-decision access to relevant documents generated during the administrative appeal – would nullify the Department's explanation. Access to documents during the course of an administrative decision would not aid claimants in determining "whether to pursue further appeal," because claimants would not yet know if they faced an adverse decision.

Id. at 1167 (emphasis in original) (quoting 65 Fed. Reg. 70,246, at 70,252 (Nov. 21, 2000)).

The Tenth Circuit summarized its holding:

> [S]ubsection (h)(2)(iii) does not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal. Instead, the regulations mandate provision of relevant documents, including medical opinion reports, at two discrete stages of the administrative process. First, relevant documents generated or relied upon during the initial claims determination must be disclosed prior to or at the outset of an administrative appeal [pursuant to subsection (h)(2)(iii)]. Second,

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> relevant documents generated during the administrative appeal – along with the claimant's file from the initial determination – must be disclosed after a final decision on appeal [pursuant to subsection (i)(5)]. So long as appeals-level reports analyze evidence already known to the claimant and contain no new factual information or novel diagnoses, this two-phrase disclosure is consistent with "full and fair review."

Id.

In *Glazer v. Reliance Standard Life Insurance Co.*, 524 F.3d 1241 (11th Cir. 2008), the Eleventh Circuit relied on *Metzger* in reaching the same conclusion. *See id.* at 1245-46. The court also noted that the plaintiff's argument that she was entitled to medical reviews during the pendency of the appeal was

> contrary to the plain text of the regulations. Subsection (h)(2)(iii) requires the plan administrator to produce all "relevant" documents. [Under subsection (m)(8),] [a] document is relevant if it "[w]as relied upon" or "[w]as submitted, considered, or generated in the course of making the benefit determination." [Here, the plan administrator] had not "relied upon" the [medical consultant's] report or used the report "in the course of making the benefit determination" until the determination had been made. After [the plan administrator] reached its final decision, all relevant documents generated during the review and initial claim determination had to be produced to the claimant [pursuant to subsection (i)(5)]. This requirement would be superfluous if the claimant had a right to the documents during the pendency of the review.

Id. at 1245.

Finally, in *Midgett v. Washington Group International Long Term Disability Plan*, 561 F.3d 887 (8th Cir. 2009), the Eighth Circuit also held the same as the Tenth and Eleventh Circuits. The Eighth Circuit essentially made the same point as the Eleventh Circuit, noting the difference between subsections (h) and (i) of the regulation.

> Section 2560.503-1(h) of the amended regulations is entitled "Appeal of adverse benefit determinations." Section 2560.503-1(h)(1) requires employee benefit plans to "establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination." Under § 2560.503-1(h)(2)(iii), a plan only provides a claimant with a full and fair review of a claim and adverse benefit determination if "the claims procedures . . . [p]rovide that [the] claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." The "adverse benefit determination" referred to throughout § 2460.503-1(h) is the plan administrator's initial denial of a claim for benefits. Accordingly, following an initial denial of a claim for benefits, §

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> 2560.503-1(h)(2)(iii) entitles a claimant to review the materials relevant to his or her claim. . . .
>
> Section 2560.503-1(i) of the amended regulations sets forth the time limits within which a claimant must be notified of a "benefit determination *on review*." Section 2560.503-1(i)(5) provides as follows: "In the case of an adverse benefit determination *on review*, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate." Section 2560.503-1(j)(3), in turn, refers to "all documents, records and other information relevant to the claimant's claim for benefits." "The inclusion of the language 'on review' [in § 2560.503-1(i)(5)] differentiates the initial 'adverse benefit determination' from later internal appeals of it." Accordingly, following a denial of a first-level or second-level appeal, § 2560.503-1(i)(5) entitles a claimant to review the materials relevant to his or her claim on appeal.

Id. at 894-95. The Eighth Circuit also found it significant that § 2560.503-1(h)(3)(iii) required a plan administrator to consult with a health care professional but did not require that a "claimant be given the opportunity to review and rebut the health care professional's conclusion." *Id.* at 896.

