UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

№ 06 Civ. 112 (RJS)

RICHARD ZOLLER,

Plaintiff,

VERSUS

INA LIFE INSURANCE COMPANY OF NEW YORK AND LUCENT TECHNOLOGIES INC. LONG TERM DISABILITY PLAN FOR MANAGEMENT EMPLOYEES,

Defendants.

MEMORANDUM AND ORDER
August 25, 2008

RICHARD J. SULLIVAN, District Judge:

Plaintiff Richard Zoller brings this action under the Employee Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.*, alleging that he was wrongfully denied long-term disability benefits under the disability plan funded by his former employer, defendant Lucent Technologies Inc., which was administered by defendant INA Life Insurance Company of New York.[1] Specifically, plaintiff alleges that the decision denying him long term disability benefits was arbitrary and capricious.

The parties now cross-move for summary judgment. For the following reasons, the Court grants plaintiff's motion for summary judgment vacating the decision denying him long-term disability benefits, and denies defendants' cross-motion. The case is remanded to the plan administrator for the

[1] During the period at issue in this case, INA Life Insurance Company of New York was known as Connecticut General Life Insurance Company, or "CIGNA." Hereinafter, solely for the purpose of convenience, the Court refers to INA as CIGNA.

sole purpose of determining the amount of disability benefits owed to plaintiff.

I. BACKGROUND

A. The Facts

The Court has taken the facts described below from the parties' respective Local Rule 56.1 statements of facts as well as the materials submitted by the parties in support of their cross-motions.[2] As an initial matter, it is undisputed that the relevant period of time for plaintiff's application for benefits was June 16, 2002 through December 24, 2002 (hereinafter, the "relevant period"). (*See* R. 171.[3]) Thus, the question before CIGNA was whether plaintiff was "disabled," as that term is defined in the plan documents, throughout this period, and the question before the Court is whether CIGNA's determination that plaintiff was not disabled throughout the relevant period was supported by substantial evidence.

1. The LTD Plan

Prior to June 2002, Zoller worked for Lucent as a "Project Manager." (*See* Lucent's 56.1 ¶ 5; Pl.'s Opp. 56.1 ¶ 5.) As a benefit of his employment, Zoller was covered under the terms of Lucent's Long Term Disability Plan (the "Plan"). (Lucent's 56.1 ¶ 6.) The terms of the Plan are set forth in a document describing the plan (the "LTD Plan"), and summarized in the Summary Plan Description (the "SPD"). (*Id.*) In regard to the contents of the LTD Plan documents and the SPD, Zoller asserts that they do not sufficiently confer "discretionary authority" on *any* particular party.

a. The SPD

The SPD in effect at the time Zoller allegedly became "totally disabled" was the SPD effective on January 1, 2001.[4] (Am. Compl. ¶ 10; *see* R. 303.) The SPD provides that it is a "description" of the "benefits available" under the Plan, that "[m]ore detailed information is provided in the official LTD Plan documents," and that, "[i]n all instances, the LTD Plan documents will control and govern the operation of the LTD Plan." (SPD 1.) Moreover, at the bottom of each page of the SPD, it provides that "[m]ore detailed information is provided in the official Plan documents which are controlling." (*See* SPD 1-20.) Elsewhere, the SPD provides that it "describe[s] the [Plan] in easy-to-understand terms," and that "[i]t is shorter and less technical than the legal LTD Plan dcouments." (SPD 16.)

The body of the SPD provides that, in order to receive LTD benefits, the applicant, for a period of "26 weeks," "must be unable to do any job for any employer for which [he is] qualified, or may reasonably become qualified by training, education or experience,

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[2] Where only one party's Rule 56.1 statement is cited, the opposing party does not dispute that faet or has offered no admissible evidence to eontrovert that fact. In resolving the parties' cross-motions, the Court has considered all seven Rule 56.1 statements submitted by the parties in this action.

[3] Dr. Abramson did not indicate that he reviewed the submission from Dr. Szczuki at *any* point.

[4] In Zoller's opening brief, he cited to portions of the SPD that was effective on January 1, 2002, and last updated on July 24, 2002. (*See* Pl.'s Mem. at 4.) However, in subsequent briefing, Zoller appeared to concede that the 2001 SPD, rather than the 2002 SPD, applied to Zoller's claim for benefits. (Pl.'s Reply Mem. at 5 & n.6.) Indeed, in his reply brief, Zoller specifically argued that the purported differences between the two SPDs have "no bearing" on the relevant issues in this case. (*Id.*) The Court agrees.

other than one that pays less than 60% of [his] annual base pay at the time [he] became disabled." (SPD 12.) The applicant must submit proof of his continuing disability to the claims administrator, who will "determine the extent of [the applicant's] disability based on medical evidence," and "reserves the right to have a physician of his or her choice examine [the applicant]." (*Id.*)

The SPD indicates that the "LTD Plan Administrator" — namely, Lucent — "has the full discretionary authority and power to control and manage all aspects of the LTD Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the LTD Plan as deemed appropriate in accordance with the terms of the LTD Plan and all applicable laws." (SPD 17.) In regard to claim determination procedures, the SPD provides that participants in the LTD Plan "have the right . . . to file a written claim for benefits with the Claims Administrator (see 'Important Contacts')" (SPD 17), and indicates that the "Claims Administrator will . . . determine the extent of [the applicant's] disability and [his] eligibility for LTD benefits." (SPD 11.) In the "Important Contacts" section, the SPD lists "CIGNA" as the "Claims Administrator" that "[a]pproves or denies claims." (SPD 15.)

b. The LTD Plan

The Plan indicates that "Disability" or "Disabled" "shall mean" that the applicant is determined, "in the sole opinion of the Claims Administrator," to be "incapable" for a period of 26 weeks "of performing the requirements of any job for any employer . . . for which the individual is qualified or may reasonably become qualified . . . other than a job that pays less than 60 percent of the Eligible Employee's Eligible Pay . . . ." (LTD 5.) The LTD Plan also provides that the "Claims Administrator . . . has the authority to evaluate disabilities, resolve claims and appeals and administer the Plan on behalf of the Company, as provided herein." (LTD 5.) Section 9.1 of the LTD Plan identifies the "Claims Administrator" as "CIGNA," and notes that CIGNA "has contracted to provide administrative services only in connection with this Plan on behalf of Lucent . . . ." (LTD 16.)

