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

LEO W. LANDAU	:	CIVIL ACTION
	:	
v.	:	
	:	
RELIANCE STANDARD LIFE INSURANCE COMPANY	:	NO. 98-903

MEMORANDUM AND ORDER

YOHN, J. March , 1999

Dr. Leo Landau ("Landau"), formerly a pediatrician practicing with an affiliate of the Hospital Service Association of Northeastern Pennsylvania, brings this action against Reliance Standard Life Insurance Co. ("Reliance") to recover long term disability benefits allegedly owed him. Landau's employer purchased a Group Long Term Disability Insurance policy (the "Policy"), which is an employee benefit plan covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132 ("ERISA"), from Reliance. In a prior memorandum, I concluded that the arbitrary and capricious standard governs my review of Landau's denial of benefits claim under ERISA, and that my review would be limited to the evidence before Reliance when it decided to deny benefits to Landau. Before the court is Reliance's motion for summary judgment which asserts that Landau's claims should be denied because its denial of long term disability benefits was neither arbitrary nor capricious. Shortly before trial of this case was scheduled to begin, Reliance also filed a Motion in Limine to Limit the Scope of Evidentiary Review and for Issuance of a Protective Order. For the reasons detailed below, Reliance's motions for summary judgment, in limine, and for a protective order are denied.

FACTUAL BACKGROUND

In October 1995, Landau became a full-time employee of Eastern Physician's Group, P.C., an affiliate of the Hospital Service Association of Northeastern Pennsylvania, and as such, was covered by its Group Long Term Disability Insurance Policy with Reliance. See Verification of Landau ("Landau Aff.") (attached to Plaintiff's Mem. of Law in Opposition to Defendant's Mot. for Partial Summ. Judgment ("Opposition") as Exhibit A). Landau suffered a heart attack on August 17, 1996, and underwent quintuple coronary bypass surgery. See id. After the operation, Landau also developed numbness, or paresthesia, in his fingers, toes and chest. See id.

In October 1996, Landau submitted a long term disability claim to Reliance and provided supporting documentation from several treating physicians, and from the hospital where his surgery was performed. See id., at 2. After reviewing this information, Reliance denied Landau's claim for benefits on April 15, 1997, asserting that Landau was not "totally disabled" within the meaning of the Policy. See Letter from Wendy McCulley to Landau, at 2 (Apr. 15, 1997) (attached to Complaint as Exhibit 11). On April 2, 1997, Landau's employer terminated him because he was "physically incapable of performing the essential functions of your duties, with reasonable accommodations, since August 19, 1996." See Letter from Carmella Sebastian to Landau (Apr. 2, 1997) (Reliance's Appendix of Exhibits to its Motion for Summary Judgment ("Reliance Appendix"), Ex. B, at RSL 81). Landau appealed Reliance's decision, which was upheld by Reliance's Quality Review Unit, on July 17, 1997. See Letter from Peter Schiller to Andrew Fichter, at 4 (July 17, 1997) (attached to Complaint as Exhibit 12). Reliance reaffirmed its decision to deny benefits to Landau on September 9, 1997, and informed him that Reliance had reached its "final determination in this matter." Letter from Peter Schiller to Andrew

Fichter, at 4 (Sept. 9, 1997) (attached to Complaint as Exhibit 15). On February 28, 1998, Landau filed this suit, claiming that Reliance had improperly denied him benefits, in violation of 29 U.S.C. § 1132 (a)(1)(B), and that Reliance had failed to provide him with a description of additional evidence it required in order to evaluate his claim for disability based on paresthesia, in violation of 29 U.S.C. § 1133(1).

SUMMARY JUDGMENT STANDARD

Summary judgment is to be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56 (c). The court should not resolve disputed factual issues, but rather, should determine whether there are factual issues which require a trial. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986). If no factual issues exist and the only issues before the court are legal, then summary judgment is appropriate. See Sempier v. Johnson & Higgins, 45 F.3d 724, 727 (3d Cir.), cert. denied, 515 U.S. 1159 (1995). If, after giving the nonmoving party the "benefit of all reasonable inferences," id. at 727, the record taken as a whole "could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial,'" Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986), and the motion for summary judgment should be granted.

DISCUSSION

A. Conflict of Interest.

Landau argues that I should revisit my previous determination that the arbitrary and capricious standard should govern my review of Reliance's decision to deny benefits to Landau

because Reliance is operating under a conflict of interest. As I expressly declined to reach this issue in my prior memorandum because it had not been briefed by the parties, I will resolve this issue now. See Landau v. Reliance Standard Life Ins. Co., No. 98-903, 1999 WL 46585, at *2 n.1 (E.D. Pa. Jan. 13, 1999).