The only court that has ruled to the contrary is the Central District of California. *See Russo v. Hartford Life & Acc. Ins. Co.*, No. 00-938-LSP (CGA), 2002 U.S. Dist. LEXIS 26566 (C.D. Cal. Feb. 5, 2002). There, the court concluded that the plan administrator had a duty to produce all pertinent documents, regardless of whether they were generated prior or subsequent to the initial benefit determination. It stated that "[d]enying a claimant access to information that is generated after an initial denial, but is subsequently relied upon by the administrator in reviewing the claim on appeal, effectively denies the claimant with a full and fair review." *Id.* at *14-15. Significantly, however, the court was addressing the interpretation of the 1977 regulation, not the 2000 regulation. *See id.* at *13 n.6 (expressly stating that the order addressed only the interpretation of the 1977 regulation). In *Midgett*, the Eighth Circuit specifically took note that, in an earlier case involving the 1977 regulation, it had required a plan administrator to provide a medical report to the claimant during the appeal process and prior to a decision on the appeal. *See Midgett*, 561 F.3d at 893-94. The Eighth Circuit pointed out that there were material differences between the 1977 and 2000 regulations. Most notably, the 1977 regulatory scheme did not specify when a claimant was entitled to review pertinent documents. The 2000 regulation, however, "set forth specific stages in the claims process at which a claimant is entitled to review the materials 'relevant' to his or her claim."

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Id. at 894. Accordingly, under the 2000 regulation, the Eighth Circuit concluded that a plan administrator did not have to provide a claimant with appeals-level medical reviews until after the decision on appeal was final. *Russo* is therefore of limited value here.

Even if the Court was not inclined to agree with circuit cases discussed above, there are, as noted above, factual problems with Ms. Fortlage's position. A brief recitation of the relevant facts should be helpful. As noted above, Ms. Fortlage submitted her appeal on April 15, 2008. *See* AR 2025 (letter, dated 4/15/2008). In the appeal, Ms. Fortlage reserved the right to supplement the appeal because she was still awaiting receipt of "a central medical report and Functional Capacity/Vocational Evaluation requested approximately 6 weeks ago." AR 2025.

Some two weeks later, on May 2, 2008, Ms. Fortlage did in fact supplement her appeal, providing Unum Life with, among other things the "central medical report" and the Functional Capacity/Vocational Evaluation. *See* AR 2431 (letter, dated 5/2/2008). At the conclusion of letter, Ms. Fortlage stated: "*If Unum obtains any medical opinion or evaluation of the evidence provided in this Appeal, we request an opportunity to review and respond to that medical evaluation before Unum makes any decision on this Appeal.*" AR 2436 (emphasis added).

Subsequently, on July 22, 2008, after the parties could not agree on tolling in order for Unum Life to obtain the Social Security claim file, Unum Life's adjuster informed Ms. Fortlage that, because she did not want it to wait for the Social Security claim file, "we are proceeding with an expedited ophthalmologist review of Ms. Fortlage's [disability] claim file as recommended by our medical consultant [*i.e.*, Dr. Berman]." AR 2660 (letter, dated 7/22/2008). Ms. Fortlage did not respond to this letter. She did not, for example, ask for a copy of the report once completed.

The medical review was then conducted, and Unum Life was given a copy of Dr. Berman's report on August 12, 2008. *See* AR 2693-95 (Dr. Berman's report). On August 18, 2008, Unum Life's adjuster asked for another medical consultation in order "to clarify my understanding of Dr. Berman's review." AR 2720 (Unum Life file note, dated 8/18/2008). Dr. Doane responded two days later. *See* AR 2720.

Thereafter, on August 22, 2008, Unum Life's adjuster sent to Mr. Fortlage a letter updating her on the status of the appeal. The adjuster stated: "We are in the process of completing our review

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of Ms. Fortlage's appeal. When we have completed our review we will send you our final determination in writing." AR 2724 (letter, dated 8/22/2008). Again, Ms. Fortlage did not respond to this letter. She did not ask for a copy of the medical review nor she did she ask for an opportunity to respond to the review.

Approximately a month later, Unum Life issued its decision, denying Ms. Fortlage's appeal. *See* AR 2755 (letter, dated 9/19/2008).

Ms. Fortlage's position is that, because she requested back in May 2008 that she be given an opportunity to respond to any medical evaluation conducted by Unum Life, Unum Life's failure to give her a copy of Dr. Berman's August 2008 report and its failure to extend the opportunity to respond to the report prior to its decision on the appeal were improper. However, as indicated above, Ms. Fortlage's position is weakened by the fact that she made the request well before the Dr. Berman report was ever contemplated by Unum Life. Even when Unum Life informed her of the medical review and later informed her that a review of her appeal was almost completed, she did not thereafter ask for any copy or an opportunity to respond.

In sum, both as a legal and a factual matter, there was no procedural violation by Unum Life when it failed to give her a copy of Dr. Berman's report and provide her with an opportunity to respond.

f. Summary

In sum, although Ms. Fortlage has asserted a number of procedural violations, the Court concludes that there was only one such violation – *i.e.*, when the Unum Life appeals adjuster decided that Dr. Carteron's June 2008 report should not be referred to the medical department for review. As noted above, the Court concludes that it is appropriate to apply the abuse of discretion standard in spite of this procedural violation. This violation was the sole procedural error in the case and was neither flagrant nor egregious, particularly when placed in context of the large body of evidence considered by Unum Life. The one procedural error of excluding Dr. Carteron's June 2008 report did not establish a pattern of selective review of the record, distortion of doctor's statements, or failure to engage in a meaningful dialogue with the Ms. Fortlage. *See Metropolitan Life*, 128 S.