In regard to the discretion accorded to the Claims Administrator, the LTD Plan erroneously indicates that

> The *BCAC* shall serve as the final review committee under the Plan and shall have sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the documents or instruments governing the Plan, any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to anticipation of Eligible Employees and eligibility for benefits, determination of all relevant facts, the amount and type of benefits payable to any Eligible Employee, lawful spouse or beneficiary, and construction of all terms of the Plan.

(LTD 19 (emphasis added).) In addition, the LTD Plan indicates that "Lucent shall have sole and complete discretionary authority to determine questions relating to eligibility of employees for membership in the Plan and to

amend or terminate the Plan at any time. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. Respective decisions by the *BCAC* and Lucent . . . shall be conclusive and binding on all parties . . . ." (LTD 21 (emphasis added).)

Lucent asserts that the references to BCAC in the LTD Plan are merely "drafting error[s]," arising from the failure to change "BCAC" to "CIGNA" when these sections of the document were copied from Lucent's short-term disability benefits plan, which is administered by the "Benefit Claim and Appeal Committee." (*See* Robinson Decl. ¶ 4.) Lucent asserts that the *effect* of the above-cited language is the same regardless of the drafting error: eligible employees are put on notice that the Claims Administrator has "discretionary authority" to resolve benefits applications. (*See* Lucent's Opp. Mem. at 8.) However, while Zoller does not dispute that the references to BCAC are the result of drafting errors, he asserts that, due to the errors, the Plan failed to properly confer discretionary authority on CIGNA as the Claims Administrator. (*See* Pl.'s Mem. at 3-4.)

2. Zoller's Application for Benefits

In March 2003, Zoller submitted an application for long-term disability benefits under the LTD Plan. (*Id.* ¶ 8.) Specifically, Zoller submitted his application to CIGNA, which was retained by Lucent to administer the LTD Plan. (*Id.*; *see* Pl.'s Opp. 56.1 ¶ 8.)

a. Medical Records

In support of his initial benefits claim, Zoller submitted medical records from two medical professionals who had previously treated him.

i. Dr. Julie Barnes

Dr. Julie Barnes, a psychologist, submitted several "Attending Physician Statements" regarding Zoller's medical condition. In a statement dated March 30, 2003, Dr. Barnes noted that Zoller had a history of depression, and was "at danger of relapse and at risk of worsening depression and anxiety." (R. 257-58.) She also noted that she had previously recommended hospitalization of Zoller but that Zoller's insurance company had "denied" such treatment. (*Id.* 257.) In regard to Zoller's capacity for work, Dr. Barnes opined that Zoller was unable to engage in stress situations or interpersonal relations, and that he was "totally disabled from [his] regular work" as well as "all other work." (*Id.* 258.)

Dr. Barnes also submitted medical records and treatment notes she made during her treatment of Zoller from July 9, 2001 through April 23, 2003, which likewise relayed her diagnosis that Zoller was suffering from polysubstance dependence, dysthymia and generalized anxiety disorder.[5] (*See id.* 195-

[5] "Dysthymia" is defined as "[a] chronic mood disorder manifested as depression for most of the day, more days than not, accompanied by some of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness." Stedmans Medical Dictionary (27th ed. 2000).

229; Pl.'s 56.1 ¶ 27; CIGNA's Opp. 56.1 ¶ 27.) In these notes, Dr. Barnes recorded several observations relating to Zoller's treatment including, in an October 17, 2002 note, her observation that Zoller attended two group therapy sessions each week and one to two meetings each day while maintaining sobriety (R. 208); and, in an April 24, 2003 note, her observation that Zoller's attendance at counseling was "good" and "regular" (R. 216).

ii. Dr. John W. Rosenberger

In addition, in a report dated September 11, 2002, Dr. John W. Rosenberger indicated that Zoller was suffering from dysthymia and was "disabled from working" at that time. (R. 242-46.) Dr. Rosenberger also opined that Zoller's prognosis "for recovery" and for a "return to work" was "good," but did not indicate an estimated timetable for Zoller's return. (R. 246.)

b. CIGNA's Denial of Zoller's Application

By letter dated May 30, 2003 (the "First Denial Letter"), CIGNA denied Zoller's claim. (*See* R. 171.) CIGNA noted that Zoller's medical records had "document[ed] a long history of polysubstance dependence, dysthymia, depression and anxiety[,] back pain, anemia and depression . . . ." (*Id.*) Nevertheless, CIGNA found that the medical documentation submitted in support of his claim did "not show the presence of severe exam findings/observations that would significantly impair [Zoller's] functionality" during the relevant period. (*Id.*) According to CIGNA, "the medical evidence provided [did] not support [Zoller's] inability to perform any job for any employer for which [Zoller was] qualified . . . ." (*Id.*)

In making this determination, CIGNA relied on the analysis and opinions set forth in the report of a "peer reviewer." Specifically, CIGNA relied on the report of Dr. I. Jack Abramson — who, while he did not examine or interview Zoller, reviewed the medical records submitted by Zoller in support of his benefit claim.[6] In a report dated May 16, 2003 (the "initial report"), Dr. Abramson opined that, based on his review of Zoller's medical records, it appeared that Zoller suffered from polysubstance dependence, dysthymia, depression, anxiety, back pain, and anemia. (R. 119-22.) However, Dr. Abramson concluded that Zoller's "activities of daily living" — including his ability to "take care of himself, walk his dog, go to meetings daily, attend his appointments, maintain grooming and [be] generally punctual with his visits [to] Dr. Barnes' office" — "do appear to be normative for someone in recovery. . . . [Zoller's] ability to function occupationally in 'any occupation' appears to be intact. I see no clinical reason in the record why he could not function in any occupation on a full time basis . . . ." (R. 182.)

