United States Court of Appeals, Third Circuit.

Thomas P. KELLY, Jr., Appellant

v.

The PENN MUTUAL LIFE INSURANCE COMPANY; Reliance Standard Life Insurance Company

No. 18-1162

Submitted Under Third Circuit L.A.R. 34.1(a) February 12, 2019(Filed: February 28, 2019)

On Appeal from the United States District Court for the District of New Jersey (D.C. No. 2:09-cv-02478), District Judge: Honorable Katharine S. Hayden

Attorneys and Law Firms

Thomas P. Kelly, III, Esq., Kelly Law Offices, LLC, Mount Laurel, NJ, for Plaintiff-Appellant

Mee Sun S. Choi, Esq., Louis P. DiGiaimo, Esq., McElroy Deutsch Mulvaney & Carpenter, Morristown, NJ, Valerie G. Pennacchio, Esq., Saul Ewing Arnstein & Lehr, Newark, NJ, for Defendant-Non-Participating

Joshua Bachrach, Esq., Wilson Elser Moskowitz Edelman & Dicker, Philadelphia, PA, James A. Keller, Esq., Caitlin P. Strauss, Esq., Saul Ewing Arnstein & Lehr, Philadelphia, PA, Edward F. Roslak, Esq., Saul

Ewing Arnstein & Lehr, Newark, NJ, for Defendant-Appellee

Before: HARDIMAN, SCIRICA, and COWEN, Circuit Judges.

OPINION*

HARDIMAN, Circuit Judge.

This appeal arises under the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 *et seq.* The District Court held that Thomas P. Kelly, Jr. was entitled to 24 months' worth of disability benefits because he could not perform his own occupation. The Court later found that Kelly could perform some occupation, so it denied his request for more benefits. Kelly now appeals three orders entered by the District Court. We will affirm.

I[1]

We begin by summarizing the facts and prolix procedural history of this case, which began in November 2005 when Kelly injured his spinein a car accident. About six months after his accident, Kelly applied for disability benefits under an ERISA plan (the Plan) sponsored by his employer, Penn Mutual Life Insurance Company, and funded and administered by Reliance Standard Life Insurance Company. *See Kelly v. Reliance Standard Life Ins. Co.*, 2011 WL 6756932, at *2 (D.N.J. Dec. 22, 2011).

Reliance used the Plan's definition of disability to evaluate Kelly's application. Under the Plan, to

receive benefits for the first 24 months of disability, a participant must show he cannot perform his "regular occupation." App. 258. The standard then becomes harder to satisfy, as the participant must show he cannot perform "any occupation ... that [his] education, training[,] or experience will reasonably allow." *Id.*

Reliance denied Kelly's initial claim after determining that he was capable of performing his "regular occupation." Kelly appealed, and in the first of three remands to Reliance, the District Court held that Kelly could offer more information supporting his claim because Reliance's administrative record was deficient. *See* Kelly Br. 15; *Kelly v. Reliance Standard Life Ins. Co.*, 2015 WL 3448033, at *1 (D.N.J. May 28, 2015). Kelly then provided supporting information, but he also claimed for the first time that he was disabled under the more stringent "any occupation" standard, which applies only to those seeking more than 24 months' benefits.

Reliance denied Kelly's claim a second time, and on December 22, 2011, the District Court again found Reliance erred. *See Kelly*, 2011 WL 6756932, at *3, *5–12. This time, the Court held that Reliance had been arbitrary and capricious in reviewing medical evidence and analyzing Kelly's regular occupation. *Id.* at *5–11. So the Court awarded Kelly 24 months' benefits, but because Reliance had never evaluated whether Kelly was entitled to more benefits under the "any occupation" standard, it remanded that claim for further review. On this second remand, Kelly sought over 60 months'

benefits. Reliance conceded it owed Kelly 24 months' benefits under the "regular occupation" standard but insisted it still needed to investigate whether Kelly satisfied the "any occupation" standard.

Kelly appealed to the District Court, arguing that the Court had already (in its **162* December 22, 2011 order) found Reliance owed him benefits under the "any occupation" standard. In a May 29, 2015 order, the Court disagreed. *See Kelly*, 2015 WL 3448033, at *2–4. It said it had found no such thing and that, in any case, it would have been powerless to do so. *Id.* at *2–3. The Court thus remanded Kelly's claim to Reliance for a third and final time.

On this final remand, Reliance denied Kelly's claim for more than 24 months' benefits under the "any occupation" standard. And on cross-motions for summary judgment, the District Court granted summary judgment to Reliance and Penn Mutual on December 31, 2017.[2] App. 53–54. It held Reliance's decision was not arbitrary and capricious because the record before Reliance supported the finding that Kellycould perform at least full-time sedentary work. App. 50.

II

In this appeal, Kelly challenges: (1) the District Court's December 22, 2011 order awarding 24 months' benefits and remanding to Reliance; (2) its May 29, 2015 order declining to award benefits under the "any occupation" standard; and (3) its December 31, 2017 order upholding Reliance's denial of "any occupation"

benefits. He makes essentially two arguments. First, he claims the District Court should have awarded him 55 months' benefits instead of remanding. Second, he asserts that on remand, Reliance should have granted him benefits under the "any occupation" standard through the end of his coverage. We address each argument in turn.

A

Kelly first argues that once the District Court held that he could not perform his "regular occupation," it followed that he could not perform "*any* occupation" through the date of its order (December 22, 2011). And if he was disabled through the order date, Reliance would owe him 55 months' benefits.

This argument suffers from a logical flaw. Just because the District Court found Kelly could not perform his *regular* occupation does not mean it found Kelly could perform *no* occupation. Kelly's regular job is merely one of many jobs that his "education, training[,] or experience [would] reasonably allow." App. 258. Similarly, while Reliance was arbitrary and capricious in deciding Kelly could perform his regular job, it does not follow that Reliance also erred when it determined that Kelly failed to show he could not perform "any occupation." *See Conkright v. Frommert*, 559 U.S. 506, 517–19, 130 S.Ct. 1640, 176 L.Ed.2d 469 (2010); *Miller v. Am. Airlines, Inc.*, 632 F.3d 837, 856 (3d Cir. 2011) ("[W]here benefits are improperly denied at the outset, it is appropriate to remand to the administrator for full consideration of whether the claimant is

disabled."). Thus, the District Court properly remanded Kelly's "any occupation" claim to Reliance.[3]

B

Kelly next argues that even if the latest remand were valid, Reliance should have awarded him benefits under the "any occupation" standard. This argument proceeds in two parts. First, Kelly requests a **163* heightened standard of review because Reliance not only has a financial conflict of interest (as both funder and administrator of the Plan), but is also procedurally biased against him. Second, Kellyasserts that under this heightened standard, Reliance's evaluation of the medical evidence was haphazard and incorrect. He claims Reliance cherry-picked evidence and erred in finding Kelly could work a job that his "education, training[,] or experience [would] reasonably allow." App. 258.

Neither part of this argument is persuasive. We review benefit denials under the deferential "arbitrary and capricious" standard where, as here, a plan grants its administrator discretionary authority. *Fleisher v. Standard Ins. Co.*, 679 F.3d 116, 121 & n.2 (3d Cir. 2012); App. 163 (Reliance Plan). Conflicts of interest, whether financial or procedural, are merely a factor *within* our deferential analysis. *See Dowling v. Pension Plan for Salaried Emps. of Union Pac. Corp. & Affiliates*, 871 F.3d 239, 250–52 (3d Cir. 2017), *cert. denied*, —— U.S. ——, 138 S.Ct. 1032, 200 L.Ed.2d 258 (2018).

We see no reason to reject Reliance's assessment of Kelly's medical condition. The record contains ample evidence that Kelly could perform an occupation allowed by his education, training, or experience. Four independent doctors conducting three separate reviews of Kelly's file have concluded Kelly is not totally disabled. Most recently, as part of its appeals process on remand, Reliance referred Kelly's file to a physician specializing in internal medicine. After reviewing 110 pages of exam reports and laboratory results, she determined Kellyhas had "no physical limitations or restrictions" since May 2008. App. 936. Indeed, as Reliance notes, public records show Kelly earned admission to the New Jersey bar and co-founded a law firm during his time of purported total disability. Thus, Reliance was not arbitrary and capricious in declining to find Kelly disabled under its "any occupation" standard.[4]

Kelly suggests that his receipt of Social Security Disability Insurance (SSDI) benefits proves otherwise. But while an SSDI benefits decision might be relevant to an ERISA plan administrator, a plan's benefits policies may differ from those that govern Social Security disability benefits. *See generally* 42 U.S.C. §§ 416(i), 423(d); 20 C.F.R. § 404.1505. Thus, Kelly concedes that SSDI decisions do not bind Reliancebecause Reliance has not incorporated SSDI policies into its Plan. Reply Br. 21; *see Moats v. United Mine Workers of Am. Health & Ret. Funds*, 981 F.2d 685, 689 (3d Cir. 1992). And even on its face, Kelly's SSDI decision hardly helps his ERISA case, because the Social Security Administration

found Kelly can perform some sedentary work. App. 1022.

* * *

For the reasons stated, we will affirm the orders of the District Court.

Footnotes

*This disposition is not an opinion of the full Court and pursuant to I.O.P. 5.7 does not constitute binding precedent.

1The District Court had jurisdiction under 29 U.S.C. § 1132(e). We have jurisdiction under 28 U.S.C. § 1291. Our review of the District Court's summary judgment is plenary, and we apply the same standard as the District Court. *E.g.*, *Blunt v. Lower Merion Sch. Dist.*, 767 F.3d 247, 265 (3d Cir. 2014).

2Kelly did not oppose Penn Mutual's motion for summary judgment, App. 53, and his arguments on appeal do not mention Penn Mutual.

3Contrary to Kelly's argument, *McCann v. Unum Provident*, 907 F.3d 130 (3d Cir. 2018), does not hold otherwise. *McCann*excused a claimant's failure to exhaust administrative remedies. *See id.* at 151–52. Exhaustion is not at issue here.

4To the extent there are gaps in the record, they result from Kelly sandbagging Reliance. Kelly evaded Relianc e's repeated requests for updated medical records, information from his successful SSDI hearing, and more. *See, e.g.*, App. 902–04 (Reliance's June 5, 2015

letter to Kelly); App. 957–58 (Reliance's July 22, 2015 follow-up); App. 960–63 (Kelly's September 4, 2015 response).

12/31/2017

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

THOMAS P. KELLY, JR. *Plaintiff*, v. RELIANCE STANDARD LIFE INSURANCE COMPANY, and PENN MUTUAL LIFE INSURANCE COMPANY *Defendants*.	Civil No.: 09-2478 (KSH) (CLW) **OPINION**

Katharine S. Hayden, U.S.D.J.

This matter has once again come before the Court on a final round of summary judgment motions brought by all parties. (D.E. 211, 215, 216.) They are aware of the facts and the legal issues involved in this case, which have been discussed in the Court's previous opinions (D.E. 106, 171, 193) and vigorously litigated since plaintiff Thomas P. Kelly, Jr. ("Kelly") first filed his complaint in May 2009 against Reliance Standard

Life Insurance ("Reliance") and Penn Mutual Life Insurance Company ("Penn Mutual") (D.E. 1).

At bottom, Kelly claims that Reliance, the company that funded and administered his long-term disability ("LTD") plan with his former employer, Penn Mutual, wrongly denied his claim for benefits in violation of the Employee Retirement Income Security Act of 1974 ("ERISA"), and that Penn Mutual breached fiduciary duties it owed him. The Court is presented with two issues on these cross-motions: First, whether Reliance's April 21, 2016 decision to deny Kelly's claim for LTD benefits based on the "any occupation" disability definition under the plan was made in an arbitrary and capricious way in violation of ERISA. And second, whether Penn Mutual has any liability for violating ERISA as a co-fiduciary.

BACKGROUND

Kelly was hired by Penn Mutual on December 2, 2002, and in 2005 he was working as a managing compliance officer. (D.E. 5-1 at 3.) As a benefit of his employment he was insured under a long-term disability policy underwritten by Reliance, which also possessed the discretionary authority to determine Kelly's eligibility for plan benefits. The terms of the LTD plan require that a plan participant seeking benefit payments must show "total disability" as the plan defines it. (D.E. 203-2 at 1-2.) In order to collect LTD benefits for an initial period of 24 months, the participant must establish that his disability extends beyond what the plan calls the "elimination period,"—a buffer zone beginning 180 days after the employee's last day of work. *Id.* Total disability for this 24-month

period is defined as the inability to perform the substantial duties of the participant's "regular occupation." If the participant qualifies and receives 24 months of payments, the plan calls for a different definition of total disability and a reevaluation of the participant. The language change is significant—under the new definition, the participant must be unable to perform the substantial and material duties of "any occupation … that [his] education, training or experience will reasonably allow." Upon that showing, the plan administrator will pay out benefits beyond the first 24-month period. The LTD plan reads in relevant part:

> "Totally Disabled" and Total Disability" mean, that as a result of an Injury or Sickness:
>
> (1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, an Insured cannot perform the substantial and material duties of his/her "Regular Occupation";
>
> …
>
> (2) after a Monthly Benefit has been paid for 24 months, an Insured cannot perform the substantial and material duties of any occupation. Any occupation is one that the Insured's education, training or experience will reasonably allow. We consider the Insured totally Disabled if due to any Injury or Sickness he or she is capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis.

D.E. 203-2 at 1-2.

The parties do not dispute that Kelly's coverage under the plan ended on his 66th birthday, which occurred on August 24, 2012. (D.E. 57-1 at 6.)

