

ERISA: A PRACTITIONER'S GUIDE
CLAIM DENIED! NEW TRENDS IN EMPLOYEE BENEFIT CLAIM LITIGATION

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The Treating Physician Opinion Quagmire

This rule requires the fact-finder to defer to the treating physician's opinion and to provide substantial reasons if they decide to reject his opinions. The treating physician rule had its birth in Social Security Disability cases where Administrative Law Judges recognized the distinction between a physician who has not "treated" the patient and the physician who examines the claimant once briefly or, in the case of a 'paper reviewer', never sets eyes on the claimant.

The treating physician rule as applied in a Social Security setting requires that the administrative law judge determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because "he is employed to cure and has a greater opportunity to know and observe the patient as an individual". *Morgan v. Commr of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999). See C.F.R. §§404.1527(d), 416.927 (d) (2001).¹ As the Court in *Regula* reasoned, "This grant of deference to a treating physicians' opinions increases the accuracy of disability determinations by forcing the administrative law judge who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record." *Regula v. Delta Family Care Disability Survivorship Plan* 266 F.3d 1130 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. June 13, 2002) (No. 01-1840)

Claimants attorneys in disability cases have argued for years that the treating physician rule should apply to cases in the non-Social Security venue. It goes beyond saying that a physician who has had the chance to examine the claimant over a period of time, to get to know the signs and symptoms of the disabling condition, prescribe medication for that condition, receive first hand reports as to its effectiveness, and basically establish a rapport of trust and understanding with the patient, has the greatest chance of assessing the medical condition, and how that condition restricts and limits the patient.

Much has been written about this rule and plaintiffs have had mixed success establishing this as a standard of practice for the ERISA disability industry. Some circuits that have rejected the application of the treating physician rule have focused solely within the framework of claims for continued health benefits. The difference between that arena,

¹ The Commissioner of Social Security will generally give more weight to opinions from treating physicians because "these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations". 20 C.F.R. § 404.1527(d)(2).

where the doctor may indeed have a financial stake in the outcome of the claim (i.e. whether his bill gets paid) and the disability context (where the claimant receives benefits because they are unable to work) is clear.

I. The Treating Physician Line Up

First Circuit:

Leahy v. Raytheon, 315 F. 3d 11 (1st Cir. 2002); *Cook v. Liberty Life Assurance Company of Boston*, 2003 U.S.App. LEXIS 1959 (1st Cir. 2003) (There should be a reasonable basis for rejecting the opinion of the treating doctor)

Second Circuit:

Connors v. Conn. Gen. Life Ins. Co., 272 F. 3d 127, 136 n. 4 (2nd Cir. 2001)(Court rejected the treating physician rule) but see *Gecevic v. Secretary of Health and Human Resources* E.D. N.Y. 1995 (The treating rule was explored and accepted by the court)

Third Circuit:

Skretvedt v. E. I. Dupont De Nemours and Co., 268 F.3d 167, 184 (3rd Cir. 2001); *Cohen v. Standard Ins. Co.* 155 F. Supp. 2d 346, 352 (E.D. Pa. 2001) (Court found conflict of interest proven by Standard’s ignoring credible evidence and relying on the opinion of non-treating physician rather than treating doctor) ; *Edgerton v. CNA Insur. Co.*, 215 F. Supp. 2d 541 (E.D.Pa. 2002) See also *Davies v. The Paul Revere Life Ins. Co.* 147 F. Supp. 2d 347 (M.D. Pa 2001)

The court in *Skretvedt* reasons that “the treating physician, having observed a patient over an extended period of time, is in a unique position to fully assess a claimant’s functional capacity”.