Dr. Abramson did caution that Zoller did not appear to have "reached maximum medical improvement," and was "making slow progress . . . putting his life in order." (*Id.*) As such, Dr. Abramson indicated that his prognosis for Zoller was "guarded," and

[6] Indeed, it is undisputed that, prior to denying Zoller's application, no medical professional working on behalf of CIGNA or Lucent examined or interviewed Zoller. (Pl.'s 56.1 ¶ 36; CIGNA's 56.1 ¶ 36.)

that Zoller would require "ongoing intensive treatment." (*Id.*)

Dr. Abramson further indicated that, on May 12, 2003, he had discussed Zoller's case with Dr. Barnes "in detail." (R. 181.) According to Dr. Abramson's initial report, Dr. Barnes indicated that Zoller was "recovering," had only been "experiencing mild to moderate levels of anxiety and depression," was "improving" in terms of his "functional capacities," and that he "could function at 'any occupation' at this time."[7] (*Id.*)

4. Zoller's First Appeal

On November 25, 2003, Zoller appealed the denial of his claim. (*See* Traub Aff. Ex. H.) Specifically, Zoller requested that CIGNA conduct a "review of the denial of [LTD] benefits." (R. 153.)

a. Medical Records

In support of his appeal, Zoller presented additional medical records from three treating physicians.

i. Dr. Barnes

In a letter to CIGNA dated November 12, 2003, Dr. Barnes submitted additional details concerning Zoller's treatment, including (1) he had received "weekly psychotherapy treatment . . . for symptoms of depression, anxiety, and substance abuse since May of 2002"; (2) in May 2002, Zoller's condition was "so severe and alarming" that Dr. Barnes advised him to seek inpatient treatment; (3) in July 2002, Zoller enrolled in an "intensive outpatient program . . . for the treatment of his substance abuse" but his "symptoms of anxiety and depression" nevertheless "continued and increased as he struggled to get sober . . ."; (4) Zoller spent the following winter "virtually bedridden by symptoms of anxiety and depression, only leaving his home to attend 12 step meetings and medical appoints"; and (5) Zoller had, at the time of the letter, been sober for "more than a year" but "still remain[ed] at [a] moderate to high risk for relapse." (R. 151-52.) Moreover, according to Dr. Barnes, Zoller's "depressive and anxious symptoms interfere with and impair his ability to function in the work environment because they impair his concentration, attention, energy, mood, and interpersonal skills." (R. 152.) As such, she opined that Zoller "is only capable of working part time in a low stress job with little responsibility," and asserted that "these facts and opinions are clearly reflected" in the materials previously submitted to CB. (*Id.*)

In addition, in the November 12 letter, Dr. Barnes sought to "clarify and correct some misinterpretations and inaccuracies . . . that were attributed to me" in the First Denial Letter. (R. 151.) Specifically, Dr. Barnes presented two "important corrections" in regard to the substance of the First Denial Letter. First, Dr. Barnes asserted that she never told Dr. Abramson that Zoller "could function at any occupation at this time";

[7] Zoller points out that Dr. Abramson was "used repeatedly" by CIGNA as a peer reviewer. (*See* Pl.'s 56.1 ¶ 39.) According to CIGNA, Dr. Abramson conducted, in 2002, 43 of 1,191 peer reviews; in 2003, 71 of 1031 peer reviews; in 2004, 46 of 1,329 peer reviews; and, in 2005, 25 of 935 peer reviews. (*See* CIGNA's Opp. 56.1 ¶ 39.)

rather, according to Dr. Barnes, she merely responded to Dr. Abramson's question regarding whether Zoller could "flip hamburgers" by stating the she "supposed [Zoller] could flip hamburgers." (*Id.*) Second, Dr. Barnes asserted that she did not indicate that Zoller was "only 'experiencing mild to moderate levels of anxiety and depression'"; rather, according to Dr. Barnes, that statement was "inaccurate" and "contradicted" by her "notes," "report[s]" and the "record of [her] conversation with Dr. Abramson." (*Id.*)

ii. Dr. Denise Szczucki

In a letter dated November 20, 2003, Dr. Denise Szczucki indicated that she had first treated Zoller on July 2, 2003, and offered information regarding her observations of his condition. She opined that Zoller "suffers from problems in concentration and short-term memory due to long-term effects of his addiction . . . ." (R. 114.) Moreover, Dr. Szczucki indicated that a "recent" examination "revealed a very somber, unshaven gentleman, with significant psychomotor retardation" whose "[a]ttention, concentration, and short term memory were limited due to depressive syndrome." (*Id.*) She also indicated that Zoller's depression had not, since he began treatment with Dr. Szczucki, "improved significantly," and that, at the time of the letter, the "unpredictability and extreme fluctuation of [Zoller's] mood and mental states . . . give rise to heightened states of anxiety which . . . complicate treatment." (*Id.*) Dr. Szczuki diagnosed Zoller as suffering from, *inter alia*, major depression that was "recurrent" and "severe," and cocaine and alcohol dependence. (*Id.*)

iii. Dr. Mark D. Green

In an Attending Physician Statement dated May 28, 2003, Dr. Mark D. Green indicated that he diagnosed Zoller as suffering from "major depression" and cocaine dependency.[8] (R. 156.) Dr. Green opined that Zoller was totally disabled from his "regular work" for a period of 3-6 months, and from "all other work" for a period of 1-3 months. (R. 157.) Dr. Green indicated that he recommended Zoller's "gradual return" to work "in 2 months . . . ." (*Id.*)

b. The Addendum

In conjunction with Zoller's appeal, on January 2, 2004, Dr. Abramson issued an addendum (the "Addendum") to his initial peer review report. (R. 0082.)[9] In the Addendum, Dr. Abramson reviewed some of the additional materials submitted by Zoller in support of his appeal, including the materials submitted by Dr. Barnes and Dr. Green. (R. 128.) He did not conduct a physical examination or interview Zoller prior to preparing the Addendum. (Pls.' 56.1 ¶ 62.)

In the Addendum, Dr. Abramson once again indicated that, in his conversation with Dr. Barnes, she stated that Zoller had "mild to

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[8] According to Dr. Green, he submitted the May 28, 2008 statement in support of Zoller's initial appeal but it appears that CIGNA never received the statement. (*See* R. 155.) As such, Dr. Green resubmitted his statement after CIGNA had issued the First Denial Letter but prior to its resolution of Zoller's first appeal. (*See* CIGNA's 56.1 ¶ 44.)

