UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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Capretta,

Plaintiff,

v.

16 Civ. 1929(DAB)
MEMORANDUM AND ORDER

Prudential Ins. Co. of Am.,

Defendant.

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DEBORAH A. BATTS, United States District Judge.

Jeffrey Capretta ("Plaintiff") brings this action against Defendant Prudential Insurance Company of America ("Prudential" or "Defendant") seeking long-term disability benefits under an employee long-term disability plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. Defendant has filed a motion to apply the arbitrary and capricious standard of review. For the following reasons, Defendant's motion is GRANTED.

I. Background

At all relevant times, Plaintiff was an Operations Manager employed by JP Morgan and a member of a Group Long Term Disability Insurance Policy (the "Plan") issued to his employer by Prudential, the claims administrator for the Plan. (Compl. ¶¶ 6, 7, 10; see also Siegel Decl. Ex. 1 at 39.) The Plan is

governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). See 29 U.S.C. § 1001 et seq.

In 2009, Plaintiff was diagnosed with lung cancer and received treatment, including surgery and radiation. (Siegel Reply Decl. Ex. C at 3.) He returned to work by the end of September 2009 and continued to work for the next four years. (Id.) On September 30, 2013, Plaintiff stopped work due to symptoms apparently arising from his cancer diagnosis and treatment, including shortness of breath and fatigue. (Compl. ¶¶ 13-14; see also Siegel Reply Decl. Ex. B at 3.) Plaintiff obtained short-term disability benefits, and then later, filed a claim for long-term disability benefits. (Compl. ¶¶ 15-16.)

Prudential denied Plaintiff's claim for long-term disability benefits on April 11, 2014, citing a failure to show any worsening in his pulmonary condition in the years since he had returned to work. (Siegel Reply Decl. Ex. B at 3.) Plaintiff filed an administrative appeal of this denial on October 22, 2014. (Compl. ¶ 20.)

On January 16, 2015, Prudential denied Plaintiff's appeal, again finding no support for any progression in Plaintiff's pulmonary condition. (See Siegel Reply Decl. Ex. B.) Following a review by Defendant's Medical Director and a physician specializing in pulmonology, Defendant concluded that many of Plaintiff's pulmonary symptoms present around the period that he

stopped working were attributable to severe sleep apnea, for which he was successfully treated in December of 2013. (Id. at 4-7.) While Plaintiff also reported receiving treatment for depression, he did not claim that his mental condition was disabling. (Id. at 5, 10.)

Plaintiff filed a second voluntary appeal on July 15, 2015. (Compl. ¶ 23.) Along with his claimed pulmonary condition, Plaintiff reported, for the first time, a cognitive impairment.[1] (Siegel Reply Decl. Ex. C at 3.) In support, Plaintiff submitted a neuropsychological evaluation concluding that Plaintiff suffered from a severe cognitive impairment, along with evidence that his neurologist had prescribed him a drug used to treat dementia.[2] (Id. at 3-4.) Plaintiff also submitted a vocational assessment finding that Plaintiff's condition prevented him from working. (Id. at 8.) For his own part, Plaintiff reported symptoms including fatigue, memory

[1] In the submissions made in his first appeal, Plaintiff's oncologist and pulmonologist noted symptoms of memory loss, but neither Plaintiff nor his providers appear to have noted any new diagnosis. Further, the submissions indicated that Plaintiff's neurological exam results were normal, and his cognitive symptoms were ultimately attributed to his sleep apnea. (See Siegel Reply Decl. Ex. B.)

[2] Without a fuller record, it is not clear what Plaintiff's official diagnosis was. The neurocognitive evaluator opined that Plaintiff experienced organic brain syndrome, see Siegel Reply Decl. Ex. C at 4, while Defendant's denial letter also referred to a dementia diagnosis presumably evidenced by Plaintiff's medication prescription. (See id. Ex. C. at 3, 9.)

impairment, and a limited capacity for attention. (Id. at 3-4; see also id. Ex. B at 5.)

Plaintiff's secondary appeal was reviewed by a separate Medical Director employed by Defendant and a neuropsychologist. The Medical Director agreed that there was no evidence indicating a progression in Plaintiff's pulmonary symptoms, other than that attributable to his now-treated sleep apnea. (Id. at 4.)