The Supreme Court, in resolving the question of which standard of review should apply to denials of benefits under ERISA, noted that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Epright v. Environmental Resources Mgmt., Inc. Health & Welfare Plan, 81 F.3d 335, 340 (3d Cir. 1996) (observing that conflict of interest may be a "factor when deciding if a denial of benefits was arbitrary and capricious). The Firestone standard of review applies both to "ERISA benefit denials based on plan interpretations . . . [and] to . . . decisions based upon purely factual questions." Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1178 (3d Cir. 1991). Though the Third Circuit has never decided a case in which it concluded that a heightened standard of review should apply because an ERISA plan administrator was operating under a conflict of interest, it has suggested that heightened review may be appropriate in such a case, and a number of other courts of appeals and district courts within the Third Circuit have applied such a standard. See Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997) (finding that de novo review must govern denials of benefits made by a plan administrator with a conflict of interest); Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794, 797 (9th Cir. 1997) (finding that degree of deference depends upon presence of conflict of interest); Mitchell

v. Eastman Kodak Co., 113 F.3d 433, 437 n.4 (3d Cir. 1997) (commenting that "there is no conflict of interest sufficient to justify heightened review of the Administrator's decision" when employer incurs no direct expense as a result of benefit awards); Chambers v. Family Health Plan Corp., 100 F.3d 818, 824-27 (10th Cir. 1996) (adopting sliding scale of review when plan administrator operates under a conflict of interest); *Review of the Developing Law Regarding Conflicts of Interest and the Arbitrary and Capricious Standard of Review*, 6 ERISA Litig. Rep., Feb. 1998, at 14, 16.

The leading case in this area, which has been adopted by most district courts in the Third Circuit, is Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991). See Sciarra v. Reliance Standard Life Ins. Co., No. 97-1363, 1998 WL 564481, at *8 (E.D. Pa. Aug. 26, 1998); Irvin v. Metropolitan Life Ins. Co., No. 96-2909, 1998 WL 401690, at * 9 (E.D. Pa. June 30, 1998); Perri v. Reliance Standard Life Ins. Co., No. 97-1369, 1997 WL 476386, at * 6 (E.D. Pa. Aug. 19, 1997); Rizzo v. Paul Revere Ins. Group, 925 F. Supp. 302, 309 (D.N.J. 1996), aff'd, 111 F.3d 127 (3d Cir. 1997); DiMichelle v. Travelers Ins. Co., No. 92-1749, 1993 WL 481713, at *6 (E.D. Pa. Nov. 17, 1993). In Brown, the Eleventh Circuit held that an inherent conflict of interest exists when an insurance company administers claims under a policy it issued because its "fiduciary role lies in perpetual conflict with its profit-making role as a business." Brown, 898 F.2d at 1561. In applying that rule to Blue Cross & Blue Shield, which both insured and administered the health insurance plan at issue, Brown emphasized that "[d]ecisions made by the issuing company on behalf of a plan based on a contract of insurance . . . inherently implicate the hobgoblin of self-interest. Adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate

coffers. The presumption that the fiduciary is acting for the future stability of the fund cannot be entertained."[1] Id. at 1568.

Based on the evidence contained in the summary judgment record, it is clear that Reliance is operating under a conflict of interest as both the administrator and insurer of the Policy it issued to Landau's employer. See Policy, at 4.0 ("When we receive written proof of Total Disability covered by this Policy, we will pay any benefits due."). Landau has met his burden of producing evidence suggesting that Reliance is conflicted with respect to its dual roles under the Policy. See Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees, 970 F.2d 1165, 1173 (3d Cir.), cert. denied, 506 U.S. 1021 (1992) (party asserting abandonment of discretionary review "has the burden of showing some reason to believe the exercise of discretion has been tainted"). Reliance's determination of Landau's benefits claim will have a direct impact on Reliance's pocketbook, as Reliance itself recognized when it referred Landau's claim to the medical review staff of the Cost Containment Unit. See Reliance Appendix, Ex. B, at RSL 204. My finding that Reliance has a conflict of interest is consistent with the conclusions of many other courts which have considered Reliance's dual roles as ERISA fiduciary and plan insurer. See Sciarra, 1998 WL 564481, at *9; Pappas v. Reliance Standard Life Ins. Co., 20 F.

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[1] Reliance urges us to conclude that an insurance company which serves as the plan administrator for a plan it insures is not inherently conflicted. In support of this proposition, Reliance refers the court to an unpublished opinion of the Third Circuit stating that "[w]e are not convinced that such a dual role presents the type of conflict of interest that would warrant discarding the arbitrary and capricious standard." See Reliance's Reply Brief, at 2 (citing Pinto v. Reliance Standard Life Ins. Co., No. 97-5297, slip. op. at 8 (3d Cir. May 28, 1998)). I am not bound to follow unpublished opinions of the Third Circuit, and decline to do so in this case, particularly because the Third Circuit provides no further explanation of its statement, and because this statement is followed by an adoption of the standard in Brown. See Third Circuit Internal Operating Procedure 5.8; Sciarra, 1998 WL 564481, at * 8 n. 7 (declining to follow Pinto).