[9] "R" refers to the administrative record prepared by CIGNA, which contains the materials reviewed by CIGNA during the benefits determination process.

moderate levels of anxiety and depression" (R. 129), thus disputing Dr. Barnes' statements to the contrary in her November 12, 2003 letter. Moreover, Dr. Abramson reiterated his conclusion that Zoller's "activities of daily living remain quite robust . . . ." (*Id.*)

In addition, Dr. Abramson noted that, in her November 12, 2003 letter, Dr. Barnes' indicated that Zoller "spent last winter bedridden," which, according to Dr. Abramson, "would clearly indicate severity of symptomatology adequate to support occupational impairment."[10] (R. 129-30.) However, Dr. Abramson rejected Dr. Barnes' observation as "not germain [sic] to the dates in question as the winter falls before June 2002." (R. 130.) This statement was incorrect: the "winter" in question — during which, according to Dr. Barnes, Zoller was "virtually bedridden" — occurred after June 2002, in late 2002 and early 2003. (*See* R. 88.)

Dr. Abramson also reviewed the materials submitted by Dr. Green, and, in particular, noted Dr. Green's observations that Zoller "could have a trial of employment commence on June 30, 2003." (R. 130.) However, Dr. Abramson did not address Dr. Green's observation that Zoller was totally disabled from his "regular work" for a period of 3-6 months, and from "all other work" for a period of 1-3 months. (R. 157.)

Ultimately, Dr. Abramson concluded in the Addendum that "[t]he extent of workers [sic] depression is not documented in the medical record to be of adequate severity to preclude full time occupational functioning from June 17, 2002 onward." (*Id.*) In making this determination, according to Dr. Abramson, he reviewed the "medical records provided with the assumption that the material is true and correct." (*Id.*)

c. CIGNA's Denial of the Appeal

On February 23, 2004, CIGNA rejected Zoller's appeal. (*See id.* Ex. 1 at 1.) CIGNA noted that, in the Addendum, Dr. Abramson indicated (1) "that the extent of [Zoller's] depression [was] not documented in the medical record to be of adequate severity to preclude full time occupational functioning from June 17, 200 to present time," and (2) while he "did not dispute [Zoller's] recovery status[,] . . . recovery per se is not an illness." (*Id.*)

5. Zoller's Second Appeal

a. Medical Records

On August 4, 2004, Zoller appealed the denial of his first appeal and, in support, submitted additional medical documentation, which the Court summarizes herein.

i. Dr. Szczucki

In support of Zoller's second appeal, Dr. Szczucki submitted a second letter, dated November 20, 2003, wherein she relayed the following observations, based on her psychiatric treatment of Zoller since July 2, 2003. She noted that Zoller reported feeling

[10] The Court notes that, contrary to portions of the Addendum, Dr. Barnes' November 12, 2003 letter indicated that Zoller was "*virtually* bedridden" rather then simply "bedridden." (*See* R. 152 (emphasis added).)

very tired, and was having "severe difficulty concentrating." (R. 84.) Moreover, she indicated that the "pace of his daily activity has noticeably slowed," he "often feels life is not worth living," and he has a "sense of hopelessness and helplessness" that "prevented him from pursuing his normal activities." (*Id.*) Dr. Szczucki concluded that the "source of his disability is a severe major depressive disorder in the context of catastrophic stressors including the death of his mother . . . , inability to work, severe family conflicts and harassment by his brother, and social isolation." (*Id.*) She indicated that Zoller had "remained depressed throughout the past year" but still suffered from "problems in concentration and short-term memory due to longer-term effects of his addiction . . . ." (*Id.*) She noted that Zoller's depression had worsened since he achieved sobriety, and that he "spends his days largely at home watching TV, listening to music and sleeping." (R. 84-85.)

ii. Dr. Alex B. Caldwell

On February 19, 2004, Dr. Alex B. Caldwell submitted a report detailing the results of a "Minnesota Multiphasic Personality Inventory-2" ("MMPI-2") test performed on Zoller.[11] (R. 101.) According to Dr. Caldwell, the test indicated that Zoller suffered from moderate to severe depression "secondary depression," was a suicide risk, and that Zoller "does not currently test as having the strength to work . . . ." (R. 102, 104.) In addition, Dr. Caldwell "strongly recommended]" that Zoller "consider[] hospitalization." (R. 104.)

iii. Dr. Paul Hymowitz

Also on February 19, 2004, Dr. Paul Hymowitz submitted a report detailing the results of a "Beck Depression Inventory Test" (the "Beck Inventory") and a second MMPI-2 test performed on Zoller. (R. 98.) Dr. Hymowitz conducted two in-person clinical interviews with Zoller in order to perform the tests. (Pl.'s 56.1 ¶ 91.) Based on these tests, Dr. Hymowitz opined that Zoller suffered from moderate to severe depression, severe anxiety, and clinical dependency. (R. 99.) In regard to the Beck Depression Inventory Test, Dr. Hymowitz observed that Zoller's score of 32 was consistent with severe depression. (R. 99.) In regard to the MMPI-2 test, Dr. Hymowitz indicated that Zoller's results indicated that the "extent of psychological distress that he reported does appear genuine." (R. 99.) Dr. Hymowitz concluded that Zoller "does not appear to be emotionally capable of sustained employment in his present condition." (R. 99.)

b. CIGNA's Denial of the Second Appeal

On February 3, 2005, CIGNA issued a letter denying Zoller's Second Appeal (the "Second Denial Letter"). (R. 75.) Specifically, CIGNA noted that it had reviewed the information submitted by Drs. Szczucki, Caldwell and Hymowitz, and concluded that Zoller's claim should be "denied for reasons detailed in our previous letters." (*Id.*) CIGNA also informed Zoller

[11] An MMPI test is defined as a "questionnaire type of psychological test for ages 16 and over, with 550 true-false statements coded in 4 validity and 10 personality scales which may be administered in both an individual or group format." Stedman's Medical Dictionary (27th ed. 2000).

that he had "exhausted all administrative levels of appeal" and that "no further appeals will be considered." (*Id.*)

B. Procedural History

On January 6, 2006, Zoller filed the complaint in this action. On April 11, 2006, Zoller filed an amended complaint. On June 28, 2007, Zoller filed the instant motion for summary judgment. On that same day, Lucent and CIGNA filed their respective cross-motions for summary judgment. On September 4, 2007, this case was reassigned from the Honorable Kenneth M. Karas, District Judge, to my docket. Thereafter, the parties submitted supplemental letter briefs concerning their cross-motions. On July 18, 2008, the Court heard oral argument regarding the motions.