The reviewing neuropsychologist found that the record did not support the presence of a disabling psychological or cognitive impairment. (Id.) While acknowledging that there was some recent evidence consistent with Plaintiff's reported cognitive symptoms, the neuropsychologist found that none of it explained the dramatically low scores that Plaintiff received across multiple domains on the neuropsychological evaluation. (Id. at 5-6.) As the neuropsychologist noted, cognitive symptoms resulting from cancer treatment generally present during the acute period of treatment or, at the latest, up to one year after; further, individuals with late-onset symptoms often show a decline in one area of testing, not multiple. (Id. at 6.) In Plaintiff's case, however, there was no evidence of cognitive issues until well after Plaintiff stopped working in 2013, either self-reported or in the records of his treating

physicians. Given that the etiology of Plaintiff's cognitive symptoms was, presumably, his cancer treatment in 2009, the neuropsychologist questioned the rapid and comprehensive cognitive decline reflected in the evaluation's results.

In light of these issues, the neuropsychologist concluded that the lack of validity testing—or testing designed to distinguish between true impairment and simply poor effort on the assessment—rendered the evaluation unreliable. (Id. at 5.) The neuropsychologist noted that the lack of such testing was especially problematic given the internal inconsistencies contained within the evaluation itself—for example, an extremely low score on auditory memory tasks despite Plaintiff's apparent ability to attend to testing for many hours, or the assertion that Plaintiff suffered from language-related problems even though Plaintiff's speech and ability to follow directions were described as normal. (Id.) Moreover, while Plaintiff reported a family history of cognitive conditions that the reviewing neuropsychologist found significant, Plaintiff's own MRI results were normal. (Id. at 6.)

Defendant also reviewed the vocational assessment submitted by Plaintiff. (Id. at 8.) While Defendant took no issue with the opinions of Plaintiff's vocational expert based on the record before him, it noted that the expert appeared to accept the

opinions of Plaintiff's treatment providers without performing any individual medical review. Because Defendant disagreed, as described above, with the findings of some of Plaintiff's providers, it arrived at a different conclusion than Plaintiff's expert regarding Plaintiff's functional capacity. (Id.)

As a whole, Defendant found that, in his secondary appeal, Plaintiff again failed to show any developments in his pulmonary condition that would justify his sudden departure from work four years after his successful cancer treatment and return. (Id.) With respect to Plaintiff's newly-reported cognitive condition, Defendant noted that: (1) none of the records from the time Plaintiff stopped working reflected cognitive issues; (2) the neuropsychological evaluation presented markedly low test scores with no evidence of validity testing; (3) the purported dementia diagnosis was not substantiated by the MRI results; and (4) Plaintiff was still able to drive despite his reported condition. (Id. at 9.) For these reasons, Defendant upheld the denial of benefits. (Id.)

On March 15, 2016, after having exhausted the administrative appeals process, Plaintiff filed this action for long-term disability benefits under ERISA. See 29 U.S.C. § 1001 et seq. Defendant now moves for a determination that this Court

will apply the arbitrary and capricious standard in reviewing Plaintiff's claims denial.

II. Discussion

a. Standard of Review of Denial of Benefits

A denial of benefits in an ERISA plan is "reviewed under a de novo standard unless the benefit plan gives the administrator . . . authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). When the plan gives the administrator discretionary authority, judicial review of a claims decision is generally limited to determining whether the decision was arbitrary and capricious or an abuse of discretion. Id. at 114-15. Nevertheless, the Second Circuit recently held that even where an administrator is granted discretionary authority, a plan's benefits denial will be subject to de novo review where the plan fails to comply with the claims-procedure regulation, 29 C.F.R. § 2560.503-1, and where such noncompliance was not simply inadvertent and harmless. Halo v. Yale Health Plan, Dir. Of Benefits & Records Yale Univ., 819 F.3d 42, 58 (2d Cir. 2016).

In this case, the Plaintiff argues only that he is entitled to de novo review under Halo, and does not dispute that the Plan's language gives Defendant the discretionary authority that

would otherwise entitle it to arbitrary and capricious review. Plaintiff contends that de novo review under Halo is appropriate because Defendant violated both 29 C.F.R. § 2560.503-1(h)(2)(iv) and 29 C.F.R. § 2560.503-1(b)(5) in its handling of Plaintiff's claim.

b. The Claimed § 2560.503-1(h)(2)(iv) Violation

Plaintiff argues that Defendant violated 29 C.F.R. § 2560.503-1(h)(2)(iv) because: (1) Defendant did not share its concerns about the deficiencies in Plaintiff's neuropsychological evaluation until after it had rendered its final decision; and (2) Defendant failed to consider all of the comments and information that Plaintiff submitted in his appeal. (Pl.'s Opp'n at 3-4.)