Fourth Circuit:

As of 1994, the Court was refusing to adopt the treating physician rule, at least in a health care setting. See *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.* 32 F. 3d 120 (4th Cir. 1994) According to her treating doctors, Sheppard’s extended hospitalization was medically necessary but the administrator denied her claim based on the opinion of in house medical reviewers and consultants. The Court upheld the administrator’s denial. See e.g., *Elliot v. Sara Lee Corp.*, 190 F. 3d 601, 607-8 (4th Cir. 1999) Recently, in *Laser v. Provident Life & Accident Co.* 2002 WL 1747528 (D. Md. 2002), the court declined to apply the rule, but signaled which direction it was headed:

“Because the Fourth Circuit has not indicated that the treating physician rule should be applied in ERISA cases, see *id.*, I will not apply it here. Still, that does not mean

that a plan administrator is free to entirely disregard a treating physician's opinion". See., e.g. *Pappas v. Reliance Standard Ins., Co.*, 20 F. Supp. 2d 923, 931 (E.D.Va. 1998).

Fifth Circuit:

Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1116 (5th Cir. 1992)
Here the court assessed whether to apply the treating physician rule to a challenge involving the medical necessity of treatment case. Interestingly, they pointed to the treating physician's conflict of interest because he stands to profit if the medical care he recommends is accepted and refused to give the treating physician's opinion about the necessity of medical care any deference. The court stated in dicta that it "has considerable doubt about holding the treating physician rule applicable in ERISA cases"

Sixth Circuit:

Darland v. Fortis 317 F.3d 516 (6th Cir. 2003) The Sixth Circuit adopted the rule and proceeded to examine whether there was substantial evidence contradicting the opinion of Darland's treating physician. The Court reasoned,

"the district court should have deferred to the opinions of Darland's treating physicians absent substantial evidence in the record contradicting those opinions. Here, there was medical evidence conclusively showing that Darland could not perform all the material duties of his job as an executive vice president of Market Finders. Although Fortis' second peer review panel concluded that Darland could perform all the material duties of his position, the views of these non treating and non examining medical consultants hired by Fortis were unduly speculative, and there was nothing in the record to indicate that Darland could stand or sit for prolonged periods of time. Quite to the contrary, the medical opinions of the physicians who actually examined or treated Darland substantiate his disability under the terms of the Fortis policy." Id at 532-33.

Seventh Circuit:

The Seventh Circuit has not yet ruled on whether the Treating Physician Rule applies, but district courts, while tiptoeing around the "rule", have found in favor of its substantive application. For instance, in *Vartanian v. Metropolitan Life Insurance Co.*, 2002 U.S. Dist. LEXIS 5459 *28-29 (N.D.Ill. 3/28/02), the court found fault with Metropolitan for relying solely on reviewing doctors opinions over those of Mr. Vartanian's treating doctors and failing to hire an independent physician to actually examine Mr. Vartanian. The Court in *LaBarge v. Life Insur.Co. of North America*, 2001 WL 109527 (N.D.Ill.), ruled in favor of LaBarge, reasoning that LINA made no independent inquiry into LaBarge's condition, did not pursue an IME, and a report of a non-examining, non-treating physician should be discounted when contradicted by all other evidence in the record and afforded less weight, citing *Millner v. Schweiker*, 725

F.2d 243, 245 (4th Cir.1984); *Browne v. Richardson*, 468 F.2d 1003, 1006 (1st Cir.1972) (The report of a doctor who did not examine plaintiff "lacks the assurance of reliability that comes ... from first-hand observation and professional examination" and cannot provide substantial evidence). *Vega v. Cherry Corp. Long Term Disability Plan (CNA)*, 2002 U.S.Dist.LEXIS 21034 (N.D.Ill. 10/31/02)- Here the court held the uncontroverted opinions of the treating doctor and physical therapist required overturning CNA's benefit denial. *Flood v. Long Term Disability Plan for First Data Corp.*, 2002 U.S.Dist.LEXIS 18183 (N.D.Ill. 9/27/02) -- the reviewing doctor's conclusory opinion was outweighed by the treating doctor's opinions.

Eighth Circuit

Donaho v. FMC Corp., 74 F. 3d 894, 901 (8th Cir. 1996) Both of Donaho's treating doctors, plus a consulting doctor who examined him agreed he was disabled yet the administrator relied on the opinion of a doctor who merely reviewed the medical records. The court found the administrator's decision unreasonable, explaining, "where the reviewing physician's conclusions are contradicted by an examining physician and two treating physicians, reliance on the reviewing physician's conclusions "seems especially misplaced" and constitutes an abuse of discretion. However, the Donaho decision has not withstood the test of time. It was whittled away by *Fletcher-Meritt v. NorAm Energy Corp.*, 250 F.3d 1174 (8th Cir. 2001), "the treating physician's opinion does not automatically control, since the record must be evaluated as a whole."