II. LEGAL STANDARDS

A. Summary Judgment

The standards for summary judgment are well settled. The moving party bears the burden of showing that he or she is entitled to summary judgment. *See Huminski v. Corsones*, 396 F.3d 53, 69 (2d Cir. 2005). Pursuant to Rule 56(c), summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); *Matican v. City of New York*, 524 F.3d 151, 154 (2d Cir. 2008). "A dispute about a 'genuine issue exists for summary judgment purposes where the evidence is such that a reasonable jury could decide in the non-movant's favor." *Beyer v. County of Nassau*, 524 F.3d 160, 163 (2d Cir. 2008) (quoting *Guilbert v. Gardner*, 480 F.3d 140, 145 (2d Cir. 2007)); *see Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986) (holding that summary judgment is unwarranted if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party").

"This standard applies equally to cases . . . in which both parties [have] moved for summary judgment." *Bronx Household of Faith v. Bd. of Educ. of City of N.Y.*, 492 F.3d 89, 96 (2d Cir. 2007) (citing *Morales v. Quintel Etmt., Inc.*, 249 F.3d 115, 121 (2d Cir. 2001)). "[W]hen parties have filed cross-motions for summary judgment, the court 'must evaluate each party's motion on its own merits, taking care in each instance to draw all reasonable inferences against the party whose motion is under consideration.'" *Bronx Household of Faith*, 492 F.3d at 96-97 (citing *Hotel Employees & Rest. Employees Union, Local 100 v. City of New York Dep't of Parks & Recreation*, 311 F.3d 534, 543 (2d Cir. 2002) (quoting *Heublein, Inc. v. United States*, 996 F.2d 1455, 1461 (2d Cir. 1993)).

B. Benefits Determinations Under ERISA

A denial of benefits under ERISA "'is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 622 (2d Cir. 2008) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). "If the insurer establishes that it has such discretion, the benefits decision is reviewed under [an]

arbitrary and capricious standard." *Krauss*, 517 F.3d at 622; *see also Celardo v. GNY Automobile Dealers Health & Welfare Trust*, 318 F.3d 142, 145 (2d Cir. 2003) ("The Supreme Court . . . has indicated that plans investing the administrator with broad discretionary authority to determine eligibility are reviewed under the arbitrary and capricious standard.").

In *Krauss*, the Second Circuit noted that any "[a]mbiguities" in making this determination shall be "construed in favor of the plan beneficiary." 517 F.3d at 622. The court also observed that

> A reservation of discretion need not actually use the words "discretion" or "deference" to be effective, but it must be clear. Examples of such clear language include authorization to "resolve all disputes and ambiguities," or make benefits determinations "in our judgment." In general, language that establishes an objective standard does not reserve discretion, while language that establishes a subjective standard does.

Id. (quoting *Nichols v. Prudential Ins. Co. of America*, 406 F.3d 98, 108 (2d Cir. 2005)) (additional internal citation omitted). At all times, the administrator bears the burden of proving that the arbitrary and capricious standard should apply. *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 249 (2d Cir. 1999).

An administrator's decision is arbitrary and capricious "if it was 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Krauss*, 517 F.3d at 623-24 (quoting *Fay v. Oxford Health Plan*, 287 F.3d 96, 104 (2d Cir. 2002)). In particular, "[s]ubstantial evidence is 'such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [administrator and] . . . requires more than a scintilla but less than a preponderance.'" *Celardo*, 318 F.3d at 146 (quoting *Miller v. United Welfare Fund*, 72 F.3d 1066, 1072 (2d Cir. 1995)).

Thus, "[u]nder the arbitrary and capricious standard, the scope of judicial review is narrow." *Celardo*, 318 F.3d at 146; *see also Miller*, 72 F.3d at 1070 ("When an employee benefit plan grants a plan fiduciary discretionary authority to construe the terms of the plan, a district court must review deferentially a denial of benefits . . . ."). Nevertheless, the Court is mindful that, while limited, "review of a determination under th[is] standard is more than [a] perfunctory review of the factual record in order to determine whether that record could conceivably support the decision to terminate benefits. Rather, such a review must include a searching and careful determination as to whether the conclusion reached by the administrator in view of the facts before it was indeed rational and not arbitrary." *Rappa v. Connecticut General Life Ins. Co.*, No. 06 Civ. 2285 (CBA), 2007 WL 4373949, at *9 (E.D.N.Y. Dec. 11, 2007) (quoting *Rizk v. Long Term Disability Plan of Dun & Bradstreet Corp.*, 862 F. Supp. 783 (E.D.N.Y. 1994) (Korman, J.).

In addition, ERISA guarantees "a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2) (emphasis added). The fiduciary's failure to provide a full and fair

review may constitute an arbitrary and capricious decision. *See Crocco v. Xerox Corp.*, 137 F.3d 105, 108 (2d. Cir. 1998).

III. DISCUSSION

Zoller argues that this Court should review defendants' determination *de novo*, and find that, contrary to defendants' decision, Zoller is entitled to long term disability benefits. (*See* Pl.'s Mem. at 7.) Defendants respond that *de novo* review is inappropriate because the LTD Plan conferred discretionary authority on CIGNA as Claims Administrator, and, therefore, that this Court should affirm defendants' denial of Zoller's application pursuant to the arbitrary and capricious standard.

For the following reasons, the Court finds that (1) the arbitrary and capricious standard of review applies, and (2) the Plan's denial of Zoller's application was not supported by substantial evidence and, therefore, should be vacated.

A. The Arbitrary and Capricious Standard Applies in this Case

It is clear that both the SPD and the LTD Plan established a sufficiently "subjective standard" that "reserve[d] discretion" to the Claims Administrator to warrant arbitrary and capricious review of the Claims Administrator's decision. *Knauss*, 517 F.3d at 622.

The Court rejects plaintiff's assertion that the language in the SPD and the LTD Plan "conflict." Rather, the Court finds that the language in both the SPD and/or the LTD Plan similarly require that the Court apply the arbitrary and capricious standard. In regard to the SPD, the document provides that Lucent, as the Plan Administrator, retains "full discretionary authority and power to control and manage all aspects of the LTD Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the LTD Plan as deemed appropriate in accordance with the terms of the LTD Plan and all applicable laws." (SPD 17.) Furthermore, the SPD provides that Lucent, as the Plan Administrator, "may allocate or delegate its responsibilities for the administration of the LTD Plan to others . . . to carry out or render advice with respect to its responsibilities under the LTD Plan, including discretionary authority to interpret and construe the terms of the LTD Plan, to direct disbursements, and to determine eligibility for LTD Plan benefits." (SPD 17.) The SPD indicates that Lucent has made such a delegation of its "discretionary authority" to the "Claims Administrator." (*Id.*) Specifically, the SPD provides that all claims for benefits should be filed with the Claims Administrator (SPD 17), which will then "determine the extent of [the applicant's] disability and [his] eligibility for LTD benefits" (SPD 11), and issue a "decision" that includes the "specific reasons" for granting or denying the claim (SPD 17). The SPD identifies "CIGNA" as the Claims Administrator that "[a]pproves or denies claims." (SPD 15.)