Supp. 2d 923, 929 (E.D. Va. 1998); Buchanan v. Reliance Standard Life Ins. Co., 5 F. Supp. 2d 1172, 1180 (D. Kan. 1998); Perri, 1997 WL 476386, at * 6. Thus, because Reliance has a conflict of interest, a heightened standard of review will apply to its denial of Landau's benefits. Determining the parameters of this heightened review, however, is the subject of much disagreement among the courts who have applied a heightened standard.

I find that the explanation of heightened review contained in Brown appropriately reflects the Supreme Court's caution that conflicts of interests should be considered when choosing a level of deference to apply to a plan administrator's denial of benefits. I, like many other district courts in the Third Circuit, will thus adopt the formulation of heightened review outlined in Brown. See Brown, 898 F.2d at 1566--67; Sciarra, 1998 WL 564481, at *8; Irvin, 1998 WL 401690, at * 9;Perri , 1997 WL 476386, at * 6; Rizzo, 925 F. Supp. at 309; DiMichelle, 1993 WL 481713, at * 6. Though many district courts in the circuit have agreed to follow the standard announced in Brown, there appears to be substantial disagreement about what the Brown standard actually means. Under Brown,

> when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Brown, 898 F.2d at 1566-67. In a footnote to this section, the court specified that the administrator's decision "must be 'wrong' from the perspective of de novo review before a court is concerned with the self-interest of the fiduciary." Id. at 1566 n.12. Though Brown repeatedly

emphasized that it was applying an arbitrary and capricious standard, it found that there were two steps to its review given the conflict of interest; the court must first determine whether the insurer's interpretation of the plan was legally correct, and then it must determine whether the insurer's interpretation was arbitrary or capricious because it was influenced by the conflict. See id. at 1570.

Several courts which have relied on Brown have characterized the first step of this framework as requiring de novo review. See Armstrong, 128 F.3d at 1265 (finding that Brown directs the court to review benefits denial under a de novo standard, given the conflict of interest); Perri, 1997 WL 476386, at * 6 (finding that Brown mandates de novo review of the administrator's decision); Rizzo, 925 F. Supp. at 309 ("the Brown analysis first requires de novo review of the plan administrator's decision in order to determine whether it is a legally correct interpretation of the relevant plan provisions"). Other courts, though expressly adopting Brown, have been less than clear about whether they were applying an arbitrary and capricious or de novo standard to determine whether the plan administrator's decision was "legally correct." See DiMichelle, 1993 WL 481713, at *7 (holding that insurer's interpretation of plan was legally correct, even under a de novo standard). For example, in Irvin, the court recognized that Brown authorized a de novo review of the administrator's interpretation of the plan, but declined to undertake a de novo review because the parties agreed on the plan's interpretation; instead, the court analyzed whether the insurer's decision to deny benefits was arbitrary and capricious. See Irvin, 1998 WL 401690, at * 9 n. 4 (commenting that denial was not arbitrary and capricious, but whether plaintiff is disabled would be a "close question" on de novo review). Alone among the district courts in the Third Circuit, Sciarra expressly declined to undertake a de novo review of

the administrator's decision as the first step of a heightened arbitrary and capricious review. See Sciarra, 1998 WL 564481, at * 9.

With all due respect, I conclude that Sciarra misinterprets the requirements of Brown. Sciarra based its decision on Brown's statement that "the abuse of discretion, or arbitrary and capricious, standard applies to cases such as this one, but the application of the standard is shaped by the circumstances of the inherent conflict of interest." Id. at *9 (quoting Brown, 898 F.2d at 1563). What Sciarra failed to note is that elsewhere in the Brown opinion, the Eleventh Circuit held that the two-step test described above is the method for reviewing cases where the "circumstances" include a conflict of interest. See Brown, 898 F.2d at 1570 (stating that two-step test is "appropriate in an instance for which [sic] conflicting interests are involved").

I will review Reliance's denial of benefits, therefore, by following the two-step procedure outlined in Brown. I will first conduct a de novo review of Reliance's decision to deny benefits to Landau. Then, if I conclude that Reliance's denial was legally incorrect, I will examine its denial under the arbitrary and capricious standard to determine whether its incorrect decision was affected by its self-interest.