Delta Family-Care Disability & Survivorship Plan v. Marshall, 258 F.3d 834 (8th Cir. 2001) Here an administrator's decision to base its denial of disability benefits on an IME examiner's opinion was found to be sufficient despite the fact that the treating physician supported the claim. The court declined to follow the treating physician rule, distinguishing the facts of this case with those where the treating physician's opinions are challenged merely by a medical consultant who did not examine him. *Donaho* was rejected by *Coker v. Met Life Ins. Co.* 281 F. 3d 793 (8th Cir. 2002)

Ninth Circuit:

The 9th Circuit issued a ground breaking decision in *Regula v. Delta Family Care Disability Survivorship Plan* 266 F.3d 1130 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. June 13, 2002) (No. 01-1840). The court found that the deference given to the treating doctor appropriately requires substantial evidence in the record and specific reasons to support a decision to reject the treating doctor's findings. *Id.* at 1147.

Furthermore, evidence of departure from the treating physician rule has been considered as evidence to support the claim that a conflict of interest exists which justifies sliding the scale of review closer to de novo review and farther from discretionary review. *Id.* at 1147.

The Ninth Circuit had an opportunity to revisit *Regula*, soon thereafter, with *Nord v. The Black & Decker Plan*, 296 F.3d 823 (9th Cir. 2002). Met Life administered the disability plan for Black & Decker, and rejected the conclusions of Nord's treating doctor, Dr. Hartman. He had treated Mr. Nord for many years even before the onset of his back condition, and after treating him for a long time, concluded that Mr. Nord was totally disabled due to a degenerative disc disease, sciatica and myofascial pain syndrome. Dr. Hartman referred Mr. Nord for evaluations by several orthopedists all of whom made nearly identical findings as to Mr. Nord's inability to perform his occupation. Their opinions were joined by that of a human resource representative of Black and Decker. The only contradictory opinion came from an examiner retained by Met Life, neurologist Dr Mitri who concluded Mr. Nord could perform sedentary work because, in his opinion, he could sit for more than an hour a day. The court found MetLife's complete rejection of the treating doctor's opinions its failure to give an adequate reason for doing so evidence that the conflicted administrator abused its discretion. The Supreme Court agreed on January 10th to decide whether the Ninth Circuit U.S. Court of Appeals properly ruled that an ERISA disability plan administrator is required to accept the opinion of a treating physician unless the fiduciary rebuts that opinion in writing based on substantial evidence on the record. The arguments were set for April 28th, 2003 at the time of this writing.

Eleventh Circuit:

Turner v. Delta Family-Care Disability and Survivorship Plan 291 F.3d 1270 (11th Circuit 2002) The court rejected the holding in *Regula*, stating,

“The 9th Circuit Court of Appeals held in *Regula*, “under such circumstances, Plan benefits decisions are subject to a less deferential standard of review”. But Turner's argument that this less deferential standard should apply here is unavailing because of the decisions of this Court to the contrary... The *Regula* decision is contrary to the law of this Circuit and cannot govern this appeal.” *Id* at 1273-74.

II. Just What is a Conflict of Interest and How to Use it To Advance Your Case

When a policy confers discretion upon a administrator or fiduciary, a review of their decision will normally be reviewed under the abuse of discretion standard. However, this standard is modified, and the deference granted by the court to the decision maker reduced, when the plan administrator operates under a conflict of interest. The United States Supreme Court advocated a less deferential review of the administrators' decision to deny benefits must be undertaken whenever there it is operating under a conflict of interest. *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 (1989).