In regard to the LTD Plan, the document unambiguously confers on the Claims Administrator the "authority to evaluate disabilities, resolve claims and appeals and administer the Plan on behalf of the Company . . . ." (LTD 5.) Moreover, the LTD Plan

provides, in the section entitled "Claims Administrator," that the "administrator identified in Section 9.1 of the Plan . . . has the authority to evaluate disabilities, resolve claims and appeals and administer the Plan on behalf of the Company, as provided herein." (LTD 5.) In Section 9.1, the LTD Plan indicates that "[t]he Claims Administrator for the Plan is Connecticut General Life Insurance Company (CIGNA) . . . . CIGNA has contracted to provide administrative services only in connection with this Plan on behalf of Lucent . . . ." (LTD 16.)

The LTD Plan also erroneously identifies "BCAC" as the Claims Administrator in Section 10 of the document. While referring to BCAC, the document provides that the Claims Administrator "serve[s] as the final review committee under the Plan and shall have sole and complete discretionary authority to determine conclusively for all parties . . . any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to anticipation of Eligible Employees and eligibility for benefits, determination of all relevant facts, the amount and type of benefits payable . . . and construction of all terms of the Plan." (LTD 19.)

In light of language previously found by the Second Circuit to confer discretionary authority, the language quoted above in both documents, taken individually or collectively, confers sufficient subjective authority on the Claims Administrator to subject its determinations to arbitrary and capricious review. For instance, in *Krauss*, the Second Circuit held that two phrases in the plan documents at issue conveyed sufficient discretion to subject the claims administrator's decision to arbitrary and capricious review. *See* 517 F.3d at 622. The first phrase provided that the plan "'may adopt reasonable policies, procedures, rules, and interpretations' to promote the orderly and efficient administration of" the plan's Supplemental Certificate of Coverage. *Id.* at 622-23. The second phrase concerned the plan's standard for determining reimbursement rates, and defined a "usual, customary, and reasonable" ("UCR") fee as either "'[t]he amount charged or the amount We [sic] determine to be the reasonable charge, whichever is less.'" *Id.* The Second Circuit found that the use of the verb "determine" conferred upon the plan "discretionary authority regarding one of the Plan terms here at issue: UCR charges." *Id.* at 623-24. Similarly, in *Mario v. P & C Food Markets, Inc.*, the Second Circuit found that, where the plan language "reserv[ed] to [the Plan Administrator] 'discretionary authority to review all denied claims for benefits under the Plan,' and provid[ed] that questions 'as to the proper interpretation of the Plan with respect to eligibility for benefits or otherwise' should be referred to [the Plan Administrator] for resolution," it was "sufficient under our cases to trigger the 'arbitrary and capricious' standard of review." 313 F.3d 758, 763 (2d Cir. 2002); *see also Ganton Techs., Inc. v. Nat'l Indus. Group Pension Plan*, 76 F.3d 462, 466 (2d Cir. 1996) (conducting arbitrary and capricious review of a benefits determination on the basis of, *inter alia*, plan language that conferred on the administrator "the authority to 'resolve all disputes and ambiguities relating to the interpretation of the Plan'"); *Jordan v. Ret. Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1269-71 (2d Cir. 1995) (applying the arbitrary

and capricious standard of review to a plan that provided that the retirement committee "shall pass upon all questions concerning the application or interpretation of the provisions of the Plan," and noting that the committee had the power of "interpretation" and must therefore "evaluate and determine facts," an "inherently . . . judgmental function") (citations and internal quotation marks omitted).

Here, the language in both the SPD and the LTD plan conferred discretionary authority upon the claims administrator to, *inter alia*, "determine the extent of [the applicant's] disability and [his] eligibility for LTD benefits" (SPD 11), and to "evaluate disabilities, resolve claims and appeals and administer the Plan on behalf of the Company . . . ." (LTD 5.) These grants of discretionary authority clearly warrant the application of the arbitrary and capricious standard.

Moreover, in regard to the references to "BCAC" in the LTD Plan, the Court finds that, even construing the evidence in the light most favorable to plaintiff, the references are clearly typographical errors that do not effect the standard of review applied by this Court. Indeed, based on the record before the Court, no reasonable fact finder could conclude that, during the course of events underlying this litigation, plaintiff believed that anyone other than CIGNA served as the Claims Administrator, and plaintiff has failed to assert any arguments to that effect.

In any event, even assuming *arguendo* that the BCAC references did create some confusion as to the *identity* of the Claims Administrator, the portions of the LTD Plan containing such references served to reinforce the ample grants of discretion to the Claims Administrator that were found elsewhere in the document. Indeed, the portions of the LTD Plan containing the BCAC references, in accord with the other sections of the document, unambiguously provided, *inter alia*, that the Claims Administrator — be it BCAC or CIGNA — retained "sole and complete discretionary authority to determine conclusively for all parties . . . any and all questions arising from administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to anticipation of Eligible Employees and eligibility for benefits, determination of all relevant facts, the amount and type of benefits payable . . . and construction of all terms of the Plan." (LTD 19.)

Finally, even assuming *arguendo* that the LTD Plan did *not* confer discretionary authority on CIGNA as the claims administrator, it is clear that the SPD did confer such authority and that, when the two documents conflict, the terms of the SPD control. Indeed, it is well settled in the Second Circuit that, "[w]here the terms of a plan and the SPD conflict, the SPD controls." *Burke v. Kodak Retirement Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003) (citing *Heidgerd v. Olin Corp.*, 906 F.2d 903, 907-08 (2d Cir. 1990)); *see, e.g.*, *Demirovic v. Building Service 32 B-J Pension Fund*, 467 F.3d 208, 210 (2d Cir. 2006) ("The language of the Fund's plan differs in some respects from that used in the SPD. As the Fund conceded below, to the extent that there is a conflict, the language of the SPD controls.") (citing *Burke*, 336 F.3d at 110); *Bacquie v. Liberty Mutual Ins. Co.*, 435 F. Supp. 2d 318, 327 (S.D.N.Y. 2006) ("When 'the terms of a plan and the SPD conflict, the SPD controls.'") (internal

citations omitted). "This may be startling at first blush but it makes sense when it is recalled that the SPD 'will be an employee's primary source of information regarding employment benefits, and employees are entitled to rely on the descriptions contained in the summary.'"[12] *Heidgerd*, 906 F.2d at 907.