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1 Ct. at 2352 ; *Saffon*, 522 F.3d at 873; *Abatie*, 458 F.3d at 972 (all discussing some of the other
2 factors that inform the scope of review).
3 C. Remand
4 While the procedural violation discussed above does not alter the standard of review, it does
5 have two implications. First, the Court must expand the administrator record to include that report.
6 *See Abatie*, 458 F.3d at 972-73 (noting that, even when the standard of review is abuse of discretion,
7 a court may take additional evidence when the procedural irregularities have prevented full
8 development of the administrative record). Second, the Court must decide whether the case should
9 be remanded to the plan administrator in light of the new evidence or whether, instead, the Court
10 should decide for itself whether the denial of benefits was proper itself based on all the evidence of
11 record, including the new evidence.
12 Numerous courts have held that, where a plan participant is in fact denied a full and fair
13 review because of procedural violations, the court may remand the matter to the plan administrator.
14 For instance, in *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 157-58 (5th Cir. 2009), the
15 court stated that "[r]emand to the plan administrator for full and fair review is usually the
16 appropriate remedy when the administrator fails to substantially comply with the procedural
17 requirements of ERISA" because "procedural violations of ERISA generally do not give rise to a
18 substantive damages remedy" and that, "[w]hen the procedural violations are non-flagrant, remand is
19 typically preferred over a substantive remedy to which the claimant might not otherwise be entitled
20 under the terms of the plan"). *See Shelby County Health Care Corp. v. Majestic Star Casino, LLC*
21 *Group Health Ben. Plan*, 581 F.3d 355, 373 (6th Cir. 2009) (stating that remand is appropriate
22 "particularly where the plan administrator's decision suffers from a procedural defect or the
23 administrative record is factually incomplete"); *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614,
24 630 (2d Cir. 2008) (stating that "[a] full and fair review concerns a beneficiary's procedural rights,
25 for which the typical remedy is remand for further administrative review"); *Gagliano v. Reliance*
26 *Std. Life Ins. Co.*, 547 F.3d 230, 240 (4th Cir. 2008) (stating that, "'[n]ormally, where the plan
27 administrator has failed to comply with ERISA's procedural guidelines and the plaintiff/participant
28 has preserved his objection to the plan administrator's non-compliance, the proper course of action

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for the court is remand to the plan administrator for a "full and fair review""")); *Walsh v. Metropolitan Life Ins. Co.*, No. 3:06-1099, 2009 U.S. Dist. LEXIS 17810, at *27 (M.D. Tenn. Mar. 9, 2009) (stating that "a district court should review new evidence and determine an ERISA plaintiff's claim only where a plan administrator has violated § 1133 and shown itself incapable of protecting the plaintiff's procedural rights"). *Cf. Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002) (stating that "[t]he remedy when an ERISA administrator fails to make adequate findings or to explain adequately the grounds of her decision is to remand the case to the administrator for further findings or explanation"); *Walters v. Prudential Ins. Co. of Am.*, No. 06-CV-20-LRR, 2007 U.S. Dist. LEXIS 92831, at *53-55 (N.D. Iowa Decl. 18, 2007) (finding, in a case where the administrator failed to consider the opinions of two doctors that it was "appropriate to remand this matter to Prudential for further consideration and discussion" of the opinions); *Finley v. Hartford Life & Acc. Ins. Co.*, No. C 06-6247 CW, 2007 U.S. Dist. LEXIS 91950, at *27 (N.D. Cal. Dec. 14, 2007) (after finding that the plan administrator had not adequately considered all evidence in the record before denying plaintiff's claims, remanding for further proceedings).

The Ninth Circuit's approach is generally in accord. In *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026 (9th Cir. 2006), the court held that "the usual remedy for a violation of § 1133 is 'to remand to the plan administrator so the claimant gets the benefit of a full and fair review.'" *Id.* at 1035. But the Ninth Circuit has also indicated that a trial court has the authority to consider the new evidence itself – *i.e.*, not to remand.[14] *See Saffon*, 522 F.3d at 872 n.2 (rejecting defendant's argument that the district court is forbidden from hearing additional evidence).