B. De Novo Review

1. Scope of Evidentiary Review

A major bone of contention between the parties, and the subject of Reliance's Motion in Limine to Limit the Scope of Evidentiary Review and for Issuance of a Protective Order, is the scope of the evidence that I will consider when determining the propriety of Reliance's denial of benefits. In my prior memorandum in this case, I did conclude that the scope of review would be limited to the documents that were part of the record when Reliance made its final benefits

determination. See Landau, slip. op. at 9-10. That conclusion, however, was based on my previous holding that the unmodified arbitrary and capricious standard would govern my review absent a consideration of the impact of a conflict of interest. See id. As explained above, I have concluded that I must engage in a de novo review of Reliance's denial as part of a heightened arbitrary and capricious review because of the conflict of interest, and thus, my prior limitation on the scope of the evidence I will consider is no longer justified. It is well-established that, in conducting a de novo review, I may consider evidence which was not before Reliance when it made its final benefits determination. See Luby, 944 F.2d at 1184-85; Chodo v. Unum Life Ins. Co., No. 98-3078, 1998 WL 743596, at * 1 (E.D. Pa. Oct. 6, 1998); Cannon v. Vanguard Group, Inc., No. 96-5495, 1998 WL 310663, at * 5 n. 10 (E.D. Pa. June 11, 1998). As the Third Circuit held in Luby, limiting the scope of de novo review to the evidence before the before the administrator "makes little sense" and "is contrary to the concept of de novo review." Luby, 944 F.2d at 1184 (citations omitted). Reliance's motion in limine and for a protective order will, therefore, be denied and Landau will be permitted to offer the testimony of his treating physicians and his vocational expert.

2. Legal Correctness of Reliance's Denial of Benefits

Reliance has moved for summary judgment on the merits of Landau's claims, asserting that its decision to deny benefits was reasonable as a matter of law. Landau, in opposition, offers a variety of arguments contending that Reliance's interpretation of the Policy was incorrect and that Reliance improperly disregarded evidence demonstrating that he was disabled. My obligation, on de novo review, is to determine whether Landau was disabled. Because I must view all of the facts in the light most favorable to Landau on Reliance's motion for summary

judgment, I cannot conclude, on the basis of the record before me, that Reliance is entitled to summary judgment.

The record presented to the court on summary judgment contains a significant dispute about facts which are crucial to the determination of whether Landau was disabled. The doctors who treated Landau and who reviewed his files for Reliance disagree substantially on facts which must be resolved before I can determine whether Landau was disabled. For example, the doctors disagree on the circumstances under which Landau suffers from angina, the effect of stressful situations on his cardiac condition, and the effect of his paresthesia on his ability to perform the technical duties of a pediatrician. See Report of Dr. Robert Kleiman (July 2, 1997) (opining that there is no evidence of significant angina, and that ii is possible that he may experience angina from stress during a hectic working day but that there is no documentation supporting this finding, and failing to comment on paresthesia); Office Notes of Dr. Gerald Gibbons (June 25, 1997) (noting that paresthesias in Landau's hands causes him to drop items and to have difficulty writing and that stress may aggravate his coronary disease); Letter from Dr. Mark Bernardi to Dr. Gerald Gibbons (June 9, 1997) (opining that Landau suffers from resting angina caused by stress); Report of Dr. Monica Cozzone (May 30, 1997) (opining that Landau is limited to sedentary employment because of breakthrough angina, that a stressful position is inappropriate for Landau, and that cervical and lumbar spondylosis may produce excessive pain); Report of Dr. Elizabeth Genovese-Stone (Apr. 8, 1997) (reporting that Landau's cardiac condition permits him to do light work but that a cardiologist should evaluate his records); Office Notes of Dr. Gerald Gibbons (Jan. 7, 1997) (noting paresthesias in Landau's hands and legs); Report of Dr. John Della Rosa (Nov. 22, 1996) (explaining Landau's paresthesias in arms, hands and legs); Office

Notes of Dr. Gerald Gibbons (Nov. 22, 1996) (noting numbness in Landau's fingers). As there are material factual disputes which must be resolved before I can determine whether Landau was disabled, summary judgment is impossible.

CONCLUSION

For the reasons explained above, Reliance's Motions for Summary Judgment, In Limine, and for a Protective Order, will be denied.

An appropriate order follows.

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LEO W. LANDAU, M.D.	:	CIVIL ACTION
	:	
v.	:	
	:	
RELIANCE STANDARD LIFE	:	
INSURANCE COMPANY	:	NO. 98-903

ORDER

AND NOW, this _____ day of March, 1999, after consideration of the parties' recent submission, IT IS ORDERED that:

1. Defendant's Motion for Summary Judgment is DENIED;

2. Defendant's Motion in Limine to Limit the Scope of Evidentiary Review and for Issuance of a Protective Order is DENIED.

William H. Yohn, Jr., J.