The district court cases cited by plaintiff do not require a contrary outcome. Plaintiff correctly notes that at least two district courts in this District have found that the SPD only trumps the plan documents "where a plaintiff has relied on the terms of a plan summary to his detriment." *Stern v. Cigna Group Ins.*, No. 06 Civ. 1400 (JSR), 2007 WL 414591, at *4 (S.D.N.Y. Jan. 30, 2007) (citing *Schultz v. Stoner*, 308 F. Supp. 2d 289, 307 (S.D.N.Y. 2004)). Here, there is no indication that plaintiff relied on the terms of the plan summary to his detriment, or that, as in *Stern*, the plan was attempting to "invoke narrow or inconsistent [Summary Plan Description] language to preclude participants from exercising rights granted by formal plan texts.'" 2007 WL 414591, at *4 (citing *Schulz*, 308 F. Supp. 2d at 307).

Accordingly, the Court applies the arbitrary and capricious standard in reviewing CIGNA's rejection of plaintiff's claim for benefits.[13]

B. CIGNA's Determination Was Not Supported by Substantial Evidence

Plaintiff asserts that the conclusions reached by Dr. Abramson and, in turn, CIGNA were not supported by substantial evidence, especially where Dr. Abramson failed to conduct an examination of plaintiff but nevertheless rejected the opinions of plaintiff's six treating physicians. Defendants argue that Dr. Abramson's conclusions and CIGNA's ultimate rejection of plaintiff's claim were based on a review of the treatment records submitted by plaintiff, and were

[12] ERISA requires employers to distribute SPDs that describe the plan's benefits to their employees. 29 U.S.C. §§ 1022(a) & 1024(b). The SPD must be written in a manner calculated to be understood by the average plan participant and must be sufficiently accurate and comprehensive to apprise participants and beneficiaries of their rights and obligations under the plan. *Id.* § 1022(a). The SPD must contain the plan's eligibility requirements for benefits as well as the circumstances which may result in disqualification, ineligibility or denial or loss of benefits. *Id.* § 1022(b); 29 C.F.R. § 2520.102-3(1).

[13] The Court also rejects plaintiff's argument that there was a "conflict of interest" arising from the fact that Lucent hired CIGNA to serve as the claims administrator, therefore requiring this Court to review CIGNA's determination under the *de novo* standard. (*See* Pl.'s July 3, 2008 Ltr. at 1.) Plaintiff has failed to present any persuasive authority in support of this argument. Moreover, the Court rejects plaintiff's assertion that his argument is supported by the Supreme Court's recent decision in *Metropolitan Life Insurance Co. v. Glenn*, 128 S.Ct. 2343 (2008). In that case, the Supreme Court determined that a "conflict of interest" exists when a single entity both funds the plan and evaluates the claims. *Id.* at 2345. That kind of conflict is not present in the instant case — here, Lucent funded the plan while Cigna made the benefit determinations. *See Stamp v. Metrop. Life Ins. Co.*, 531 F.3d 84, 88 (1st Cir. 2008) (declining to find a *Glenn* conflict of interest where one entity funded the plan and another entity made "final benefit determinations").

supported by substantial evidence found therein. For the following reasons, the Court finds that CIGNA's rejection of plaintiff's claim was arbitrary and capricious, especially where it principally relied on the flawed Report issued by Dr. Abramson.

As an initial matter, the Court notes that there is no "treating physician rule" in the context of ERISA claims — that is, courts may not "require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). Moreover, it is well settled that, in denying a claim for benefits under ERISA, the plan administrator may rely on the opinion of independent medical reviewers who have not conducted an examination of the applicant, even where the reviewer's opinion conflicts with that of the treating physicians. *See, e.g.*, *Fitzpatrick v. Bayer Corp.*, No. 04 Civ. 5134 (RJS), 2008 WL 169318, at *14 (S.D.N.Y. Jan. 17, 2008) ("[A]ny suggestion that an administrator's physicians are required to conduct an in-person, physical examination of a plaintiff rather than a review of the record in a case such as this is unsupported by law . . . ."); *Wagner v. First Unum Life Ins. Co.*, No. 02 Civ. 9135 (RLC), 2003 WL 21960997, at *5 (S.D.N.Y. Aug. 13, 2003). Nevertheless, the Court finds that, under the circumstances of the instant case, CIGNA's determination was not supported by "substantial evidence," *Miller*, 72 F.3d at 1072, or, in other words, that the record does not contain evidence that "a reasonable mind might accept as adequate to support the conclusion reached by" CIGNA, *Celardo*, 318 F.3d at 146 (internal quotations and citation omitted).

1. The Reviews Prepared by Dr. Abramson Do Not Support the Denial of Plaintiff's Claim

In rejecting plaintiff's application, CIGNA principally relied on the initial report and the addendum (collectively, the "Reviews") prepared by Dr. Abramson. However, several of the conclusions contained in the Reviews were not supported by substantial evidence and were marked by at least one serious factual error resulting in the arbitrary rejection of relevant evidence. Therefore, Dr. Abramson's Reviews could not support any reasonable finding that plaintiff was not disabled within the meaning of the LTD Plan.