On November 7, 2005, a truck backed into the car Kelly was driving, exacerbating an existing back injury he had sustained while snowmobiling in the 1990s. (D.E. 106 at 2.) After deciding he could not return to work, Kelly sought medical treatment from an orthopedic surgeon, Dr. Walter Dearolf, who examined him on five occasions between November 2005 and June 2006. (D.E. 29-2 at 29-31.) Kelly was familiar with Dr. Dearolf's practice because he was previously treated by a colleague of Dearolf's in connection with the older snowmobiling injury. After Kelly's first visit on November 15, 2005, Dr. Dearolf described his condition:

> He has a history of being involved in a motor vehicle accident eight days ago where he was the restrained driver, driving forward when a truck that was in the intersection backed up into him. There was no airbag deployment. He noted immediate pain initially in his neck and in his back. He then developed numbness and tingling down his right leg. The right leg seemed like it wanted to buckle on him. He has had back problems before but they would come and go and they didn't involve any leg symptoms. There was no loss of consciousness at the time.
>
> He has no new medical problems. He has been otherwise healthy in the interim.

Id. at 29.

Dr. Dearolf also noted the results from the exam:

> Exam shows today some mild tenderness in the trapezius and neck vertical motion is good. Exam of his back shows tenderness over the sacroiliacs. There is some spasm. Lumbar motion is moderately restricted. There is painless rotation of the hips. Sitting root test is positive on the right, negative on the left. There is some mild toe extensor weakness on the right with some decreased lateral border of the right calf and foot. There is no weakness or sensory disturbance on the left.

AP and lateral lumbar spine films are taken. There is narrowing at L4/5 and L5/S1.

> I recommend he have an MRI performed to see if he has a herniated disc accounting for his radiculopathy. He has some mild weakness. This may also be partly due to pain. I have discussed the significance of this with him. Should he worsen or develop any progressive symptoms, he is to go to the emergency room or get back to me immediately. Otherwise, we will proceed with the MRI to see if he might benefit from the Medrol Dosepak or epidural. In addition, prescription for Percocet 30 tablets to take as needed for pain.

Id.

On November 18, Dr. Dearolf's notes indicate that he left Kelly a voicemail message stating that the

MRI report "showed no change from the previous" MRI that was taken before the accident.[1] *Id.*

Kelly's second visit was on January 20, 2006, generating these notes:

> Still having a lot of pain in his back. He can't straighten up all the way. It radiates into his thigh somewhat. He had seen his family doctor. He got a prescription for some Flexeril. It really knocked him for a loop. It made him groggy. It did take away a lot of his spasm. He finds the pain medicine didn't really help him as much.
>
> On exam today he has trigger points in both sacroiliacs. Lumbar motion is moderately restricted. Sitting root and straight leg raising test are mildly restricted and produce some buttock pain. There is no sensory disturbance or motor weakness.
>
> Because of his symptoms, I recommend he get into some outpatient therapy. Also add a TENS unit. He will follow up in a month.

Id. at 30.

On March 7, 2006 Kelly began physical therapy at Cornerstone Physical Therapy under the direction of James J. Seykot, MSPT. Kelly underwent a physical therapy regimen that included 25 visits through June 2006. (D.E. 29-2 at 39-53.)

---

[1] It appears from the record that Dr. Dearolf was referencing an MRI report contained in Kelly's medical file taken in connection with the earlier snowmobiling injury.

On March 14, Kelly saw Dr. Dearolf for a third time. The treatment record from that visit reads:

> Going to therapy. It seems to be helping somewhat. He is still quite stiff. Apparently they have told him about his abdominal musculature is weak. No pain radiating down the legs. He is using a fair amount of Motrin. It seems to be helping.
>
> On exam there is mild tenderness in the paraspinal lumbar and thoracic musculature. Lumbar motion is still restricted. Sciatic tension signs, however, are negative today.
>
> I have discussed things with him. He will continue in his therapy. He will follow up in six weeks.

Id. at 30.

On May 2, 2016, Kelly saw Dr. Dearolf for a fourth time. From his notes on that visit:

> Finds that the therapy seems to be helping. Hasn't really helped with the pain but he feels he is more flexible. He feels a little more limber. He thinks it is helping. He has occasional flickering symptoms into his right leg. He has had similar trouble to that in the past. He may end up requiring an epidural.
>
> Exam today shows that there is still some mild tenderness in the paraspinal musculature, in both the lumbar and thoracic region. Motion

> is still restricted but improved from last time. Sitting root and straight leg raising are negative. Sitting root on the right makes him tend to arch his back a little. There is no toe extensor weakness.
>
> We will continue therapy at this point. It seems to be helping. He will follow up in a month.

Id. at 31.

The notes from Kelly's final visit on June 28, 2006 read:

> Therapy is helping. He gets a lot more limber and feels better but then it tightens up and he gets pain again. It seems like he is not making progress as fast as he would like.
>
> Exam shows he has trigger points in the thoracic and lumbar spines today. There is painless rotation of the hips. There is no toe extensor weakness.
>
> I reviewed his therapy report with him. We will go ahead and continue him in therapy. He will follow up in about six weeks unless there is a problem sooner.

Id. at 31.

Kelly timely filed an application to Penn Mutual for long-term disability benefits. It was Penn Mutual's obligation to forward his claim along with accurate supporting documentation, such as a job description, to Reliance. The administrative record at the time that

Reliance began to administer it consisted of the job description provided by Penn Mutual, Dr. Dearolf's treatment records from the five visits, notes from the physical therapy sessions at Cornerstone Physical Therapy, and two letters written by the physical therapist. (D.E. 29-1-2.)

On July 26, 2006, Reliance's vocational rehabilitation specialist, John J. Zurich, reviewed Kelly's claim file, and classified Kelly's occupation at Penn Mutual as "sedentary." (D.E. 29-1 at 36-38.) Marianne P. Lubrecht, BSN, a Reliance nurse, reviewed Kelly's medical records and concluded that, based on the description of Kelly's occupation as sedentary, the medical records did not support the stated restrictions. *Id.* at 89-101.

In October 2006, Reliance denied Kelly's claim for LTD benefits, and Kelly timely appealed. In support, he submitted an updated job description, but no new medical records. Zurich reviewed the file with the revised job description, and once again concluded Kelly's occupation should be considered "sedentary."

In February 2007, Reliance referred Kelly's file to an independent physician, Dr. Howard Choi, who reviewed all the medical information and completed a report with the following conclusions:

> There is no evidence provided that conclusively supports that plaintiff suffered any injuries other than a potential lumbar sprain/strain injury.
>
> It is not clear at what level the disc herniation was, when it was first noted, how it was

> diagnosed (e.g. clinically, MRI), and whether it was a chronic/ degenerative condition.
>
> Overall, the claimant's alleged degree and duration of functional impairment seem significantly out of proportion with the nature of the injury and objective findings.
>
> Dr. Dearolf's disability statements were lacking in any detail regarding the claimant's activity levels and did not provide any objective evidence to support the allegation that the claimant could not do any work; and there is no objective basis for any restrictions or limitations from sedentary-level work provided in the documentation available for any time period.

D.E. 29-1 at 91.

In March 2007, Reliance affirmed its denial of Kelly's LTD's claim. (D.E. 29-1 at 97.) Two years later, Kelly sued both Reliance and Penn Mutual, claiming that Reliance's denial of benefits was arbitrary and capricious in violation of ERISA, and that Penn Mutual had breached its fiduciary duties as a co-fiduciary of the LTD plan by providing the wrong job description to Reliance. (D.E. 1.) The original complaint included RICO claims against both defendants, which were dismissed on motion, and a claim against Penn Mutual alleging a violation of the Family and Medical Leave Act, which was dismissed by stipulation. The claims in the remaining first two counts alleged ERISA violations against both defendants.

In the spring of 2010, the parties cross-moved for summary judgment (D.E. 55, 56, 57). On December 14,

2010, after oral argument, the Court found that the administrative record was deficient; that Reliance had relied on an incorrect definition of Kelly's occupation; that Penn Mutual provided an incorrect job description to Reliance; and that Kelly had not been helpful in providing information during the claim process. The Court remanded the claim back to Reliance and directed it to make a decision on the merits, while also permitting Kelly to supplement the administrative record. (D.E. 87.)

Kelly did submit a supplemental certification on January 11, 2011 (D.E. 101-2 at 7-14) that aimed to rectify the "incorrect and misleading statements about [his] job title and associated duties" at Penn Mutual. Kelly maintained that his work mandated at least 45% travel, and that the job description Reliance was using left out other travel requirements necessary for his position. Kelly attached a supplemental letter report dated January 4, 2011 from Dr. Dearolf, as well as the photocopies of the MRI images taken when he began his treatment with Dr. Dearolf in November 2005. In the supplemental letter report, Dr. Dearolf wrote in full:

> To Whom It May Concern:
>
> > Thomas Kelly has been a patient in our practice since the early 1990s when he sustained a compression/burst fracture of T12 and he was treated by my partner Dr. Henry DeVincent. He has since retired and I have seen Mr. Kelly over the years dating back to the mid 90's. In November 2005, he was involved in a motor vehicle accident which aggravated his underlying condition. MRI scan at that time revealed his previous compression fracture at T12 with degeneration of the disc T12-L1 and

> T11-12. There was also a posterior spur at the T11-12 interspace with gibbus deformity. This was unchanged from previous but was aggravated by the motor vehicle accident. In addition, there was a left sided disc herniation at L5- S1. He was seen by me during this period. He had radicular symptoms along with limited motion in his lumbar and thoracic spine, lumbar sprain and strain, lumbar radiculopathy and degenerative joint disease in his back. Since that period of time, he has been unable to return to his previous occupation as a compliance officer for Penn Mutual Life Insurance Company. In addition, he has been unable to sit for any prolonged period of time or stand for any prolonged period of time making him incapable of sedentary work. Driving for any period of time also aggravates his symptoms.
>
> It is my medical opinion that he is unable to perform sedentary and non-sedentary duties associated with his regular occupation or with any occupation at this time. His symptoms on a permanent basis are unlikely to improve over time.
>
> I hope this information is sufficient for your needs.

D.E. 203-2 at 92.

Also, in the supplemental certification Kelly claimed for the first time that he suffered from chronic cardiac issues dating back to the age of 25, when he was "diagnosed with Supraventricular Tachycardia, a condition that caused, inter alia, a spontaneous increase

in heart rate." (D.E. 101-2 at 21-23.) Over the years, Kelly stated, doctors had conducted several cardiac procedures on him, and in the spring of 2007 he began seeing a cardiologist, Dr. Dina Yasmajian. He complained to Dr. Yasmajian of his shortness of breath and chest pains. Kelly also stated that he was previously diagnosed by another cardiologist with myocardial infarction resulting from a blocked vessel. According to Kelly's certification:

> 64: The symptoms associated with chronic atrial fibrillation are routinely severe enough to stop me from performing even sedentary activities until I am able to catch my breath and relax until the symptoms have passed. As one might expect, this condition also caused me an increased level of anxiety, which increased the time necessary for the symptoms to subside.
>
> 65. The fatigue resulting from my cardiac symptoms is debilitating and generally long-lasting and prevents me from performing most activities. Moreover, the onset and increase of my cardiac symptoms has interfered with the pain management that is associated with my spinal cord injury and associated back pain. This is true because the medication necessary to alleviate my cardiac symptoms contraindicates the use of most pain relievers that could otherwise be used to offset my severe back pain.

D.E. 101-2 at 23.

Reliance sent Kelly's file with the supplemental materials to two specialists who issued a joint report on

February 3, 2011. Dr. Robert Green, an orthopedic surgeon, noted there was a complete absence of orthopedic treatment post-June 2006, and concluded that Kelly had a "lumbar sprain of a mild degenerative, previously somewhat compromised spine." (D.E. 102-2 at 13-27.) He found "no objective evidence for restrictions or limitations" from an orthopedic standpoint. *Id.*

A cardiologist, Dr. Gregory Helmer, noted in that report, that Kelly's cardiovascular system was stable "both by exam and EKG" in August 2006, and that a stress test administered in September 2006 "showed excellent exercise tolerance with normal left ventricular functions and no myocardial ischemia." Dr. Helmer concluded that "Mr. Kelly had stable coronary artery disease" and there are "no limitations on sitting, walking, standing, pushing, conversing, phone use, computation, or paperwork." (D.E. 103-3 at 18-19.)

On February 18, 2011 Reliance denied Kelly's claim for benefits on the basis that he did not show that his disability made him unable to perform his regular occupation beyond the 180- day elimination period. (D.E. 103-2 at 2.) In the denial letter, Reliance cited a report completed by a vocational specialist, Jodi Barach, who reviewed Kelly's supplemental certification and concluded that notwithstanding his claimed medical problems, "Mr. Kelly would be capable of performing the material duties of a Managing Agent at Penn Mutual Life Insurance Company." (D.E. 103 at 6.) Additionally, Reliance solicited the opinion of Kelly's superior at Penn Mutual, Frank E. DePaola, regarding the travel requirements associated with Kelly's job. In a letter sent to Reliance, DePaola said that Kelly had to

travel about 10% of the time, and had the authority to delegate many of these travel duties if he wanted to. *Id.*

Kelly moved for summary judgment on his ERISA claims against Reliance. In an opinion dated December 22, 2011 (D.E. 106), this Court determined that the remand decision was arbitrary and capricious because it selectively reviewed the medical evidence in the administrative record and placed an undue emphasis on doctors who never treated Kelly. The Court found that Reliance's "apparent wholesale rejection of Kelly's description of his job duties was unreasonable and led to the additional unreasonable failure to countenance the existence of any restrictions or limitations during the Elimination Period." *Id.* at 11. And, "Reliance's failure to consider the duties Kelly was actually performing prior to the accident and whether Kelly was physically capable of performing those duties after the accident was unreasonable and demonstrates Reliance's exercise of discretion in denying Kelly's claim was arbitrary and capricious." *Id.*

The Court entered an order (D.E. 107) that directed Reliance to provide all benefits due Kelly "consistent with the rulings" in its written opinion (D.E. 106). Kelly's motion for summary judgment on his claim against Penn Mutual was denied. The order gave Kelly leave to file an application for counsel fees, noting that this did not mean that an award would be granted. The parties were directed to appear before then-Magistrate Judge Patty Shwartz for a settlement conference the following month. (By this time the 24-month period for payment of LTD was long past and Kelly's cut-off date of August 24, 2012 for additional LTD payments was on the horizon.)