With respect to the first argument, Plaintiff claims that Defendant discredited the neurocognitive evaluation solely because it lacked validity testing, and deprived Plaintiff of a chance to respond to this concern by failing to divulge it while the appeal was still pending. For its part, Defendant argues that, to the extent that Plaintiff was denied a chance to respond to Defendant's concerns, it was only because Plaintiff raised his claimed neurological condition for the first time during his final appeal, and submitted the supporting

documentation on the very last day of the appeals submission period.[3]

29 C.F.R. § 2560.503-1(h)(2)(iv) provides that, in order to provide a claimant with a full and fair review of an adverse benefit determination, the claims procedure must

> Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503-1(h)(2)(iv). An administrator denies the claimant a full and fair review where it "arbitrarily refuse[s] to credit a claimant's reliable evidence, including the opinions of a treating physician." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003); cf. Waksman v. IBM Separation Allowance Plan, 138 Fed. App'x 370, 371 (2d Cir. 2005) ("ERISA requires . . . the administrator to consider all pertinent evidence reasonably available to her."). However, ERISA does not require that an administrator defer or give special weight to a plaintiff's conclusions or those of his treating physicians; rather, the administrator need only give the plaintiff's submissions fair consideration. See Black & Decker, 538 U.S. at

[3] Defendant also argues that any noncompliance was inadvertent and harmless because Plaintiff's neurocognitive condition was not continuous throughout the 182-day elimination period. Because the resolution of this issue is not necessary to decide the current Motion, the Court takes no position on it.

834; Finkelstein v. UBS Global Asset Mgmt. (US) Inc., No. 11 CV 00356(GBD), 2011 WL 3586437, at *7 (S.D.N.Y. Aug. 9, 2011) ("A Plan Administrator has discretion to 'weigh competing evidence, but it may not ... cherry-pick the evidence it prefers while ignoring significant evidence to the contrary.'" (quoting Winkler v. Metro Life Ins. Co., 170 Fed. App'x 167, 168 (2d Cir. 2006)); Fitzpatrick v. Bayer Corp., No.04-Civ.-5134(RJS), 2008 WL 169318, at *13 (S.D.N.Y. Jan. 17, 2008) ("ERISA does not require a plan administrator to afford greater deference to the plaintiff's treating physician than that afforded to physicians retained by the administrator to review the case-provided that the evidence put forth by the claimant is not arbitrarily discredited by the administrator."); Karce v. Building Serv. 32BJ Pension Fund, No. 05 Civ. 9142(CSH), 2006 WL 3095962, at *5 (S.D.N.Y. Oct. 31, 2006). Where an administrator has afforded such consideration to a claimant's submissions, the fact that it does not agree with their conclusions does not deny the claimant a full and fair review. See Demirovic v. Building Serv. 32BJ Pension Fund, 467 F.3d 208, 212 (2d Cir. 2006); Finkelstein, 2011 WL 3586437, at *7; Testa v. Hartford Life Ins. Co., No. 08–CV–816 (FB), 2011 WL 795055, at *9 (E.D.N.Y. Mar. 1, 2011); Butler v. N.Y. Times Co., No. 03 Civ. 5978(RCC), 2007 WL 703928, at *6 (S.D.N.Y. Mar. 7, 2007).

Here, the Court is unconvinced that Defendant failed to consider properly the neuropsychological evaluation submitted by Plaintiff in his secondary appeal. Defendant devoted pages of its denial letter to the reviewing neuropsychologist's assessment of the evaluation and engaged with its substantive findings; ultimately, however, Defendant found the evaluation's globally low scores unreliable in light of Plaintiff's medical history, internal inconsistencies, and the absence of measures designed to validate these scores.[4] Accordingly, Defendant's reference to the lack of validity testing was not simply a pretext for discrediting the evaluation, but instead, one of a number of reasons why Defendant declined to adopt uncritically its conclusions—which, under 29 C.F.R. § 2560.503-1(h)(2)(iv), Defendant was not required to do. Nor was Defendant required to give Plaintiff an opportunity to respond to its opinions of the evaluation before making its final determination.[5]

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[4] Thus, the Court disagrees that McCauley v. First Unum Life Ins. Co. lends support to Plaintiff's position. See 551 F.3d 126, 135 (2d Cir. 2008). In that case, the administrator completely refused to consider a medical report because it was not signed by a physician; here, Defendant considered the neuropsychological testing, and simply disagreed with its methodology and conclusions.