A conflict of interest may be established through many avenues, but they are headed in the same direction, to show the financial motivation behind the decision making process. The goal for a claimant's advocate is to prove that a conflict of interest

tainted the entire decision making process, causing the tunnel vision of the administrator to have deprived the claimant of a full and fair review. The first issue to resolve is whether the plan provides for discretionary or de novo review, for only when there is discretionary review, does an analysis of conflict of interest take place. Once the battle lines are drawn, and discretionary review is the accepted modicum, then the focus should be directed on establishing that a conflict of interest existed. In some jurisdictions, the mere fact that an insurance company both funds and administers the plans is enough to convince the court that a conflict exists, at which time the burden shifts to the administrator to prove that the conflict did not affect their decision making process. This is called the presumption of a conflict. A decision maker's dual role in both administering and insuring the plan creates at least the potential for a conflict of interest, because that party "bears the financial consequences and reaps the financial rewards of its own coverage decisions." *Bedrick v. Travelers Ins. Co.*, 93 F. 3d 149, 151 (4th Cir. 1996)

Some circuits adopt the approach that if certain factors exist, there is a presumption of a conflict and the burden shifts to the administrator to prove that a conflict of interest did not infect the process. *Adams v. Thiokol Corp.* 231 F. 3d 837, 842 (11th Cir. 2000); *Bedrick, supra* at 154. *Brown v. Blue Cross & Blue Shield, Inc.* 898 F. 2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991)

If the fiduciary funds the benefits, it is presumed that its decision making process was affected by its recognition that by deciding to pay benefits on a claim, it is simultaneously committing its own funds to do so. In some circuits, an inherent or apparent conflict is presumed to be an actual conflict of interest, because, "a conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F. 3d 287 (5th Cir. 1999); *Armstrong v. Aetna Life Ins. Co.*, 128 F. 3d 1263 (8th Cir. 1997); *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F. 3d 118 (10th Cir. 1994)

In some circuits, the plaintiff has the burden to both establish the conflict and to demonstrate that the conflict infected the administrative process. Here the claimant has the burden of proving there was an actual conflict of interest in the handling of the claim and that the bias infected the decision making process. *Snow v. Standard Ins. Co.* 87 F. 327, 331 (9th Cir. 1996); *Atwood v. Newmont Gold Co.* 45 F.3d 1317, 1323 (9th Cir. 1995); *Whitney v. Empire Blue Cross*, 106 F. 3d 475 (2nd Cir. 1997); *Doe v. Travelers Ins. Co.*, 167 F. 3d 53, 57 (1st Cir. 1999); *Besten v. Delta American Reinsurance Co.* 1999 U.S. App. LEXIS 34489 (6th Cir. 1999); *Perlman v. Swiss Bankcorp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 986 (7th Cir. 1999). The Plaintiff should seek discovery outside of the administrative record to establish the existence and extent of the conflict. Obviously, the Court is not limited to the evidence in the administrative record in determining what level of deference to apply to a claim administrator's decision. *Dorsey v. Provident* 2001 Westlaw 119362 (E.D.Pa. 2001).

Once a conflict has been identified, there are essentially two choices; remain with the discretionary review but modify the discretion, or apply a de novo review. Some

circuits apply what is known as a “modified abuse of discretion standard” and some review the plan administrators’ decision de novo.

The 9th Circuit applies de novo review. See *Regula*, 266 F. 3d at 1145-46; See also *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d at 794, 799-800 (9th Cir. 1997).

Many other circuits apply the modified approach. The Fourth Circuit regularly applies the modified abuse of discretion standard to consider conflict of interest as a factor in assessing reasonableness based on the potential for conflict in cases in which a plan administrator is also the plan insurer. *Bernstein v. Capital Care Ins.*, 70 F.3d 783 (4th Cir. 1995). When a court evaluates the decision of an ERISA plan administrator under the modified abuse of discretion standard, “the question for the court is whether the administrators and fiduciaries abused their discretion in the context of a sliding-scale review, which comes down to whether plaintiff received a full and fair review”. *Willis v. Baxter Int’l, Inc.*, 175 F. Supp.2d 819, 831 (W.D.N.C.2001). “The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary’s decision must be and the more substantial the evidence must be to support it”. *Ellis v. Metro. Life Ins. Co.*, 126 F. 3d 228 (4th Cir. 1997) See also the Fifth Circuit decision in *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999); *Peruzzi v. Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998)