Judge Shwartz presided over the settlement conference and very shortly thereafter, Kelly's lawyer

filed a letter to her on the docket confirming that a settlement agreement had been reached. The letter, dated January 30, 2012, reads in full:

> Your Honor:
>
> I am pleased to inform the Court that a settlement has been reached between the plaintiff and defendant Reliance Standard Life Insurance Company in the above- captioned matter. Subsequent to Friday's Settlement Conference, negotiations continued between these two parties. Ultimately, the plaintiff's final offer of settlement was accepted. These parties have agreed that, with respect to Reliance Standard, Judge Hayden's ruling on plaintiff's motion for counsel fees shall be final and that no appeal shall be filed.
>
> The claims against defendant Penn Mutual have not been settled. On behalf of the plaintiff, thank you for assisting the parties with their dispute resolution efforts.

D.E. 116.

The letter confirmed Reliance and Kelly had agreed on a settlement number and the counsel fee application would be decided by the Court – but resolving the Penn Mutual claim proved particularly nettlesome for the parties. Ultimately Reliance reported an impasse in a letter to Judge Shwartz dated February 27, 2012:

> On January 27, 2012, the parties attended a settlement conference before you. Immediately following the settlement conference, Reliance Standard and Plaintiff agreed to a settlement. Thereafter, Reliance Standard sent to Mr. Kelly the proposed settlement agreement. Mr. Kelly asked that certain changes be made to it, many of which were incorporated. However, Mr. Kelly refused to agree to certain terms which are essential to the settlement.

D.E. 120.

In the letter, Reliance asked Judge Shwartz to schedule a telephone conference to address the settlement issues. The next day Kelly filed a motion to enforce the settlement, attaching an email he had received from the attorney for Reliance right after the January 27th settlement conference:

> While walking to the train, my client decided to accept your final offer in order to put the matter to rest. We will pay 400,000 to satisfy the benefit claim, Judge Hayden will decide the fee motion and no party will appeal the court's decisions, re benefits, RICO, etc. Including the fee ruling.

D.E. 121.

Kelly argued in his motion papers that he had accepted the settlement offer, and that in violation of their agreement Reliance was now tacking on additional conditions. *Id.* On Reliance's application, the Court administratively terminated his enforcement motion because by filing it, Kelly violated a prior scheduling order directing the parties to request leave of court

before filing any motions. (D.E. 124.) Kelly thereafter re-filed the motion after obtaining leave (D.E. 126) and, unsurprisingly, Reliance disagreed with his narrative and contended he was the party who upended the settlement by refusing to sign a release and continuing to pursue claims against Penn Mutual. (D.E. 127.) (By pursuing damages from Penn Mutual, Kelly was exposing Reliance to a claim for indemnification were he successful.) A month later, the Court referred the matter to Hon. James F. Keefe Sr. (ret.) to mediate the settlement issues, and Kelly's enforcement efforts were administratively terminated without prejudice. (D.E. 130.)

In September 2012, Penn Mutual advised the court that mediation had failed. (D.E. 135.) One week later, Kelly renewed his motion to enforce. (D.E. 136.) While it was pending, Kelly filed a letter on the docket asking the Court to set a date to try his claims against Penn Mutual despite the ongoing dispute about whether the ERISA claims against Reliance were actually resolved. (D.E. 140.) Penn Mutual responded by filing a letter on the docket arguing that a trial date was not appropriate at the time, instead requesting that the Court "convene a conference at which time we can discuss the appropriate resolution of the remaining issues either by means of settlement or motion practice." (D.E. 141.)

On September 18, 2013, Kelly filed a Rule 11 motion for sanctions against Reliance and its attorneys for $36,000,000 (thirty-six million dollars) for "their willful abuse of the judicial system." (D.E. 143-1 at 5.) In that motion, Kelly stated that "[s]anctions are necessary here because in this case, and in dozens of others like it over the last decade, the defendant and its lawyers have been engaged in a scheme whereby they

force disabled plaintiffs to re-litigate well- settled legal issues with the intent of delaying payment of insurance benefits." *Id.* On Reliance's application, the Court administratively terminated Kelly's motion for sanctions because he had again failed to request leave before filing. (D.E. 153.) In February 2014, Kelly filed a letter on the docket addressed to Magistrate Judge Waldor requesting leave to file sanctions, and both defendants opposed the motion.

Looming over the settlement efforts, and fueling the parties' motion practice at the time, was the hotly contested issue of whether this Court's favorable decision in December 2011 required Reliance to pay LTD benefits to Kelly as unable to work at "any occupation," as opposed to directing payment of the 24-month LTD benefit based on inability to work at his "regular occupation."

On July 21, 2014, the Court denied Kelly's motion to enforce the settlement terms that had been described in the parties' exchanges in January 2012. (D.E. 171.) The Court noted at the outset that "[w]hile Kelly is frustrated with the length of time it has taken to resolve his issues with Reliance, the Court's review of the record reveals that the movement Kelly wants is stalled by all parties' confusion over what happens next with his claims against the other defendant, Penn Mutual." *Id.* at 1. The Court also pointed out that that the parties had been talking past one another:

> The time has come for Kelly to define what he wants from [Penn Mutual], and for Reliance and [Penn Mutual] to indicate what Reliance was settling by way of the [January 2012] email and what if anything [Penn Mutual] plans to offer

> Kelly by way of benefits. Filling in those gaps motivated the Court's directions that *all* parties, not just Kelly and [Penn Mutual], pursue negotiations as to Penn Mutual's obligations. Evidently negotiations and even mediation failed as the vehicle for clarification and resolution. As a consequence, the Court denies Kelly's motion, and in the absence of any indication the parties can reach agreement, the Court orders motion practice.

Id. at 2.

In a letter dated August 5, 2014, Reliance asked Kelly to provide additional information to supplement the administrative record so Reliance could administer Kelly's "any occupation" claim. (D.E. 216-6 at 2-4.) Specifically, Reliance asked Kelly to furnish, among other things, a daily living questionnaire, an authorization form whereby Reliance could review the records of his disability application to the Social Security Administration, copies of income tax returns. Reliance also served interrogatories seeking information about Kelly's work as an attorney.

While the litigation was going on, Kelly had applied for social security disability ("SSD") benefits and on August 6, 2014, an administrative law judge ("ALJ") issued a favorable ruling after holding a hearing at which Kelly and a vocational expert testified. The ALJ found that Kelly was disabled under the regulations issued by the Commissioner of Social Security, with an onset date of November 10, 2005. In making his determination, the ALJ considered Kelly's age, then 67, in light of the "grid," or the Medical-Vocational Rules, that guide SSD determinations. The opinion reads in relevant part:

The claimant testified he suffered a back fracture and other back injuries in a 1993 incident and thereafter experienced an exacerbation of these injuries in a 2005 motor vehicle accident; he reported he was prescribed a cane after this accident and continued to use it. He testified that he has also suffered from cardiac conditions since young adulthood, with a blockage in 2000, catherization in 2001 (with stent placement) and heart attacks in 2008 and 2012. The claimant indicated he experienced shortness of breath and fatigue in connection with his cardiac condition.

The claimant testified he was also experiencing tingling and a lack of sensation in his right hand and noted he could only walk a couple hundred yards with a cane. He testified he could stand for 20-25 minutes and sit for about the same amount of time. Though he indicated he could lift up to 30 pounds, he reported he would be unable to walk the next day. He complained of daily low back pain that radiated to his groin; he reported his pain level was the same as 2 years ago. The claimant reported he underwent about half dozen epidural steroid injections and continued to suffer from difficulty sleeping.

In a prepared statement, the claimant reported he continued to experience shortness of breath and fatigue for periods of varying duration. He indicated his cardiac symptoms were routinely severe enough to stop him from performing even sedentary activities until his symptoms

> resolved. In his 2011 Function Report, he reported he required rest throughout the day, awakened several time a night, had difficulty dressing/bathing due to pain, had decreased attention span/attention to detail and complained of general difficulty lifting more than 10- 15 pounds.
>
> …
>
> The undersigned finds that he can sit for 30-40 minutes and walk for 5-10 minutes.
>
> …
>
> Although the vocational expert testified that an individual with the claimant's age, education, work experience and residual functional capacity could perform other work in the national economy, the Medical-Vocational Rules direct a finding of disability.

D.E. 203-2 at 16-22.

On October 9, 2014, Reliance notified Kelly that it would be issuing payment of $180,127.52 on his "regular occupation" claim for 24 months of disability benefits. (D.E. 216- 15.) Reliance then filed a motion to remand so that it could administer the "any occupation" claim. (D.E. 179.) In response, Kelly filed a cross-motion to hold Reliance in contempt for its "unlawful refusal to comply with the Court's 2011 Order" because "this Court completely rejected the defendant's current position and awarded the plaintiff more than five years' worth of disability benefits, most of which has not been paid." (D.E. 183-1 at 5.)

In an opinion dated May 28, 2015 (D.E. 186), the Court held that it was "beyond dispute" that the December 22, 2011 opinion (D.E. 106) "only extended to the claims Reliance had already considered, namely, Kelly's claim for benefits on his account for his inability to perform the duties of his regular occupation." *Id.* at 2. The Court held it was "powerless" to decide the "any occupation" issue, and granted Reliance's motion to remand for an administrative determination. *Id.* at 3.

Additionally, the Court denied Kelly's cross-motion for civil contempt sanctions, concluding that "Kelly fail[ed] entirely to show how Reliance disobeyed any aspect of that decision or order. To the extent Kelly claims Reliance failed to comply in that it refused to pay LTD benefits beyond 24 months under the 'any occupation' standard, the Court already has ruled herein that the December 22, 2011 order did not encompass such relief." *Id.* At 3.

On June 5, 2015 and July 22, 2015, Reliance sent Kelly correspondence requesting that he furnish additional information to help it administer his "any occupation" claim. (D.E. 203-2 at 86.) Meanwhile on June 11, 2015, Kelly filed a motion for reconsideration (D.E. 188), which the Court denied in an opinion dated August 31, 2015 (D.E. 193), stating in relevant part:

> Kelly makes the same argument in this reconsideration motion as he made in opposition to Reliance's motion to remand and his own cross-motion for summary judgment. He contends that Reliance did "*consider*" his claim for benefits under the "any occupation" standard, and the Court's finding that he was "entitled to receive the LTD benefits owed to

> him under the Plan" therefore encompassed such relief. This argument, once again, goes too far. Was Kelly's claim for "any occupation" benefits presented to Reliance, along with his claim for "regular occupation" benefits? Yes. Did Reliance *decide* whether Kelly was entitled to benefits under the "any occupation" standard? No, it indisputably did not.

Id. at 3.

On September 15, 2015, Reliance denied Kelly's claim for benefits under the "any occupation" provision of the LTD plan. (D.E. 203-2 at 50-54.) The file on Kelly consisted of what had been provided when Reliance made its decision after the Court remanded his claims in 2011, Kelly having decided not to provide the additional information Reliance sought in 2015.[2]

On March 4, 2016, Kelly appealed Reliance's denial with a raft of arguments supporting his claim to "any occupation" LTD benefits. (D.E. 216-16 at 1-24.) Regarding Reliance's request for additional information, Kelly argued it was "outside the permissible scope of what Mr. Kelly was required to provide." In sum, Kelly maintained that the record was complete and up-to-date as of January 11, 2011, when he provided the supplemental certification in support of his original claim for benefits. According to Kelly's appeal submissions,

---

[2] In paragraphs 1 through 6 of the Supplemental Statement of Material Facts Reliance submitted on its cross-motion for summary judgment (D.E. 216-2), Reliance states that Kelly was admitted to the New Jersey bar in 2008, remains in active status, holds himself out as a partner in the firm Kelly Law Offices, LLC., and has authored published practice articles.

> The applicant is not required to assist a plan administrator who is on an obvious fishing expedition like the one here. [Reliance] was obviously searching for ways to deny Mr. Kelly's claim for benefits instead of evaluating the claim based on the objective medical evidence that was provided in 2011.

Id. at 18.

Kelly also argued that Reliance's calculation of benefits in 2014 was incorrect. He stated that there was no basis for the reduction of monthly LTD benefits due to his theoretical eligibility for social security disability benefits. As part of the appeal process, Reliance referred Kelly's claim file to a fourth independent physician, internist, Dr. Stephanie Kokseng, in February 2016, who concluded that Kelly's medical file did not support a finding of total disability. As she indicated in her report:

> Based on the enclosed documentation and with a reasonable degree of medical certainty, since 05/25/08 the claimant has no physical limitations or restrictions. After that date, the claimant followed up with cardiology, and the documented physical findings during those visits do not support the placement of physical limitations or restrictions. The examinations included normal neurologic and extremity examinations. The physician did not perform extensive neurologic or musculoskeletal examinations and therefore, did not document any physical limitations or impairments that the claimant may have.