In the instant case, the Court concludes that a remand is not necessary. At best, the June 2008 report of Dr. Carteron, which found, *inter alia*, a multi-system inflammatory autoimmune disorder responsible for the cardiogenic syncopy, might affect the conclusion that Ms. Fortlage's conditions were pre-existing. Dr. Carteron's diagnosis, if correct, would establish that Ms. Fortlage's conditions were attributable to a new disease (*i.e.,* an autoimmune disorder rather than

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[14] The court has further noted that, where the parties submit significant new evidence to the court, "it may be impossible for the court to grant *any* deference to the decision of the claims administrator, as that decision will perforce have been made without taking into account the new evidence." *Saffon*, 522 F.3d at 873-74 (emphasis in original).

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pre-existing anxiety causing her cardiogenic syncopy) for which she had not been treated during the look back period.

But, as noted above, Unum Life denied benefits also because it found that Ms. Fortlage's symptoms did not prevent her from working with reasonable restrictions and limitations. While Ms. Fortlage focuses on the new diagnosis of Sjogren's as a cause of her symptoms, she fails to show how this diagnosis would alter Unum Life's conclusion that those impairments were not disabling. The same exact symptoms and the correlative restrictions and limitations allowing her to work would obtain even if the new diagnosis were accepted. In short, the new diagnosis is immaterial to the independent basis of Unum Life's denial – that Ms. Fortlage was not disabled under the policy. Hence, remand would serve no purpose, and the Court shall decide for itself whether the denial of benefits was proper itself based on all the evidence of record, including the new evidence.

D. Abuse of Discretion Analysis

As a preliminary matter, the Court notes that, although it reviews Unum Life's conclusion that Ms. Fortlage's symptoms were not disabling for an abuse of discretion, the fact that new evidence is being considered (Dr. Carteron's June 2008 report) does as a practical matter has some effect on the level of deference that the Court may accord to Unum Life's decision. *See,* e.g., *Saffon*, 522 F.3d at 873-74 (noting that, where the parties submit significant new evidence to the court, "it may be impossible for the court to grant *any* deference to the decision of the claims administrator, as that decision will perforce have been made without taking into account the new evidence") (emphasis in original). But the effect is largely minimal since, as noted above, there is nothing to indicate that Dr. Carteron's new diagnosis in June 2008 had any impact on what Ms. Fortlage's ability to work was.

The Court concludes that, even if Dr. Carteron's 2008 report is taken into consideration, Unum Life did not abuse its discretion in denying Ms. Fortlage's claim because there was substantial, indeed nearly unrebutted evidence, that even with the medical condition diagnosed by Dr. Carteron, Ms. Fortlage was not disabled within the meaning of the policy. In fact, the Court would reach the same conclusion even if it were to review the record *de novo*.

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The diplopia that Ms. Fortlage suffered could be, as Dr. Berman concluded, addressed with prism glasses, surgery, or even the mere occlusion of one eye. *See* AR 2695 (Dr. Berman's report). There is no evidence in the record that the diagnosis of either an autoimmune disorder or ocular myasthenia gravis would change that conclusion.[15] While Ms. Fortlage contends that Dr. Berman's report fails to take into account the fact that her right eye, not her left, was operated on for the childhood strabismus, and it is her left eye that now has symptoms of diplopia, Dr. Berman's report specifically took note that one of her treating sources (Dr. Lee) eliminated Ms. Fortlage's double vision (right hypotropia, left hypertropia) with a prism over her left eye. *See* AR 2694 (Dr. Berman's report). There is no substantial evidence to the contrary.

Similarly, the syncope that Ms. Fortlage suffered could be accommodated with reasonable restrictions and limitations. Both Dr. Dubey (Ms. Fortlage's primary care physician at Stanford) and Dr. Zei (Ms. Fortlage's cardiologist at Stanford) agreed she could work so long as, *inter alia*, there were no rapid position changes, no prolonged fixed positions, no frequent bending below waist, an opportunity to wear compression stockings, regular access to fluids (every 2 - 2 ½ hours), and no driving. *See* AR 1701 (letter, dated 3/23/2007, and sign-off, dated 3/29/2007); AR 1732 (letter, dated 5/1/2007, and sign-off, dated 5/10/2007). There is no indication that these accommodations could not have been implemented for the position that Ms. Fortlage had held as a Human Resources Director or for any sedentary-type position. *See* AR 164 (policy) (providing for 21 months of benefits if a claimant were disabled from doing her own occupation; thereafter, requiring proof of disability for performing *any* occupation). Again, there is no evidence that the diagnosis of an autoimmune disorder (*i.e.*, Sjogren's disease) would change that conclusion.