The Third Circuit also adopts a modified approach. If the beneficiary establishes that a conflict of interest exists, the court then applies a “sliding scale” which requires the court to engage in a two-part analysis to consider how the conflict affected the process by which the administrator arrived at its decision. This is obviously an inexact standard, admittedly subjective, dependant on the court’s assessment as to how far to move the scale. *Pinto v. Reliance Standard Life Insurance Company* 214 F. 3d 377, 393 (3rd. Cir. 2000) If the beneficiary proves that a significant conflict of interest exists and that it affected the decision making process, the Court will review the fiduciary’s decision with a “high degree of skepticism”. *Id* at 395. The Court will look to the procedural abnormalities, which include 1) the insurer’s reversal of its original determination without the examination of additional evidence, 2) a self-serving selectivity in the use of the evidence, and 3) a bias in decision-making to the benefit of the insurer. *Russell v. Paul Revere Life Insurance Co.*, 148 F. Supp. 2d 392, 405 (D. Del. 2001). *Goldstein v. Johnson & Johnson*, 251 F. 3rd 433, 2001 U.S. App. LEXIS 10834, Slip. Op. at 3 (3rd Cir. 2001) A conflict of interest may also be demonstrated by evidence of bad faith. *Davies v. Paul Revere* 147 F. Supp. 2d 347 (E.D.Pa. 2001)

Self Funded Plans:

In view of the increasing decision of larger companies to self fund their own health benefit plans, Courts have evaluated how the conflict of interest analysis might apply to them. They are subjected to the same scrutiny as the insurance company.

In the case of a self-funded plan, the manner of funding the plan, together with the claims handling process, may support a finding of a conflict of interest. In *Regula v. Delta*, 266 F.3rd 1130, 1138 (9th Cir. 2001), the Court evaluated a self-funded plan and concluded that the manner of funding the plan, together with the claims handling process, was infected by self-interest and an incestuous relationship between the Benefits Committee and Delta. This supported a finding that a conflict of interest existed, based in large part on the evidence that the members of the administrative committee were appointed by the Delta Board of Directors, and although the benefit fund was organized as a trust, it was funded exclusively by Delta companies based on actuarial data. In effect, Delta acted as both administrator and the funding source for the plan. Other courts have recognized the conflicts that exist in self-insured plans and applied the less deferential analysis to the claims process. *Parente v. Aetna Life Insurance Com.* 2001 WL 177086, at 2 (E.D.Pa. January 25, 2001) (“A reviewing court must analyze each individual plan to determine the extent of any conflict of interest, and the resulting level of review”)

See also *Freiberg v. First Union Bank of Delaware* 2001 WL 82 6529 (D. Del. 2001) at *3. The court in Freiberg applied the heightened standard based on its conclusion that defendants had a financial incentive to deny borderline claims because benefits paid are essentially expenses incurred. See also *Greene v. Syngenta Crop Protection, Inc.* 207 F. Supp. 2d 537 (M.D. La 2002) The *Greene* Court examined the self-funded plan and found that a conflict of interest existed “since the administrative Committee (all company employees) serve at the “pleasure of the Board”. In *Bill Gray Enters, Inc, Employee Health and Welfare Plan v. Gourley*, 248 F.3d 206, 216 (3rd Cir. 2001), clear bias or partiality requires that a heightened standard of review applies. Evidence of a direct financial benefit to the self-insured company, with every denial of benefits, is evidence that the conflict completely tainted and obfuscated the full and fair review the claimant was entitled to. *Skretvedt v. E.I. DuPont D. Nemours & Co.* 119 F. Supp. 2d 444, 451 (D. Del 2000).

The Treating Physician Rule and the Conflict of Interest approach to examining the decision of the administrator remain hotly litigated issues in ERISA cases nationwide. There is a wide divergence of approaches which generates disparate treatment of litigants. Hopefully, the Supreme Court will synergize the variances and distill them into a reasonable approach to be universally applied.