D.E. 216-8 at 2-8.

Reliance forwarded the claim file with Dr. Kokseng's report to Reliance's Quality Review Unit. On April 21, 2016, Richard Hellwig, a Senior Benefits Analyst, issued a written denial, which stated in relevant part:

> As noted in Dr. Dearolf's notes just after the accident, an MRI revealed no changes compared to a previous MRI performed prior to the accident. Physical consultation notes documented that Mr. Kelly reported improvement and in fact every physical therapy note beginning March 28, 2006, until the most recent note dated June 15, 2006, documented that Mr. Kelly reported his pain was either the same or decreased, and that functional mobility was either the same or improved with each successive visit. Furthermore, although you and Mr. Kelly have alleged that his cardiac symptoms are impairing, cardiology records dated May 25, 2008 provide ongoing support that Mr. Kelly is stable from a cardiac standpoint. In light of Mr. Kelly's cardiac diagnoses, Dr. Helmer provided restrictions and limitations which would be well within the requirements necessary to perform full-time sedentary work. Mr. Kelly stated in his affidavit that the fatigue resulting from his cardiac symptoms is "debilitating and generally long-lasting and prevents me from performing most activities" however, the most recent record from Dr. Yazmajian, which is dated only two months earlier, confirmed that Mr. Kelly was

> doing well with no new symptoms and that he has "no cardiac complaints."
>
> The available information in Mr. Kelly's claim file does not support a severity of impairment to the extent he would be precluded from full-time sedentary work; actually, the alleged extent of symptoms and complaints asserted by Mr. Kelly did not appear consistent with any physical examination findings or diagnostic studies. Mr. Kelly's ability to perform at least full-time sedentary work is supported by the independent opinion of four separate physicians.

D.E. 203-2 at 80-90.

As for Kelly's cardiac problems, Hellwig referenced the most recent treatment notes that Reliance retrieved from Dr. Yazmajian. On August 26, 2009, Dr Yasmajian indicated that Kelly had been exercising regularly with a trainer, experienced dyspnea only on exertion with humidity, and reported rare palpitations. *Id.* The most recent office visit note from Dr. Yazmajian, dated November 1, 2010, reflected that Kelly "was doing well and is without new medical issues" and "[he] has no new cardiac complaints." *Id.*

Hellwig noted that Kelly had been uncooperative with Reliance's Claims Department:

> The Claims Department requested that you provide the additional information as part of your assessment to determine whether Mr. Kelly was unable to perform the material duties of Any Occupation and was therefore Totally Disabled as of May 25, 2008, the date the

> definition of Total Disability changed. On the dates of June 5, 2015 and July 22, 2015, the Claims Department requested you provide the following information: a completed and signed Activities of Daily Living Questionnaire; an executed Authorization for Use in Obtaining Information; an executed Social Security Authorization form; evidence of Mr. Kelly's wages and earnings for the years 2006 through 2013; copies of all individual or joint tax returns, W-2s, or 1022s, as well as copies of tax returns for Kelly Law Offices, LLC from 2006 to the present; a copy of all supporting documentation of any payments and/or settlements Mr. Kelly received from The Penn Mutual Life Insurance Company; and details concerning any Other Income Benefits Mr. Kelly received from 2006 to the present. You never provided any of the requested information; furthermore, the only correspondence or information you submitted was a letter dated September 4, 2015, in which you demanded payment through the Maximum Duration of Benefits and did not provide or address any of the requested documentation. As a result, the Claims Department moved forward with the review of Mr. Kelly's claim based on the available information in the claim file.

Id. at 86.

Hellwig determined that Kelly was capable of at least full-time sedentary work. Regarding Kelly's claim that Reliance unlawfully offset the SSD benefits, Hellwig noted that a letter Reliance had sent to Kelly cited a policy provision that allows for the reduction of

Kelly's LTD monthly benefit due to his eligibility for SSD benefits. *Id.* at 87. That letter "clearly stated that any written request for review of the decision must be submitted within 180 days of your receipt of the letter," otherwise it would "constitute a failure to exhaust the administrative remedies available" under ERISA. *Id.*

Hellwig additionally indicated that Reliance had referred the claim file to four independent physicians who all concluded that Kelly was not totally disabled. *Id.* Hellwig addressed the July 2014 ALJ opinion, too.

> [Reliance] acknowledges that Mr. Kelly has been awarded Social Security Disability benefits. Although we have requested from you on multiple occasions any information which was submitted to or considered by the Social Security Administration ("SSA") in connection with his claim for SSD benefits, we have received nothing from you on the matter. Additionally, you never provided our office an executed Social Security Authorization form, which would have allowed us to request information directly from the SSA, despite repeated requests to do so. In any event, please be aware that while that while we consider the determinations of the SSA or other insurers, they are not binding on [Reliance's] decision as to whether or not Mr. Kelly meets the Policy definition of Total Disability. A person's entitlement to each of these benefits may be based upon a different set of guidelines, which may sometimes lead to differing conclusions. Each benefit provider may also be considering different medical evidence in the evaluation of a claim. For example, in Mr. Kelly's situation,

> the SSA may not have the results of the multiple Peer Reviews, or other medical information [Reliance] may have developed in Mr. Kelly's file. If the SSA were to review this information, they may reach a similar conclusion. Please be advised that the receipt of SSD benefits does not guarantee the receipt of LTD benefits or vice versa.

Id. at 89.

In September 2016, following Reliance's denial of his appeal, Kelly made a letter request that the Court reopen his case. (D.E. 197.) After a status conference with Magistrate Judge Waldor, the parties have filed these cross-motions for summary judgment (D.E. 211, 215, 216), on which the Court held oral argument on November 29, 2017.

DISCUSSION

Kelly contends that Reliance's denial of his administrative appeal was arbitrary and capricious because it cherry-picked the medical evidence, ignored the findings of his treating physician Dr. Dearolf, and did not assign proper weight to the ALJ opinion. He also maintains that Reliance failed to provide notice of an adverse benefit determination within 45 days of the original claim, and that it wrongfully offset SSD benefits. Reliance opposes on the basis that Kelly failed to sustain his burden to establish disability under the terms of the plan, and obstructed the claims process. For its part, Penn Mutual maintains that it cannot be held liable under a co-fiduciary theory under ERISA because a dispute over a claim for LTD benefits cannot

constitute a breach of fiduciary duty under ERISA, and, in any event, Kelly did not address any of Penn Mutual's arguments in his most recent motion (the last point was conceded at oral argument).

Under the familiar summary judgment standard, a court "shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

When, as here, cross-motions for summary judgment are pending, "the Court must rule on each party's motion on an individual and separate basis, determining, for each side, whether a judgment may be entered in accordance with the summary judgment standard." *Marciniak v. Prudential Fin. Ins. Co. of Am.*, 184 Fed. Appx. 266, 270 (3d Cir. 2006). In ERISA cases, the task is relatively straightforward, as the question presented by both motions is whether or not, based on the undisputed administrative record, the plan administrator's decision was arbitrary and capricious. *Id.* Under the arbitrary and capricious standard a court may only overturn a decision of the plan administrator if "it is without reason, unsupported by substantial evidence or erroneous as a matter of law." *Miller v. Am. Airlines, Inc.*, 632 F.3d 837, 845 (3d Cir. 2011). Substantial evidence is "sufficient evidence for a reasonable person to agree with the decision." *Courson v. Bert Bell NFL Player Retirement Plan*, 214 F.3d 136, 142 (3d Cir. 2000).

The parties do not formally specify the administrative record for this Court's review of the decision not to grant benefits beyond the 24-month period. Notwithstanding, their briefs discuss the administrative record already reviewed by the Court in

conjunction with its December 2011 opinion, along with Kelly's supplemental certification (with the attached Dearolf report) submitted in 2011, the Green-Helmer medical report responding to the supplemental certification in 2011, a vocational report by Jodi Barach also responding to the supplemental certification, the 2014 ALJ opinion, the 2015 vocational report by Carol S. Vroman report which found that Kelly had "transferrable skills," and the Kokseng report in 2016. The Court reviews these materials for purposes of deciding whether Reliance was arbitrary and capricious in its decision, and finds that the administrative record closed on April 21, 2016 with the Hellwig letter decision denying Kelly's appeal.

Turning to that decision, it states in relevant part:

> The available information in Mr. Kelly's claim file does not support a severity of impairment to the extent he would be precluded from full-time sedentary work; actually, the alleged extent of symptoms and complaints asserted by Mr. Kelly did not appear consistent with any physical examination findings or diagnostic studies. Mr. Kelly's ability to perform at least full-time sedentary work is supported by the independent opinion of four separate physicians.

Initially, Reliance both funded and administered the plan, which raises the issue of conflict of interest. In the Third Circuit this "structural" factor is weighed as part of the overall arbitrary and capricious analysis. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000). Another preliminary inquiry is the

"process" mandated by the plan, *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007), and here the plan language is precise about the burden placed upon an applicant for LTD benefits. Kelly bears the burden of establishing that he:

> (1) Is Totally Disabled as the result of a Sickness or Injury covered by the Policy
> (2) Is under the regular care of a physician
> (3) Has completed the Elimination Period; and
> (4) Submits satisfactory proof of Total Disability to us

D.E. 29-1 at 16.

It is in this context that the Court considers Kelly's main arguments: that in making its decision Reliance overlooked the January 2011 Dearolf letter report, and that it failed to give proper weight to the ALJ opinion.

A review of the record as a whole reveals substantial evidence supporting Reliance's decision to deny Kelly's claim for "any occupation" LTD benefits despite the conclusion of Dr. Dearolf. Solid support is found in the reports of four physicians, all of whom concluded that Kelly was not totally disabled. Kelly's failure, whether through refusal or inability, to obtain additional medical documentation, and the absence of any clinical examinations or diagnostic tests after June 2006, lend credence to Reliance's assertion that Kelly had not met his burden under the plan.

The conclusions in Dr. Dearolf's 2011 letter report were made without a new examination, albeit five years had passed since he had last examined Kelly. As such, his opinion that Kelly's symptoms are

permanent and unlikely to improve over time is not grounded in what a treating doctor who was actually providing ongoing treatment might be able to offer about Kelly's symptoms and prognosis. And the letter with those conclusions actually is belied by the improvements to Kelly's condition that are noted in the 2006 treatment records of the physical therapists and Dr. Dearolf.

Importantly, it is Kelly's burden under the plan to show that he is "under the regular care of a physician," thereby demonstrating *continued* total disability. In its denial letters, Reliance regularly informed Kelly that the documentation in his file was insufficient to support an impairment that would prevent him from working in "any occupation" after May 2008, and gave him the opportunity to supplement. Instead, Kelly has clung to his argument that the Court's decision in December 2011 embraced his claim for "any occupation" disability, even in the face of two subsequent decisions firmly rejecting his interpretation. While he is free to disagree with the Court, his failure to provide supporting material on the "any occupation" remand seriously undermines his challenge to the administrative decision. In this regard, it is difficult to ignore Kelly's accomplishments in being admitted to the New Jersey bar and establishing a law practice with his son during the relevant time period.

Kelly in effect closed down his contributions to the file on orthopedic issues with his supplemental certification and Dr. Dearolf's 2011 reprise of the findings he made back in 2006. The Court must repeat what Reliance is banging the drums about: there are simply no treatment records, diagnostic studies, office visit notes, or consultation records beyond Kelly's visit on June 28, 2006 with Dr. Dearolf. The medical records

from Dr. Dearolf consist of five medical notes spanning three pages containing observations from Kelly's appointments with him and his findings from the 2005 MRI. The choice that Kelly has made to limit his orthopedic medical records on the accident to those generated with Dr. Dearolf renders unpersuasive the "cherry- picking" arguments about the counterweight reports from the non-examining doctors.

The medical reports obtained by Reliance support the finding that Kelly had the capacity to perform at least full-time sedentary work. The internist Dr. Choi concluded that "there is no evidence provided that conclusively supports that plaintiff suffered any injuries other than a potential lumbar sprain/strain injury." (D.E. 29-1 at 91.) The orthopedic surgeon Dr. Green found "no objective evidence for restrictions or limitations" from an orthopedic standpoint. (D.E. 103-3 at 13-27.) The cardiologist Dr. Helmer said that Kelly had "no limitations on sitting, walking, standing, pushing, conversing, phone use, computation, or paperwork." (D.E. 103-3 at 18-19.) It stretches credulity for the Court to accept Kelly's argument that he has actually offered evidence that contradicts these conclusions—he has merely offered a contrary conclusion, in the form of a short letter report from Dr. Dearolf, without objective medical evidence supporting it post 2006.

In 2016, in connection with Kelly's administrative appeal, Reliance took the extra step of having another physician, Dr. Kokseng, review Kelly's entire medical file. She concluded in her report[3] that "[b]ased on the

[3] Kelly argues in these motions that Reliance improperly relied on Dr. Kokseng's report because she was not involved in the earlier assessment of his claim, and he did not have the opportunity to

enclosed documentation and with a reasonable degree of medical certainty, since 05/25/08 the claimant has no physical limitations or restrictions." (D.E. 216-8 at 6.)

The Court next turns to Kelly's argument that Reliance failed to give sufficient weight to the ALJ opinion. It is well-established that a social security award in itself does not show that a contradictory administrator's decision was arbitrary and capricious, and that "a plan administrator is not bound by the SSA decision." *Marciniak v. Prudential Fin. Ins. Co. of Am.*, 184 Fed. Appx. 266, 269 (3d Cir. 2006). A plan administrator and a social security decisionmaker analyze an application for disability benefits along differing lines. As noted in *Burk v. Broadspire Servs., Inc.*, 342 F. App'x 732, 738 (3d Cir. 2009), "The Social Security Administration's determination of 'disability' is not binding ... where the determination is governed by the plan terms rather than statute."