[5] The Department of Labor amended 29 C.F.R. § 2560.503-1 in January of 2017 so that there is now a provision that requires plans providing disability benefits to provide a claimant with any new rationale considered for denying disability benefits and allow them time to respond prior to the adverse benefit determination. See 29 C.F.R. § 2560.503-1(h)(4)(ii). While it is

Plaintiff also argues that Defendant failed to consider the nonmedical information submitted by Plaintiff in his secondary appeal. Plaintiff claims that this is evident from the denial letter's statement that the reviewing physicians "provided their opinions as to Mr. Capretta's *medically supported* level of functional capacity." (Siegel Reply Decl. Ex. C at 8 (emphasis added).)

While Plaintiff selects this language in an attempt to showcase Defendant's purported disregard for the *non*medical evidence submitted with his appeal, in context, it is clear that Defendant considered both medical and nonmedical evidence alike. Defendant specifically states that it "considered the opinions expressed by [Plaintiff], [and] [Plaintiff]'s treatment providers including Dr. Weiss and vocational expert Mr. Pasternak," id., and both reviewing physicians discussed and engaged with Plaintiff's reported symptoms. (See id. at 4-6.) The denial letter also contains a paragraph-long discussion of the vocational report submitted by Plaintiff, including an explanation as to why Defendant differed in its own conclusions regarding Plaintiff's functional capacity. (Id. at 8.) Because neither case law nor ERISA regulations require an administrator

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possible that Defendant's conduct could have violated the *amended* version of the regulation, this version was not in effect during the time of the administrative determination in question, and Plaintiff does not, in any case, raise it.

to accept indiscriminately a claimant's evidence, the Court cannot find that Defendant violated 29 C.F.R. § 2560.503-1(h)(2)(iv) by considering, but ultimately rejecting, the opinions of Plaintiff and his experts.

c. The Claimed § 2560.503-1(b)(5) Violation

Plaintiff next argues that Defendant cannot demonstrate compliance with section (b)(5) of the regulation, which requires plans to maintain administrative processes designed to ensure that similarly-situated claimants are treated consistently and in accordance with plan documents. See 29 C.F.R. § 2560.503-1(b)(5). Plaintiff claims that he has not seen Defendant's claims procedures, and so cannot specifically identify where Defendant is noncompliant. However, Plaintiff argues that under Halo, it is Defendant's burden to demonstrate compliance with the regulations.

In Halo, the Second Circuit found that:

> **[A] plan's failure to comply with the Department of Labor's claims-procedure regulation, 29 C.F.R. §2560.503-1, will result in that claim being reviewed de novo in federal court, unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulation in the processing of a particular claim was inadvertent *and* harmless. Moreover, the plan bears the burden of proof on this issue since the party claiming deferential review should prove the predicate that justifies it.**

Halo, 819 F.3d at 58 (internal quotation marks omitted). District courts have since disagreed about whether the plan's burden of proof requires it to demonstrate compliance with the regulation in general, or simply to show that any noncompliance was inadvertent and harmless. See Hafford v. Aetna Life Ins. Co., No.16-CV-4425(VEC)(SN), 2017 WL 2774434, at *9 (S.D.N.Y. June 13, 2017)("[T]he Court of Appeals . . . placed the burden of proof squarely on the plan administrator to demonstrate that a deviation was 'inadvertent and harmless.'"); Salisbury v. Prudential Life Ins. Co. of Am., No. 15-CV-9799(AJN), 2017 WL 780817, at *5 (S.D.N.Y. Feb. 28, 2017)("In Halo, the Court wrote that the Plan bears the burden of proving that the 'inadvertent and harmless' exception applies."); Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Plan, 217 F. Supp. 3d 608, 629 (N.D.N.Y. 2016) ("[T]he burden is on Defendants to show that these procedural failings were 'inadvertent *and* harmless.'"). Compare Schuman v. Aetna Life Ins. Co., No.3:15-CV-1006(SRU), 2017 WL 1053853, at *12 (D. Conn. Mar. 20, 2017) ("[T]he plan bears the burden to show that the denial decision was made using compliant procedures."). The only district court to squarely address this issue found that:

> **Although Halo held that the plan administrator has the burden to prove which standard of review to apply, surely that burden does not require that a defendant affirmatively show that it complied with DOL**

> **regulations when the plaintiff makes no showing to the contrary. Rather, a fair reading of *Halo* requires only that the administrator show that it had discretionary authority to administer the plan; and its burden to prove compliance with DOL regulations arises, if it ever arises, only after a plaintiff makes a reasonable showing that the defendant violated DOL rules.**

Donlick v. Standard Ins. Co., No. 3:16-CV-617, 2017 WL 1683060, at *3 n.1 (N.D.N.Y. May 2, 2017).