Nor does Ms. Fortlage's reliance on her functional capacity evaluation ("FCE") as proof of her disability alter the outcome. As a preliminary matter, the Court notes that Ms. Fortlage made no more than a passing reference to the FCE in her opening motion for judgment and instead focused

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[15] In his report, Dr. Berman actually found that there was insufficient evidence to support any diagnosis of myasthenia gravis. *See* AR 2694-95. That other doctors, including Dr. Carteron, reached a different conclusion does not establish that Unum Life abused its discretion. As the Ninth Circuit has noted, "'[i]n the ERISA context, even decisions directly contrary to evidence in the record do not necessarily amount to an abuse of discretion.'" *Boyd v. Bell*, 410 F.3d 1173, 1178 (9th Cir. 2005).

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on the procedural violations discussed above. Only in her reply brief did she discuss the FCE in any detail. In any event, the FCE concluded that Ms. Fortlage had significant visual problems but notably did not address the remedial issues raised in Dr. Berman's report – *i.e.*, that any visual problem could in effect be cured through prism glasses, surgery, or simply occusion of one eye. As for the FCE's discussion of Ms. Fortlage's fatigue, her treating physicians at Stanford – including her primary care physician, Dr. Dubey – did not find any of her symptoms to be a bar to a return to work so long as certain restrictions and limitations were imposed.

Significantly, both self-reporting as well as objective medical testing did not support the claimed debilitating fatigue by Ms. Fortlage. With respect to self-reporting, Ms. Fortlage told the evaluator who prepared the FCE that, as part of her typical day, she would go to the gym in the afternoon and spend thirty to sixty minutes on the treadmill or elliptical machine. *See* AR 2492 (FCE). Her daily activities also indicate she is capable of an active lifestyle. *See* AR 2550. As for objective testing, a stress test was administered to Ms. Fortlage in March 2006 during which she was able to exercise for ten minutes to the 87% maximum predicted heart rate. *See* AR 2543 (review by RN Murphy). In November 2007, Ms. Fortlage exercised on a Bruce protocol (a treadmill test[16]) for twelve minutes before reaching 156% FAC (functional aerobic capacity). *See* AR 2190 (Mayo Clinic record). Also in November 2007, when a stress test was administered to Ms. Fortlage, she was able to exercise for 12 minutes to 13 METS[17] before stopping due to fatigue, and there was no ischemia on her EKG.[18] *See* AR 2570 (review by RN Murphy) (discussing Mayo Clinic records);

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[16] *See* Jonathan Hill & Adam Timmis, Exercise Tolerance Testing, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1123032/ (National Center for Biotechnology Information website) (last visited on 12/16/2009) (providing article from *BMJ*, a medical journal).

[17] "To carry out the activities of daily living an exercise intensity of at least 5 METs is required." Jonathan Hill & Adam Timmis, Exercise Tolerance Testing, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1123032/ (last visited on 12/16/2009); *see also* http://www.americanheart.org/presenter.jhtml?identifier=3046878 (American Heart Association website) (last visited 12/16/2009) (noting that "[f]itness levels range from 1.5 MET for the lowest exercise capacity to 20 METs for the highest capacity" and that "[t]he average fitness level is 8 METs").

[18] It also appears that Ms. Fortlage's performance on graded exercise tests was equally strong. As noted in Unum Life's final denial, the medical records indicate that, in one graded exercise test (date unspecified), Ms. Fortlage was able to "walk[] up a hill at 14 degrees at 3.4 miles per hour." AR 2757 (denial of appeal). In November 2007, she had another graded exercise test "which documented her ability to walk up a 16% grade at 4.2 miles per hour for three minutes with a normal physiologic

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see also AR 2550 (review by RN Murphy) (noting that "[c]ardiac stress testing and ECHO have revealed no abnormalities and the claimant was able to exercise to a minimum of 10 METS, stopping only due to fatigue," which "would be equivalent to the capacity for performing activities within the moderate/medium demand level").

Accordingly, the Court concludes that, even if the June 2008 report of Dr. Carteron were taken into account, there was no abuse of discretion on the part of Unum Life in denying Ms. Fortlage disability benefits because there is overwhelming, evidence she is not disabled within the meaning of the policy. Further, were the Court to review the record *de novo*, it would reach the same conclusion.

III. CONCLUSION

Accordingly, the Court recommends that the assigned judge enter judgment in favor of Unum Life. Unum Life did not abuse its discretion. Remand is not warranted.

Any party may file objections to this report and recommendation with the district judge within ten days after being served with a copy. *See* 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 72(b); Civil L.R. 72-3.

Dated: December 18, 2009

EDWARD M. CHEN
United States Magistrate Judge

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response and no report of diplopia." AR 2757.