Markedly, the record before Reliance is devoid of any reference to the materials upon which the ALJ relied, but this was not for lack of trying. Reliance asked Kelly multiple times to provide a social security authorization form. The only piece of evidence related

---

review her findings before the appeal was decided. This argument must fail. The administrative record did not close until April 21, 2016, when Reliance made its final determination on appeal. Kelly does not cite to authority that would support for a right to review, rebut, or otherwise respond prior to the administrative decision on appeal. To the contrary: "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[.]" *Metzger v. Unum Life Ins. Co.*, 476 F.3d 1161, 1166–67 (10th Cir. 2007).

to his social security application Kelly did furnish—the ALJ opinion itself—indicates that he *can perform* other work in the national economy. The ALJ explicitly held at the end of his opinion:

> Although the vocational expert testified that an individual with the claimant's age, education, work experience and residual functional capacity could perform other work in the national economy, the Medical-Vocational Rules direct a finding of disability.

In the end, the conclusion is inescapable that Kelly has not met his burden under the terms of the LTD plan where, "instead of providing quantitative data or clinical evidence of a disabling condition, [he] offered…a scattershot series of subjective complaints… [and] pointed [Reliance Standard] to no objective corroboration for these subjective claims…." *Kao v. Aetna Life Ins. Co.*, 647 F. Supp. 2d 397, 421 (D.N.J. 2009) (Irenas, J.).

Kelly advances two other arguments in his summary judgment papers that lack merit. First, he maintains that Reliance did not provide a full and fair review of his January 2011 claim on remand because it failed to consider a claim for benefits under the "any occupation" standard. But in its July 21, 2014 opinion, the Court specifically rejected Kelly's contentions that Reliance was flouting its previous orders.

On May 28, 2015, the Court denied Kelly's motion for civil contempt and remanded the claim for disability benefits to Reliance. In making that motion Kelly was again relying on his position that Reliance was flouting the Court's directions in the December 22, 2011 opinion

by not paying "any occupation" disability benefits. And again the Court disagreed. Kelly raised the same arguments in a motion for reconsideration, which was denied. The Court will not change its ruling and rejects this argument, which is based on the same contention that the remanded claim back in 2011 embraced "any occupation" benefits.

Second, Kelly contends that Reliance's decision to offset social security benefits against Kelly's "regular occupation" disbursement was unlawful because no SSD benefits were actually remitted to Kelly by the SSA from May 2006 to May 2008. The Court finds that this argument fails because Kelly failed to exhaust his remedies within the administrative process.

"A federal court will generally refuse to consider claims to enforce the terms of a benefit plan if the plaintiff has not first exhausted the remedies available under the plan." *Bennett v. Prudential Ins. Co.*, 192 F. App'x 153, 155 (3d Cir. 2006) (*citing Weldon v. Kraft, Inc.*, 896 F.2d 793, 800 (3d Cir. 1990)). "The exhaustion requirement is waived, however, where resort to the plan remedies would be futile." *Bennett*, 192 F. App'x at 155 (*citing Berger v. Edgewater Steel Co.*, 911 F.2d 911, 916 (3d Cir. 1990)).

Reliance's October 9, 2014 letter to Kelly identified the benefit amount owed under the terms of the plan, provided Kelly with an explanation of the decision, and advised Kelly on his appeal rights. (D.E. 203-2 at 2-5.) Kelly never appealed that determination. He first raised the issue 16 months later, and has not adequately shown why an appeal would have been futile. He may not now pursue this claim in this court.

Turning to Penn Mutual's motion for summary judgment, as indicated earlier in this opinion, Kelly has

not opposed it, and conceded as much at oral argument. He does not mention Penn Mutual at all in his motion papers, and the motion is deemed unopposed. Reviewing the record, it appears that the only actionable conduct on Penn Mutual's part that Kelly identified is his allegation that it had provided an incorrect job description to Reliance in 2007 when it first began administering Kelly's LTD claim. Kelly eventually amended that incorrect job description, and Reliance has not used it since in its determinations.

Resurrecting a stale argument that has no relevance to this administrative record, if that is what Kelly is doing, is flimsy enough. There are also real problems with Kelly's theory that Penn Mutual could be liable as a co-fiduciary under ERISA. As Penn Mutual points out, this is a lawsuit over a claim for benefits. The Third Circuit has held that a "claim for breach of fiduciary duty is actually a claim for benefits where the resolution of the claim rests upon an interpretation and application of an ERISA-regulated plan rather than upon an interpretation and application of ERISA." *Harrow v. Prudential Insurance Company of America*, 279 F.2d 244, 254 (3d Cir. 2002). As is very obvious, the Court's review of Reliance's claim determination must and does rest upon an examination of the plan itself, not the ERISA statute. Kelly's breach of fiduciary duty theory fails, and Penn Mutual's motion is granted.

For the reasons stated above, Kelly's motion for summary judgment will be denied, and the defendants' motions for summary judgment will be granted. In making this ruling, the Court has addressed the claims in counts one and two, which are the ones remaining. The case remains open for the sole purpose of adjudicating the application for counsel fees and costs of

suit that was addressed in the order of December 22, 2011 (D.E. 107).

In that order the Court gave Kelly permission to pursue legal fees from both defendants on his ERISA claim, while indicating that permission did not guarantee an award would be made. For purposes of deciding the application at this pass, the Court will not entertain fees incurred for legal services rendered after the parties' conference with Judge Shwartz in January 2012. Kelly has failed in his repeated attempts, documented in this lengthy opinion, to tag Reliance as having failed to adhere to Court orders, and Reliance has paid benefits consistent with those orders. Kelly's claims against Penn Mutual, while apparently having much to do with the impasse to settlement, relate solely the information it gave Reliance about his job description. That happened well before the December 2011 decision. The Court is satisfied that the expense of the litigation Kelly has pursued since January 2012 falls outside the period relevant to Kelly's entitlement for fees under ERISA.

Additionally, no legal services that may have been performed by plaintiff Kelly shall be eligible for a fee award.

The parties shall appear in person before Magistrate Judge Cathy Waldor promptly for her directions on the length, content, and timing of their submissions. Plaintiff Thomas P. Kelly shall attend.

s/ Katharine S. Hayden
Katharine S. Hayden, U.S.D.J.

Dated: December 31, 2017

United States District Court, D. New Jersey.

Thomas P. KELLY, Jr., Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

and

The Penn Mutual Life Insurance Company, Defendants.

Civil No. 09–2478 (KSH).

May 28, 2015.

ORDER

Defendant Reliance Standard Life Insurance Company ("Reliance") having filed a motion to remand plaintiff Thomas P. Kelly, Jr.'s claim for insurance benefits [D.E. 179], and Kelly having filed a cross-motion to hold Reliance in civil contempt [D.E. 184]; and for the reasons set forth in the opinion filed herewith, IT IS on this 28th day of May, 2015, ORDERED that Reliance's motion to remand [D.E. 179] is GRANTED and Kelly's motion to hold Reliance in contempt [D.E. 184] is DENIED; and it is further ORDERED that Kelly's claim for disability benefits is remanded to Reliance for further proceedings consistent with this decision.

/s/ Katharine S. Hayden

Katharine S. Hayden, U.S.D.J. C

United States District Court, D. New Jersey.

Thomas P. KELLY, Jr., Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

and

The Penn Mutual Life Insurance Company, Defendants.

Civil No. 09–2478 (KSH).

Signed May 28, 2015.

Attorneys and Law Firms

Thomas Patrick Kelly, III, Kelly Law Offices LCC, Mount Laurel, NJ, for Plaintiff.

Louis P. Digiaimo, Mee Sun Choi, Valerie Grace Kesedar, McElroy, Deutsch, Mulvaney & Carpenter LLP, Morristown, NJ, Edward Francis Roslak, Saul Ewing LLP, Newark, NJ, James A. Keller, Caitlin M. Strauss, Saul Ewing LLP, Joshua Bachrach, Wilson Elser Moskowitz Edelman & Dicker, LLP, Philadelphia, PA, for Defendants.

Opinion

KATHARINE S. HAYDEN, District Judge.

Before the Court is defendant Reliance Standard Life Insurance Company's motion to remand Thomas Kelly's claim for long-term disability to the plan administrator and Kelly's cross-motion for civil

contempt sanctions. Central to the Court's resolution of these motions is a determination as to what has or has not already been considered by Reliance in its denial of Kelly's application for benefits—namely, whether Reliance only determined that Kelly was unable to perform his own "regular" occupation, or whether it also found that Kelly was unable to perform "any" occupation that his education, training and experience would otherwise allow. For the reasons that follow, Reliance's motion to remand is granted and Kelly's cross-motion for civil contempt sanctions is denied.

I. *Background*[1]

Following a car accident that took place on November 7, 2005, Kelly applied for long-term disability ("LTD") benefits under a plan sponsored by his employer, Penn Mutual Life Insurance Company ("Penn Mutual"). Reliance processed the claim, and determined in a letter dated October 23, 2006 that Kelly was capable of performing the duties of his "regular occupation" and therefore not entitled to benefits under the policy. After the determination was upheld on final appeal, Kelly filed suit in this Court against both Reliance and his employer, Penn Mutual, claiming in part that Reliance's denial of benefits was arbitrary and capricious and that Penn Mutual had breached its fiduciary duties as co-fiduciary of the plan. The Court concluded on December 14, 2010 that the administrative record was deficient, that Reliance had relied on an incorrect definition of Kelly's occupation, that Penn Mutual provided an incorrect job description, and that Kelly had not been helpful in providing

information during the claim processing. On that basis, the Court remanded the claim to Reliance and permitted Kelly to offer additional information supporting his claim.

Kelly gave Reliance a supplemental certification regarding his job description and, for the first time, claimed that his inability to perform the required duties of "*any occupation* [has] been further exacerbated by the onset and increase of chronic cardiac symptoms." (Kelly's SJ Br., Ex. B, Supplemental Cert. ¶ 51) (emphasis added). The difference between the modifiers, "regular" as opposed to "any," is significant. The "regular occupation" standard asks whether the claimant is capable of "perform[ing] the substantial and material duties of [his] regular occupation" and pays benefits for a period of 24 months. By contrast, disability benefits under the "any occupation" standard are due only where the claimant is incapable of performing the material duties of "any occupation .... that [his] education, training or experience will reasonably allow" and are paid to the claimant after expiration of the first 24 month period.

After remand by this Court, Reliance again considered Kelly's application and this time made note of his new claim for "any occupation" benefits—it referenced Kelly's contention that he purportedly was "physically unable to work in '*any occupation* that [his] education, training and experience would otherwise reasonably allow." (Kelly Br., Ex. A at 1, hereinafter "February Letter.") But in defining "Total Disability" Reliance referred only to the extent to which Kelly was

capable of "perform[ing] the substantial and material duties of [his] *regular occupation*." Reliance then concluded that Kelly "fail [ed] to meet the Policy's definition of 'Total Disability' (quoted above), and as such, no benefits [would be] payable." (February Letter at 9.)

Kelly again challenged the denial before this Court. And in an opinion dated December 22, 2011, the Court concluded that Reliance "conducted an inappropriately selective review of the evidence, placed unreasonable emphasis on the reports of consultants who never examined Kelly, chose not to use an IME, and failed to engage in a meaningful analysis of Kelly's material job duties." The Court found that, taken together, this amounted to an arbitrary and capricious exercise of discretion in violation of ERISA and concluded that "Kelly [was] entitled to receive the LTD benefits owed to him under the Plan."

A dispute then arose about whether the Court intended for Kelly to receive LTD benefits under the "regular" or "any" occupation standard. In a letter dated January 12, 2012, Reliance took the position that "benefits have been awarded during the 'own [or regular] occupation' period but Mr. Kelly's ongoing disability under the more stringent 'any occupation' standard beyond 24 months must be further investigated by Reliance Standard." (Reliance Reply Br., Ex. B.) Counsel stated further that "[i]t is Mr. Kelly's position that benefits are to be paid to the present (for 68 months) pursuant to [the Court's order], despite the change in definition." (Reliance Reply Br.,

Ex. B.) According to counsel, this dispute ultimately precipitated the collapse of a proposed settlement of all claims, previously agreed to in principle on January 27, 2012. On September 26, 2014, approximately three months after the Court denied Kelly's motion to enforce the proposed settlement, Reliance paid to Kelly an amount equal to 24 months of benefits with pre-and post-judgment interest. (Reliance Reply Br., Ex. C ("Enclosed is Reliance Standard's check in the amount of $180,127.53 representing twenty-four (24) months of benefits with pre-judgment and post-judgment interest.")) The transmittal letter described how those benefits were calculated and advised Kelly of his right to appeal the decision. On November 7, 2014, Reliance filed the present motion to remand Kelly's claim for benefits for further consideration [D.E. 179]. Kelly filed his opposition and moved for civil contempt sanctions [D.E. 184] on December 6, 2014, contending that Reliance has failed to pay the benefits he believes were ordered by this Court's December 22, 2011 order.

II. *Analysis*

Kelly takes the position that: (1) the Court has already, in its December 22, 2011 decision, determined he was entitled to LTD benefits under the "any occupation" standard; and (2) the amount of benefits already paid is insufficient even under the "regular occupation" definition. Reliance now moves to remand the "any occupation" issue for its review, arguing that Kelly failed to exhaust his administrative remedies. The Court agrees.