The Court agrees with this framework of analysis. Requiring a plan to prove affirmatively compliance based on the mere allegation that it *might* have violated the regulations would spawn endless litigation prior to reaching the merits in ERISA cases, and would permit circumvention of the standards regarding the scope of discovery, discussed below. Indeed, even in the district court case finding that the plan's burden required it to prove compliance with the regulations, the court noted that the plaintiff had first "identified specific evidence" of noncompliance. Schuman, 2017 WL 1053853, at *12. Here, Plaintiff neither makes a showing that Defendant failed to maintain a reasonable claims procedures nor alleges how Defendant's claims procedure—or its application thereof—might have violated the regulations. Because Plaintiff has failed to make such a minimal showing, Defendant will not be required to prove affirmatively its regulatory compliance. To the extent that this argument dovetails with Plaintiff's request for discovery regarding the alleged noncompliance, it is discussed below.

d. Plaintiff's Discovery Request

Plaintiff requests that he be allowed to conduct discovery regarding both Defendant's claims procedures and its conduct in handling his specific claim. Plaintiff seeks this discovery in order to support his allegations of Defendant's regulatory noncompliance.

In order to take discovery outside of the administrative record, a plaintiff challenging a claims decision must show that there is "a reasonable chance that the requested discovery will satisfy the good cause requirement." Shelton v. Prudential Ins. Co. of Am., No. 16-CV-1559(VEC), 2016 WL 3198312, at *2 (S.D.N.Y. June 8, 2016) (internal quotation marks omitted); see also Durham v. Prudential Ins. Co. of Am., 890 F. Supp. 2d 390, 397 (S.D.N.Y. 2012). To do so, the plaintiff "must do more than merely claim that it is needed to determine whether she received a full and fair review." Hamill v. Prudential Ins. Co. of Am., No. 11 CV 1464 SLT, 2012 WL 6757211, at *10 (E.D.N.Y. Sept. 28, 2012) (internal quotation marks omitted). Instead, he must "make specific factual allegations to support the discovery request." Gosselin v. Sheet Metal Workers' Nat'l Pension Fund, No. 16-cv-4391 (ADS)(AKT), 2017 WL 3382070, at *5 (E.D.N.Y. Aug. 4, 2017) (internal quotation marks omitted); see also Baird v. Prudential Ins. Co. of Am., No. 09 Civ. 7898(PGG), 2010 WL 3743839, at *9

(S.D.N.Y. Sept. 24, 2010); Burgio v. Prudential Life Ins. Co. of Am., 253 F.R.D. 219, 232 (E.D.N.Y. 2008). Indeed, even where a plaintiff has sufficiently alleged good cause, discovery requests may not be overly broad or redundant of what is already in the administrative record. Shelton, 2016 WL 3198312, at *3.

Plaintiff here has not alleged facts with sufficient specificity to show that there is a reasonable chance that discovery will satisfy the good cause standard. Plaintiff fails to show that Defendant did not maintain reasonable claims procedures, or explain how Defendant's application of its procedures may have been irregular or noncompliant in this case. Plaintiff also fails to request specific documents, instead broadly seeking permission "to explore the claim handling conduct, and the potential additional violations of 29 C.F.R. §2560.503-1." (Pl.'s Opp'n at 6).

With respect to Plaintiff's request for Defendant's claims procedures, Defendant contends that it provided the Group Disability Memorandum it uses to document its claims review process to Plaintiff's attorney on January 20, 2016. (See Siegel Decl. Ex. F at 2.) It is thus unclear what Plaintiff's request for a claims procedure seeks to achieve, and why such a request would not be redundant.

Accordingly, the Court declines to grant Plaintiff's discovery request.

III. Conclusion

For the foregoing reasons, Defendant's motion to apply the arbitrary and capricious standard of review is GRANTED. The Parties are to appear for a Rule 16 Conference on September 21, 2017 at 11:30 am.

SO ORDERED.

Dated: August 28, 2017
New York, New York

Deborah A. Batts
United States District Judge