Reliance noted in the February Letter that Kelly claimed entitlement to "any occupation" benefits but, quite clearly, found only that he was not "Totally Disabled" as defined therein—*i.e.* that he was not incapable of "perform[ing] the substantial and material duties of [his] *regular occupation*." The Court subsequently considered this decision and found it to be arbitrary and capricious, but did not—as Kelly suggests—rule that Kelly was entitled to LTD benefits under the "any occupation" standard. The Court held only that Kelly was "entitled to receive the LTD benefits owed to him under the Plan." Read together with the remainder of the Court's opinion and the February Letter, it is beyond dispute that the Court's holding extended only to those claims Reliance had already considered—namely, Kelly's claim for benefits on account of his inability to perform the duties of his regular occupation.

Even if the Court had wished to go further and opine on Kelly's claim for benefits under the "any occupation" standard, it would have been powerless to do so. In *Pakovich v. Broadspire Services, Inc.*, 535 F.3d 601 (7th Cir.2008), the district court considered the defendant insurer's denial of Pakovich's claim for benefits under the "own occupation" standard. The district court found that the insurer's determination was arbitrary and capricious, and then went on to conclude that Pakovich was not entitled to benefits under the "any occupation" standard. The Seventh Circuit vacated this latter ruling on appeal and found that, because the insurer "did not issue any decision on Pakovich's eligibility for disability benefits under the

'any occupation' standard," the district court was left "with nothing to review." *Id.* at 607. And although the district court "was able to piece together its conclusion that Pakovich was physically capable, and had the 'training, education and experience' to perform sedentary work, there was no decision by the Plan Administrator for the Court to review" and the record therefore was "not fully developed on this issue." The Seventh Circuit then "order[ed] that the district court remand the case to the Plan Administrator to determine whether Pakovich was eligible for disability benefits beyond [24 months] under the Plan's 'any occupation' standard." *Id.* at 607.

As in *Pakovich*, Reliance considered only the "regular" or "own occupation" standard of disability, and never determined whether Kelly was entitled to LTD benefits beyond 24 months under the "any occupation" standard. No decision of this Court could have changed that. And because "[Reliance] has not issued a decision on a claim for benefits that is now before the [Court], the matter must be sent back to [Reliance] to address the issue in the first instance." *Id.* at 607. Reliance's motion for remand is therefore granted.

Kelly's cross-motion for civil contempt sanctions against Reliance is denied. To succeed, Kelly must demonstrate—by clear and convincing evidence—that (1) a valid court order existed; (2) defendant had knowledge of the order; and (3) defendant disobeyed the order. The Third Circuit has described this showing as a "heavy burden," and cautioned courts to hesitate in

awarding civil contempt sanctions "when there is ground to doubt the wrongfulness of the conduct." *Quinter v. Volkswagen of Am.*, 676 F.2d 969, 974 (3d Cir.1982).

The basis for Kelly's motion is Reliance's alleged failure to comply with the December 22, 2011 opinion and order of the Court, which found Kelly was "entitled to receive the LTD benefits owed to him under the Plan." However, Kelly fails entirely to show how Reliance disobeyed any aspect of that decision and order. To the extent Kelly claims Reliance failed to comply in that it refused to pay LTD benefits beyond 24 months under the "any occupation" standard, the Court already has ruled herein that the December 22, 2011 order did not encompass such relief. And to the extent that Kelly relies on Reliance's alleged failure to pay the correct amount owed under the "regular occupation" standard, he provides the Court with no evidentiary basis for a finding of civil contempt. Kelly argues only that "[w]hen it finally did pay some of the benefits owed ..., [Reliance] miscalculated the amount due for the specified benefit period .... and applied incorrect rates for pre and post-judgment interest that do not comply with the Court Rules." (Kelly Br. at 5, n. 1) This falls well short of meeting Kelly's "heavy burden" here. Kelly's failure to support this contention with competent, clear and convincing evidence—or any argument outside of a footnote—is fatal to his motion for civil contempt.

Conclusion

For the foregoing reasons, defendant Reliance's motion to remand is granted and Kelly's cross-motion for civil contempt sanctions is denied. An appropriate order will be entered.

Footnotes

1This case has a long history before the Court. A full recitation of the facts underlying Kelly's claim for coverage appears in the written opinion dated December 22, 2011 [D.E. 106], which granted Kelly's cross-motion for summary judgment.

NOT FOR PUBLICATION

United States District Court, D. New Jersey.

Thomas P. KELLY, Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY, and The Penn Mutual Life Insurance Company, Defendants.

Civ. Action No. 09–2478 (KSH).

Dec. 22, 2011.

ORDER

Katharine S. Hayden, U.S.D.J.

The Court having made rulings in its written opinion of today's date on plaintiff Thomas P. Kelly's second motion for summary judgment [D.E.101], and defendant Reliance Standard Life Insurance Company's ("Reliance") cross-motion for summary judgment [D.E. 102]; and good cause appearing,

IT IS on this 21st day of December, 2011,

ORDERED that Kelly's motion for summary judgment is GRANTED with respect to Count I of the Amended Complaint and DENIED with respect to Count II, and it is further

ORDERED that Reliance's cross-motion for summary judgment is DENIED; it is further

ORDERED that defendant Penn Mutual Life Ins. Co. shall immediately provide all benefits consistent with the rulings set forth in the Court's written opinion granting Kelly's motion for summary judgment; and it is further

ORDRERED that Kelly's claim is hereby **REMANDED** to defendant Reliance for continued administration and payment of benefits, consistent with the terms of this Order and the Court's written opinion; and it is further

ORDERED that Kelly is granted leave to file a motion to recover reasonable costs of suit and attorney fees, as provided for by 29 U.S.C. § 1132, *et seq.*, by January 20th, 2012 and defendants must file any opposition by February 7th, 2012. No reply will be entertained, and this does not constitute a ruling that fees will in fact be awarded; and it is further

ORDERED that there shall be a settlement conference before Magistrate Judge Shwartz on January 6, 2012 at 9:30 a.m. in an effort to resolve the remaining claims against defendant Penn Mutual. Trial counsel and clients with full settlement authority are required to appear inperson at the conference.

/s/ Katharine S. Hayden
Katharine S. Hayden, U.S.D.J

NOT FOR PUBLICATION

United States District Court, D. New Jersey.

Thomas P. KELLY, Plaintiff,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY, and The Penn Mutual Life Insurance Company, Defendants.

Civ. Action No. 09–2478 (KSH).

Dec. 22, 2011.

Attorneys and Law Firms

Thomas Patrick Kelly, III, Law Office of Thomas P. Kelly, Mount Laurel, NJ, for Plaintiff.

Joshua Bachrach, Wilson Elser Moskowitz Edelman & Dicker, L.L.P., Philadelphia, PA, Louis P. Digiaimo, Mee Sun Choi, McElroy, Deutsch, Mulvaney & Carpenter L.L.P., Morristown, NJ, for Defendants.

OPINION

KATHARINE S. HAYDEN, District Judge.

This case comes before the court on cross-motions for summary judgment filed by plaintiff, Thomas P. Kelly and defendant Reliance Standard Life Insurance Company ("Reliance"). Earlier, in addressing dispositive motions brought by the parties, the Court remanded to the Reliance Plan Administrator for a "full and fair review" of Kelly's claim for long-term disability ("LTD") benefits. The matter has been re-opened

because Reliance again denied Kelly's claim for benefits, and Kelly has appealed the decision to this Court.

The Court must now determine whether Reliance's denial of LTD benefits on remand was an abuse of discretion under the terms of the plan.

I. Factual Background

In November of 2005, Kelly was employed as a "Managing Director/Advanced Planning/Compliance Officer" at the Edison, New Jersey office of Penn Mutual Life Insurance Co. ("Penn Mutual"). (Pl's Br., Ex. B, Supplemental Cert., ¶ 3.) In this "multiple function position," Kelly had a number of responsibilities, including coordinating and supervising recruiting, running annual compliance meetings and the quarterly supervisor program, coordinating and monitoring joint work among associates, conducting continuing education classes, overseeing trading operations for compliance purposes, and monitoring new business for suitability. (*Id.* at Ex. B, sub-Ex. A.) Kelly was also responsible for conducting yearly Private Office Visits ("POVs") for every agent under the Edison agency's supervisory jurisdiction. (*Id.* at Ex. B, Supplemental Cert., ¶ 18–20.) In addition, Kelly supervised the "HTK department" and interacted with the "HTK compliance department on all issues concerning the agency." (*Id.* at Ex. B, sub-Ex. A.) As explained by Kelly in his certification, HTK was made up of the "non-housed registered representatives of broker-dealer Horner Townsend and Kent" located throughout New Jersey, whom Kelly helped to manage,

train and supervise. (Pl's Br., Ex. B, Supplemental Cert., ¶ 15.) One of Kelly's tasks was to complete a yearly visit to "every HTK Producer of the Edison agency who did not conduct business from an NASD registered branch office." (*Id.* at ¶ 23.) To facilitate Kelly's required travel, Penn Mutual provided him with full lease reimbursement for his car. (*Id.* at ¶ 10.) Though the parties dispute the degree to which Kelly was required to travel for his job, both agree that there was a requirement that he travel at least 10% of the time. (*Id.*)

On Monday November 7, 2005, Kelly was injured in an automobile accident which "exacerbated existing spinal cord injuries" and prevented him from "being able to perform the duties of [his] current occupation on even a part time basis." (*Id.* at ¶ 46.) Previously, Kelly's back had been injured in a 1993 snowmobile accident in which he suffered a compression fracture of his spine at T12, degeneration of discs T12–L1 and T11–12, and a posterior spur at the T11–12 interspace with a gibbous deformity. (AR166; Pl's Br., Ex. B, sub-Ex. H.) This resulted in a hospital stay, and Kelly later returned to work at his prior place of employment on partial disability. (AR166.) Kelly told his agency manager at Penn Mutual about his residual disability from the 1993 accident at the time he was employed by Penn Mutual. (Pl's Br., Ex. B, Supplemental Cert., ¶ 45.)

Kelly's doctor, Dr. Dearolf, concluded that the November 7, 2005 car accident aggravated the prior injuries and resulted in an additional "left side disc

herniation at L5–S1." (Pl's Br., Ex. B, sub-Ex. H.) Kelly suffered "radicular symptoms along with limited motion in his lumbar and thoracic spine, lumbar sprain and strain, lumbar radiculopathy and degenerative joint disease in his back." (*Id.*) Dr. Dearolf instructed Kelly "not to perform any work of any kind," and prescribed steroid injections and physical therapy. (Amended Compl. ¶ 24.)

At the time of the accident, Kelly was a participant in Penn Mutual's long-term employee disability plan. (Pl's Br. at 4.) Defendant Reliance, the plan administrator, had the discretionary authority to determine eligibility for plan benefits and was also responsible for making benefit payments to eligible participants. (*Id.*) The Reliance plan entitled a "Totally Disabled" participant to receive a monthly benefit of 66–2/3% of his Covered Monthly Earnings after 180 days of total disability (the "Elimination Period") until the age of 66. (Amended Compl. ¶ 51.) In February of 2006, Penn Mutual's Vice President wrote to Kelly about whether Kelly intended to submit a claim for LTD benefits. (*Id.* at ¶ 49.) Kelly timely notified Penn Mutual of his intent to file a claim and completed the necessary forms by May of 2006. (*Id.* at ¶¶ 52–53, 56.) The forms were first sent to the Penn Mutual claims department. (*Id.* at ¶ 55.) It was Penn Mutual's obligation to forward Kelly's claim for benefits along with accurate supporting documentation, such as a job description, to Reliance. (*Id.* at ¶ 61–62.) However, as this Court concluded in the prior summary judgment proceedings, Penn Mutual failed to provide Reliance with Kelly's correct job title or an accurate list of his

job duties. (*Id.* at ¶¶ 77–79; Tr. 9:20–10:16 Dec. 14, 2010.)

In an October 23, 2006 letter Reliance denied Kelly's claim for LTD benefits. (Amended Compl. ¶ 95.) The letter included a list of criteria Reliance had used to determine that Kelly was purportedly capable of performing the duties of his "regular occupation." In pertinent part the letter stated:

> Please be aware that your own regular occupation is not your job with a specific employer, it is not your job in a particular work environment, nor is it your specialty in a particular occupation field. In evaluating your eligibility for benefits, we must evaluate your inability to perform your own regular occupation as it is performed in a typical work setting for any employer in the general economy.
>
> ...
>
> While you may believe that your *job* required a greater level of physical exertion, your *occupation* is classified as *sedentary* by the United States Department of Labor's, *Dictionary of Occupational Titles* ("DOT"). Your claim for benefits has been evaluated based on your ability to perform a *sedentary* occupation.

(AR121–22.) Kelly timely appealed the denial of benefits. (Amended Compl. ¶ 119.) On March 12, 2007, Reliance informed Kelly that it upheld its denial on appeal. (*Id.* at ¶ 136.)

As a result, Kelly filed suit in this Court against both Reliance and Penn Mutual claiming that Reliance's denial of benefits was arbitrary and capricious and that Penn Mutual had breached its fiduciary duties as a co-fiduciary of the plan. Kelly's complaint included RICO claims against both defendants, which were later dismissed on defendants' motions to dismiss. In addition, the complaint contained a claim alleging a violation of the Family and Medical Leave Act on the part of Penn Mutual, which was dismissed by a stipulation. The remaining claims alleged that the actions of Reliance and Penn Mutual violated ERISA.

Kelly and Reliance filed cross-motions for summary judgment which were argued on December 14, 2010. The Court concluded that the administrative record was deficient, that Reliance had relied on an incorrect definition of Kelly's occupation (a definition which the Third Circuit had already concluded was improper), that Penn Mutual provided an incorrect job description, and that Kelly had not been helpful in providing information during the claim processing. (Tr. 4:1–5:15; 7:15–8:25; 9:20–10:1 Dec. 14, 2010.) As a result, the Court ordered a remand to the Plan Administrator and directed that Reliance should "make a decision on the merits." (*Id.* at 13:3–4.) Kelly was permitted to submit additional evidence to more fully develop the record. (*Id.* at 13:18–25.)

Kelly submitted a supplemental certification which included a detailed description of his job responsibilities, a copy of the correct Penn Mutual job description for his position, and forms indicating other

duties delegated to him. (Pl's Br., Ex. B.) Kelly included a follow-up letter from his doctor and MRI scans of his back. (*Id.*) He also claimed for the first time that his inability to perform the required duties "of any occupation have been further exacerbated by the onset and increase of chronic cardiac symptoms." (*Id.* at Ex. B, Supplemental Cert., ¶ 51.)

On February 18, 2011, Reliance rendered its remand decision, again denying Kelly LTD benefits. (*Id.* Ex. C.) The remand decision was based on the reports of two independent consultants who completed paper reviews of Kelly's claim file-Dr. Robert Green, an orthopedic surgeon and Dr. Gregory Helmer, a cardiology specialist-as well as a report by Jody Barach, the in-house Vocational Specialist, and a letter from Kelly's former supervisor, Frank DePaola, who provided a critique of Kelly's description of his job duties. (*Id.*) The denial letter reiterated the policy language, noting that disability benefits will be paid only where a claimant demonstrates total disability for the Elimination Period. (Pl's Br. Ex. C.) "Elimination period" is defined as "180 consecutive days of Total Disability." (*Id.*) And "Total Disability" is defined as an inability to "perform the substantial and material duties of your regular occupation." (*Id.*) The Elimination Period for Kelly's claim was determined to run from November 26, 2005 to May 25, 2006.[1] (*Id.*) The letter noted that both Dr. Green and Dr. Helmer "opined that no restrictions and limitations [on Kelly's ability to work] are supported through the records for either condition from the date of disability through the end of the 180–day Elimination period." (*Id.*) Specifically, Dr.

Green concluded that "there was not sufficient objective information to determine why he was having this discomfort," and thus there was "insufficient evidence to support that there would be any restrictions or limitations during the mentioned timeframe." (*Id.*)

The denial letter further concluded that while Kelly's certification "suggests a job that requires a much greater level of exertion and more extensive travel than would be expected for a generally sedentary-type office job," the letter from Kelly's supervisor indicated that Kelly "grossly exaggerate[d] the level of physical activity involved in [his] job at PML as well as the travel duties." (*Id.*) The denial letter relied on Penn Mutual HR Personnel's May 31, 2006 form, which indicated that Kelly's position "required frequent sitting and only occasional standing and walking with no lift or carry." (*Id.*) As a result, Reliance denied the claim for benefits because neither of the specialists' opinions supported "restrictions or limitations at or following the date of disability," and neither concluded that Kelly's ability to travel was limited. (*Id.*)

Kelly appealed the remand decision to this Court and is seeking summary judgment on the grounds that the denial of benefits was arbitrary and capricious. Reliance has cross-moved for summary judgment in its favor.

II. Standard of Review

A. Motion for Summary Judgment

Summary judgment may be granted when there is no genuine issue as to any material fact and [ ] the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). The role of the court is not to "weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A factual dispute is genuine if a reasonable jury could find in favor of the nonmoving party and it is material only if it bears on an essential element of the plaintiff's claim. *Fakete v. Aetna, Inc.*, 308 F.3d 335, 337 (3d Cir.2002). When deciding a summary judgment motion, a court must view the record and draw all inferences in a light most favorable to the opposing party. *Knopick v. Connelly*, 639 F.3d 600, 606 (3d Cir.2011). "This standard does not change when the issue is presented in the context of cross-motions for summary judgment." *Appelmans v. City of Phila.*, 826 F.2d 214, 216 (3d Cir.1987).

B. Standard of Review for Administrator's Determination Under ERISA

When a benefit plan vests the claim administrator with discretion to make the claim determination, "its interpretations of plan language and benefit determinations are generally subject to an 'abuse of discretion' or 'arbitrary and capricious' standard of review." *Schwarzwaelder v. Merrill Lynch & Co., Inc.*, 606 F.Supp.2d. 546, 557 (W.D.Pa.2009) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80

(1989)). "In the ERISA context, the arbitrary and capricious and abuse of discretion standards of review are essentially identical." *Miller v. Am. Airlines, Inc.*, 632 F.3d 837, 845 n. 2 (3d Cir.2011). Both of these phrases are understood to require the Court to uphold the Administrator's decision "unless an underlying interpretation or benefit determination was unreasonable, irrational, or contrary to the language of the plan." *Schwarzwaelder*, 606 F.Supp.2d. at 557. The court's assessment involves evaluating "the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps." *Glenn v. MetLife*, 461 F.3d 660, 674 (6th Cir.2006), *aff'd by Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008). The burden is on Kelly to demonstrate that Reliance's denial of benefits was arbitrary and capricious. *Schwarzwaelder*,606 F.Supp.2d. at 558 (citing *Moskalski v. Bayer Corp.*, 2008 WL 2096892 at *4 (W.D.Pa. May 16, 2008)).

Because "benefits determinations arise in many different contexts and circumstances, ... the factors to be considered [in reviewing a plan administrator's exercise of discretion] will be varied and case-specific." *Estate of Schwing v. Lilly Health Plan*, 562 F.3d 522, 526 (3d Cir.2009) (internal quotations omitted). When, as here, the ERISA plan administrator is responsible for both determining eligibility for benefits and paying the benefits awarded, an inherent conflict of interest arises. *Glenn*, 554 U.S. at 114. The Supreme Court has directed that this conflict of interest be viewed as one of the several factors

considered in evaluating whether the administrator has abused its discretion. *Id.* at 117.

The focus of review is the "plan administrator's final, post-appeal decision." *Funk v. CIGNA Group Ins.*, 648 F.3d 182, 191 n. 11 (3d Cir.2011)(citing 29 C.F.R. §§ 2560.503–1(h), 2560.503–1(h)(2)(i)-(ii), 2560.503–1(h)(2)(iv) & (3)(ii)). The court may in the course of its review consider prior decisions "as evidence of the decision-making process that yielded the final decision, and it may be that questionable aspects of or inconsistencies among those pre-final decisions will prove significant in determining whether a plan administrator abused its discretion." *Id.* (citing *Miller*, 632 F.3d at 855–56).

III. Analysis

In evaluating the reasonableness of Reliance's final, post-appeal determination denying Kelly's claim, the Court considers Reliance's inherent conflict of interest, the questionable aspects of its pre-final decision making process, and, most importantly, three troubling aspects of Reliance's final review: (1) an inappropriately selective evaluation of the evidence, (2) the rejection of self-reported and subjective evidence while relying on a claimed lack of objective evidence, and (3) an absence of any substantive evaluation of material job duties and the claimant's ability to perform them.

A. Inappropriately Selective Evaluation of the Evidence

It is abundantly clear that in making its claim determination Reliance relied heavily on the paper-review reports of its hired independent consultants, Dr. Green and Dr. Helmer, while giving less weight to the treatment records of Kelly's treating physician and physical therapist. It is true, as noted by Reliance in its brief, that ERISA plan administrators need not give special deference to the opinions of treating physicians, and are under no "discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003). However, an administrator may not "arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of treating physicians." *Id. See also Michaels v. Equitable Life Assur. Soc.*, 305 Fed. App'x 896, 906–07 (3d Cir.2009) (questioning administrators choice to give determining weight to the conclusions of experts paper review reports over the conclusions of claimant's treating physicians); *Moskalski*, 2008 WL 2096892 at *9 ("[T]he selective, self-serving use of medical information is evidence of arbitrary and capricious conduct.")

Reported decisions reflect that courts are troubled where a plan administrator denies a claim by relying on the paper-review reports of consultants that oppose the conclusions of treating physicians. *Schwarzwaelder*, 606 F.Supp.2d. at 559. *See e.g.*, *Elms v. Prudential Ins. Co. of Am.*, 2008 WL 4444269 at *15 (E.D.Pa. Oct.2, 2008) (It is "important to note that no doctor who has actually treated [plaintiff]

or examined her in person, as opposed to performing a 'file review' has found her to be capable ... of performing work-related tasks."); *Winkler v. Met. Life Ins. Co.*, 170 Fed. App'x 167 (2d Cir.2006) (vacating denial as arbitrary where it was based "entirely on the opinions of three independent consultants who never personally examined [plaintiff], while discounting the opinions" of the treating physicians.); *Glenn*, 461 F.3d at 671 (finding it "perplexing" that the plan administrator disregarded the opinion of the "only physician to have personally treated or observed" the claimant); *Kinser v. Plans Admin. Comm. of Citigroup, Inc.*, 488 F.Supp.2d 1369, 1382–83 (M.D.Ga.2007) (concluding it was unreasonable for the plan administrator to ignore the treating physician's "clearly stated and supported opinion" and rely instead on "a cold record file-review by a non-examining" consultant.).

A strong emphasis on paper review reports is of even greater concern where, as in this case, the plan administrator had the discretion to supplement the record by requiring an independent medical evaluation ("IME") but chose not to. *See Schwarzwaelder*, 606 F.Supp.2d. at 558–9. The "decision to forgo an IME and conduct only a paper review, while not rendering a denial of benefits arbitrary *per se*, is another factor to consider in the Court's overall assessment of the reasonableness of the administrator's decision-making process." *Id.* at 559 (citing *Glenn*, 461 F.3d at 671). *See also Post v. Hartford Ins. Co.*, 501 F.3d 154, 166 (3d Cir.2007), *abrogated on other grounds by Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008) (noting that while a plan

administrator is not required to give treating physicians' opinions special weight, "courts must still consider the circumstances that surround an administrator ordering a paper review."); *Elliot v. Metro. Life Ins. Co.*, 473 F.3d 613, 621 (6th Cir.2006) ("[A] plan's decision to conduct a file-only review—especially where the right to conduct a physical examination is specifically reserved in the plan—may, in some cases, raise questions about the thoroughness and accuracy of the benefits determination." (internal quotations omitted)).

Here, Dr. Green's report, prepared from a paper file review, discounts Dr. Dearolf's conclusions about Kelly's condition with little or no explanation and appears to selectively ignore the treatment information in the reports of Kelly's physical therapist which detail his pain and progress. Dr. Green noted that Dr. Dearolf found "Kelly is unable to sit for any prolonged period of time or stand for any prolonged period of time which he felt would make him incapable of performing sedentary work. He felt the symptoms would be on a permanent basis unlikely to improve over time." (Pl's Br., Ex. D.) As to this, Dr. Green offered what is, at best, speculation about Dr. Dearolf's medical assessment and a conclusion that is otherwise unsupported:

> I think if Dr. Dearolf had felt that this was a significant back problem, to prevent this Mr. Kelly from returning to work in even a sedentary position, there would have been further studies to more definitively elucidate the problem. So based on the records that I have

> reviewed and from an orthopedic standpoint only, it is my opinion that there is no objective evidence for restrictions or limitations.

(*Id.*)

Moreover, despite the fact that Dr. Green did not examine Kelly and admittedly did not review an MRI report[2] and thus did not know "the extent of the supposed herniation of L5–S1," he opined that the proper diagnosis of Kelly's symptoms was less severe than what Dr. Dearolf had posited. (*Id.*) "This information reviewed *sounds to me* like a lumbar sprain of mild degenerative, previously somewhat compromised spine." (*Id.* (emphasis added) .) Dr. Green's report provides no medical basis for coming to this conclusion.

Further, Dr. Green discounts the records of Kelly's visits to Dr. Dearolf by noting "most of the complaints and findings reported were subjective in nature." In response to Penn Mutual's request that he evaluate whether Kelly's condition would have resulted in restrictions or limitations during the Elimination Period, Dr. Green simply noted that although there are records of Kelly complaining of pain, "there was not sufficient objective information to determine why he was having this discomfort" and thus "there is insufficient evidence to support that there would be any restrictions or limitations during the above mentioned timeframe." (*Id.*)

Similarly, Dr. Green only mentioned the "significant notes from the [physical] therapist" briefly,

observing that "at the conclusion of each visit, the therapist stated the claimant tolerated the procedure well and was gradually showing improvement." (*Id.*) Dr. Green did note that in the last physical therapy evaluation in the record, dated June 15, 2006, "the therapist mentioned that claimant still had a significant pain level." But Dr. Green's report does not reference the portion of that report in which the therapist noted Kelly still had

> functional difficulties with bathing, bending, reaching, standing, work activities, riding in a car, climbing stairs, sitting and standing for prolonged periods of more than 15 minutes. He can sit for 30–40 minutes and walk for about 5–10 minutes. Functionally, he notes overall fatigue and diminished attention secondary to fatigue and pain. He also has difficulty driving.... He remains quite frustrated with the overall impact on function that pain is causing and difficultly returning to work.

(AR139–40.) This report was written almost a month after the conclusion of the Elimination Period, demonstrating that Kelly suffered from severe pain and had functional difficulties through the end of the relevant period, which provides evidence of restrictions or limitations during the Elimination Period.

In denying Kelly's claim, Reliance relied on Dr. Green's report and failed to give any independent weight to Dr. Dearolf's conclusions or the physical therapy records. (*Id.* at Ex. C.) In fact, aside from quoting Dr. Green's report discounting Dr. Dearolf's

medical opinion, Dr. Dearolf's findings and conclusions about Kelly's medical condition as Kelly's treating physician are not mentioned in the denial letter at all. (*Id.*) The problematical reliance on Dr. Green's opinions is clearly evident where the denial letter concludes its evaluation of Kelly's medical condition by stating:

> Both specialists therefore opined that no restrictions or limitations are supported through the records for either condition from the date of disability through the end of the 180–day Elimination Period. What's more, as mentioned above, Dr. Green felt that a lack of follow-up testing ordered by Dr. Dearolf appears inconsistent with your self-reports of the severity of your pain.

(*Id.*) Reliance appears to have disregarded the medical opinion of the only doctor that actually treated Kelly and ignored the reports of his physical therapist which further elaborated on his condition, and instead relied solely on Dr. Green's conclusion that there was a "lack of objective evidence for restrictions or limitations." As indicated, Reliance also chose to forgo an IME.

This is significant because, while it is acceptable for the administrator to credit the contrary evidence of a non-treating physician, where a non-treating physician's opinion simply cites to an absence of information it does not serve to refute the treating physician's conclusions, and in and of itself is not a reasonable explanation for denying benefits. *See Mishler v. Met. Life Ins. Co.*, 2007 WL 518875 at *9 (E.D.Mich. Feb.15, 2007). Courts have

noted "the particular appropriateness and helpfulness of an IME in cases in which the claim involves subjective complaints." *Schwarzwaelder*, 606 F.Supp.2d. at 560. (citing *Klinger v. Verizon Comm., Inc.*, 2007 WL 853833 at *3 (E.D.Pa. Mar.14, 2007)(noting that a claim administrator who requests an IME "avoid[s] the uncomfortable argument ... that the administrator reasonably gave greater weight to the opinions of physicians who have not physically examined the plaintiff than to those physicians who did."); *Adams v. Metro. Life Ins. Co.*, 549 F.Supp.2d 775, 790 (M.D.La.2007) (where a "case involves subjective accounts ... the fact that only a file review was conducted is relevant."). Because Reliance (1) substantially relied on Dr. Green's paper review, which discounted and selectively ignored much of the evidence of Kelly's ailments, (2) failed to request an IME, and (3) gave no independent weight to the opinion of the only physician that actually treated Kelly, the Court concludes its exercise of discretion in deciding this claim was arbitrary and capricious.

B. Unreasonable Rejection of Self–Reported and Subjective Evidence

Courts have also found denials arbitrary where the decision is based largely on the rejection of the claimant's self-reported symptoms and the treating physician's conclusions about those symptoms, when no reasonable basis for rejecting such observations is identified. *See, e.g., Schwarzwaelder*, 606 F.Supp.2d. at 561–62. A claimant's subjective accounts cannot be wholly dismissed, particularly where, as here, "the plan

itself does not restrict the type of evidence that may be used to demonstrate total disability."[3] *Glenn*, 461 F.3d at 672. Courts have also concluded that a claimant's account of pain cannot be ignored simply because it can be characterized as "subjective." *See Audino v. Raytheon Co. Short Term Disability Plan*, 129 Fed. App'x 882, 885 (5th Cir.2005). In a factually similar case involving a claimant with back problems, one court concluded

> The defendants are not free to ignore the plaintiff's chronic and severe pain under the apparent theory that MRIs or EMGs must demonstrate some structural deformity for a person to be disabled because of back pain. Unfortunately for all parties involved, back pain, even severe pain, is not so simple.

Gellerman v. Jefferson Pilot Financial Ins. Co., 376 F.Supp.2d 724, 734, 376 n. 9 (S.D.Tex.2005).

Here, Dr. Green's report generally ignored Kelly's complaints of pain noted in the physical therapy records, and found that "most of the complaints and findings reported" in Dr. Dearolf's treatment notes "were subjective in nature." (Pl's Br. at Ex. D.) Dr. Green's report further concludes that because "there was no documentation of any other studies recommended such as an electromyography, functional capacity evaluation, repeat MRI with possible discogram, or any other studies that would help elucidate the problem," there was "no objective evidence for restrictions or limitations." (*Id.*) He also stated that he felt Dr. Dearolf would have requested or

completed "further studies to more definitely elucidate the problem" if it was actually as serious as Kelly suggested. (*Id.*)

Reliance accepted Dr. Green's conclusion that there was "no objective evidence of limitations or restrictions" in denying Kelly's claim. The determination that objective evidence was lacking appears to have been influenced by the fact that Dr. Dearolf did not complete more tests to evaluate Kelly's condition. Indeed, Reliance reiterated in the denial letter that this was one of the reasons for denying the claim. But the plan does not explicitly limit the evidence of disability to "objective evidence." Reliance's decision to accept the conclusions of one physician's paper review, and to discount Kelly's account of his pain which is supported by the observations of the treating physician and physical therapist, further demonstrates that its exercise of discretion in deciding Kelly's claim was arbitrary and capricious.

C. Absence of any Substantive Evaluation of Material Job Duties

Under the Reliance benefit plan, "Total Disability" is defined as an inability to "perform the substantial and material duties of your regular occupation." (Pl's Br. Ex. C.) In denying the parties first cross-motions for summary judgment and ordering a remand, the Court noted that Reliance had denied Kelly's claim by (1) relying on an incorrect job description from Penn Mutual, and (2) improperly defining "regular occupation" generally as opposed to

taking into account the actual job duties performed, a practice the Third Circuit expressly rejected in *Lasser v. Reliance Standard life Ins. Co.,* 344 F.3d 381, 387 (3d Cir.2003). (Tr. 9:20–24, Dec. 14, 2010.) By permitting Kelly to supplement the administrative record on remand with correct information related to his job responsibilities. The Court pointed out that "now we have the golden opportunity with the blessing of the district court to do it right." (*Id.* at 14:14–15.)

Kelly submitted a 67 paragraph supplemental certification detailing his job responsibilities and injuries and attached nine Exhibits, including the correct Penn Mutual Job Description from his personnel file, as well as numerous delegation forms from his supervisor detailing other responsibilities that had been delegated to him. (Pl's Br. Ex B.) Reliance provided this information to Kelly's supervisor at Penn Mutual, Frank DePaola, who responded with a three page letter critique. The letter essentially noted that the job description and delegation forms were accurate but that Kelly, as a supervisor himself, could choose to delegate many of the tasks he discussed and that Kelly traveled approximately 10% of the time, but never as much as 45% of the time. (Pl's Br. Ex. E.) This information, along with the reports of Dr. Green and Dr. Helmer, were provided to Reliance's Vocational Specialist for review.

The Vocational Specialist submitted a two page review. The first page is almost completely filled with a copied bulleted list of the job responsibilities for Kelly's Managing Director/Advanced Planning/Compliance

Officer position, and half of the second page consists of copied portions of Dr. Green's and Dr. Helmer's paper review reports. (Def's Br. Ex. D.) Beyond the copied portions, the report offers only conclusory remarks and refers to Kelly's position by the wrong title. (*Id.*) It concludes, without any elaboration, that Kelly was required to travel only 10% of the time, had the ability to delegate job duties, "and in light of the medical information referenced, Mr. Kelly would be capable of performing the material duties of a Managing Agent at Penn Mutual Life Insurance Company." (*Id.*)

When evaluating whether Kelly's medical condition precluded him from performing the material duties of his job, Reliance relied heavily on the submission of the Vocational Specialist. (Pl's Br. Ex. C.) Neither the Vocational Specialist nor Reliance determined which duties were material duties of Kelly's job, which duties could be delegated, what degree of physical exertion was required to complete the material duties and whether Kelly could, during the Elimination Period, complete those tasks. In the denial letter, Reliance also uses the DePaola letter to discredit Kelly's description of the physical requirements of his job responsibilities, observing that based on DePaola's information, "many of the statements [Kelly] made in [his] affidavit concerning [his] job requirements grossly exaggerate the level of physical activity involved in [his] job at PML as well as travel duties." (*Id.*)

What actually is "grossly exaggerated" is Reliance's characterization of Kelly's certification. DePaola's letter states that many of the duties Kelly

was required to perform were duties he had the option to delegate, and that Kelly from time to time attended out of office meetings he was not required to attend. (Pl's Br. Ex. E.) Reliance inflates DePaola's comments to a broadside attack on Kelly's supplemental certification. But the fact that Kelly had the option to delegate certain job responsibilities he was actively performing prior to the car accident does not mean that by explaining those duties Kelly was exaggerating the requirements of his job in his certification. Moreover, in *Lasser*, the Third Circuit expressly held that the assessment of a claimant's inability to "perform the material duties of his/her regular occupation" requires consideration of the "usual work that the [claimant] *is actually performing* immediately before the onset of the disability." 344 F.3d at 387 (emphasis added).

The apparent wholesale rejection of Kelly's description of his job duties was unreasonable and led to the additional unreasonable failure to countenance the existence of any restrictions or limitations during the Elimination Period. In light of Dr. Dearolf's conclusion that Kelly was unable to perform non-sedentary and sedentary work, and the physical therapist's detailed notes about Kelly's impaired functional ability, it is surprising that neither Dr. Green's report nor Reliance's ultimate denial of benefits suggest that Kelly's condition warranted *any* work place restrictions or limitations. Dr. Green's report concluded there was no objective evidence to support any restrictions or limitations without considering the actual requirements of Kelly's job. The Vocational Specialist relied on Dr. Green's conclusion that no

restrictions or limitations were warranted in summarily concluding that Kelly was capable of performing his job duties. Reliance relied on both of these reports to thereafter deny Kelly's claim for benefits without giving any weight to his treating physician's diagnosis or his own description of his job activities. Reliance's failure to consider the duties Kelly was actually performing prior to the accident and whether Kelly was physically capable of performing those duties after the accident was unreasonable and demonstrates Reliance's exercise of discretion in denying Kelly's claim was arbitrary and capricious.

IV. Conclusion

On remand, Reliance conducted an inappropriately selective review of the evidence, placed unreasonable emphasis on the reports of consultants who never examined Kelly, chose not to use an IME, and failed to engage in any meaningful analysis of Kelly's material job duties. These deficiencies in the context of Reliance's inherent conflict of interest and questionable pre-final decision activities amount to an arbitrary and capricious exercise of discretion in violation of ERISA.

Accordingly, Kelly's motion for summary judgment with respect to Count I of his Amended Complaint is granted[4], and Reliance's motion for summary judgment is denied. Kelly is entitled to receive the LTD benefits owed to him under the Plan.[5] The Court will entertain Kelly's request to recover costs and attorneys' fees. An appropriate order will be entered.

Footnotes

1As noted above, in his supplemental certification Kelly also claimed to have cardiovascular issues. This resulted in a review of the records from his cardiologist on remand. Because the first cardiac treatment record in the administrative file is dated August of 2006, after the conclusion of the Elimination Period, the Court has not considered Kelly's cardiac condition in its analysis. Therefore, the Court will not discuss the portion of the claim denial related to Kelly's cardiac condition, or the report of the independent cardiologist consultant.

2In their briefs, the parties argue at length about the MRI. Kelly claims that Reliance withheld the 16 pages of MRI images from its consultants. (Pl's Br. p. 7.) Reliance, counters by noting that it gave the images to its consultants but Kelly never provided an MRI report analyzing the MRI images. (Def's Opp. Br. p. 12.) In a letter written after the claim determination, Dr. Green confirmed that he had seen the 16 images but they were poor copies and thus he did not base his conclusions on them. (*Id.* at Ex. F.) This debate appears irrelevant to the ultimate inquiry because regardless of who had what, Dr. Green confirmed he did not rely on the MRI scans in completing his report.

3The Reliance policy merely states that "written proof of Total Disability must be sent to us within ninety (90) days after Total Disability occurs." (AR013.) The policy does not delineate what is and is not acceptable "written proof."

4It should be noted that Kelly moved for Summary Judgment against both Reliance, Count I of his Amended Complaint, and Penn Mutual, Count II of his Amended Complaint. Penn Mutual filed an opposition brief that opposed only an award of compensatory damages in the event the Court concluded that the denial was arbitrary and capricious. Because neither Kelly nor Penn Mutual presented any arguments relating to Kelly's "specific allegations" against Penn Mutual, the Court has not granted summary judgment as to Count II.

5Kelly has also requested an award of "money damages" from Reliance, distinct from the LTD benefit payments owing. Kelly has not argued in his brief why such money damages are warranted, nor presented any facts or law to support the request. Therefore, the court denies Kelly's request for additional money damages.

3/28/2019

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 18-1162

THOMAS P. KELLY, JR.,
Appellant

v.

THE PENN MUTUAL LIFE INSURANCE COMPANY; RELIANCE STANDARD LIFE INSURANCE COMPANY

(D. N.J. No. 2-09-cv-02478)

SUR PETITION FOR REHEARING

Present: SMITH, *Chief Judge*, MCKEE, AMBRO, CHAGARES, JORDAN, HARDIMAN,

GREENAWAY, JR., KRAUSE, RESTREPO, BIBAS, PORTER, SCIRICA* and COWEN*, *Circuit Judges*.

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the panel and the Court en banc, is denied.

BY THE COURT,

s/ *Thomas M. Hardiman*
Circuit Judge

Dated: March 28, 2019
Lmr/cc: Thomas P. Kelly, III
Joshua Bachrach

* Judge Scirica and Judge Cowen's votes are limited to panel rehearing