It is undisputed that the Reviews were prepared entirely on the basis of a review of plaintiff's treatment records, rather than a first-hand interview or examination of plaintiff. Some courts have elected to "discount the opinions of psychiatrists who have never seen the patient for obvious reasons. Unlike cardiologists or orthopedists, who can formulate medical opinions based upon objective findings derived from objective clinical tests, the psychiatrist typically treats his patient's subjective symptoms . . . ." *Sheehan v. Metrop. Life Ins. Co.*, 368 F. Supp. 2d 228, 255 (S.D.N.Y. 2005) (Haight, J.); *see also Winkler v. Metropolitan Life Ins. Co.*, 170 Fed. Appx. 167, 168-69 (2d Cir. 2006) ("[The claims administrator's] exclusive reliance on second-hand opinions adds to the overall picture of its decision as less than fair. First-hand observation is especially important

in the context of assessing psychiatric disabilities.") (citing *Sheehan*, 368 F. Supp. 2d at 255). Thus, although it is not *per se* error for a claims administrator to rely on second-hand opinions of psychiatrists in rejecting a claim for benefits, the practice seriously undermines a reviewing court's confidence in such opinions where they appear to be, as in the instant case, unsupported and arbitrary rejections of the opinions of treating physicians as well as objective indications of disability. Indeed, in this case, there is no reasonable conclusion other than that Dr. Abramson "arbitrarily refuse[d] to credit [Zoller's] reliable evidence, including the opinions of [several] treating physician[s]." *Black & Decker*, 538 U.S. at 834.

In the Reviews, Dr. Abramson concluded that plaintiff's "ability to function occupationally in 'any occupation' appear[ed] to be intact." (R. 181-82; *accord* R. 130.) This finding is not consistent with the overwhelming amount of evidence in the record. Rather, the record evidence indicates that plaintiff was likely "disabled," as that term is defined by the Plan, during the relevant period — namely, from June 16, 2002 through December 24, 2002. Specifically, the record contains the following observations of plaintiff's condition during the relevant period: (1) on July 23, 2002, Dr. Barnes indicated that plaintiff's condition "significantly affect[ed]" his ability to "[m]aintain safety of self and others," "[m]aintain[] control of emotions appropriate to situations," and "concentrate[] on essential[] tasks" (R. 245); (2) on September 5, 2002, Dr. Barnes indicated that plaintiff's condition "significantly affect[ed]" his ability to "[m]aintain[] control of emotions appropriate to situations" (R. 241); (3) on September 11, 2002, Dr. Rosenberger indicated that plaintiff was "disabled from working" at that time (*see* R. 242-43, 246); (4) on October 31, 2002, Dr. Barnes indicated that plaintiff's condition "significantly affect[ed]" his ability to "[i]nteract sufficiently and appropriately with others to maintain teamwork requirements of job" and "to manage goals, objectives and performance measurements," and that, while his "[e]motional ability" had "improved," his "concentration and attention and difficulties with others [had] increased" (R. 239); and, (5) on December 19, 2002, Dr. Barnes indicated that plaintiff's condition "significantly affect[ed]" his ability to "concentrate[] on essential[] tasks," "[i]nteract sufficiently and appropriately with others to maintain teamwork requirements of job" and "to manage goals, objectives and performance measurements," and that his "anxiety and interpersonal difficulties have increased" (R. 237).

The record also includes the following observations by plaintiff's physicians occurring after the close of the relevant period:[14] (1) on March 30, 2003, Dr. Barnes

[14] Defendants assert that any treatment records or diagnoses that were made after the end of the relevant period — on December 24, 2002 — are "irrelevant" to the benefits determination. (*See* CIGNA's Opp. Mem. at 15.) The Court rejects this argument. Defendants have failed to cite to any statute or authority foreclosing this Court from considering medical evaluations that were prepared after the close of the relevant period. Indeed, Dr. Abramson's reports specifically addressed and relied, at least in part, on such evidence. (*See* R. 130.) Similarly, CIGNA's Denial Letters relied, at least in part, on what it believed to be Dr. Barnes' assessment of plaintiff's functional capacity at a time well after the close of the relevant period. For instance,

indicated that plaintiff was unable to engage in stress situations or interpersonal relations, and that he was "totally disabled from [his] regular work" as well as "all other work" (R. 258); (2) on May 28, 2003 Dr. Green opined that, at that time, plaintiff was "totally disabled" from his "regular work" for a period of three to six months as well as from "all other work" for a period of one to three months, and indicated that he "would encourage [plaintiff's] gradual return to work in 2 months, increasing intensity as tolerated" (R. 157); (3) on November 20, 2003, Dr. Szczuki opined that plaintiff suffered from "significant psychomotor retardation," that his "[a]ttention, concentration, and short term memory were limited due to depressive syndrome," and that his "depression has not improved significantly" (*see* R. 114-15); and (4) on November 7, 2004, Dr. Szczucki opined that the "pace" of plaintiff's daily activities had "noticeably slowed," and that, from July 2003 (when plaintiff began treatment with Dr. Szczucki) through the end of the year, plaintiff "remained depressed . . . ," and that "[t]o date Mr. Zoller's depression has minimally improved." (*See* R. 84-85.)

Moreover, the record includes two medical evaluations of plaintiff's condition based on clinical interviews and diagnostic testing conducted after the relevant period. On February 9, 2004, Dr. Caldwell opined, based on the results of the MMPI-2 test administered to plaintiff, that plaintiff "does not currently test as having the strength to sustain employment, and this weakness strongly recommends considering hospitalization." (R. 104.) Subsequently, Dr. Hymowitz opined — based on the MMPI-2 test results, clinical interviews of plaintiff conduct on February 6 and 19, 2004, a "Beck Inventory" completed by plaintiff on February 19, 2004, and [h]is "review of documents" — that plaintiff's "fragility strongly recommends considering hospitalization" and that, "[a]lthough a functional assessment of his actual capabilities was not performed, he does not appear to be emotionally capable of sustained employment in his present condition."[15] (R. 98-99.)

The entirety of this evidence supports the conclusion directly contrary to that reached by Dr. Abramson and, ultimately, CIGNA. That

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in the First Denial Letter, dated May 30, 2003, CIGNA relied upon Dr. Barnes' purported statement on May 12, 2003 that plaintiff "could function at any occupation at *this time*." (R. 170 (emphasis added).) In any event, it is clear that such evidence is highly relevant to determining the impact of plaintiff's condition, especially where much of the evidence corroborates the observations of plaintiff's treating physicians that were made during the relevant period. *See Locher v. Unum Life Ins. Co. of Am.*, 126 F. Supp. 2d 769, 775 (S.D.N.Y. 2001) (rejecting the plan administrator's "bald assertion that a subsequent examination can never be probative as to the existence of a condition on a prior date" as "plainly overbroad," and noting that "the [examining] witness's relationship (in time and treatment) to the subject of the report are factors that go to the weight, not the relevance, of this evidence"), *aff'd in part and reversed in part on other grounds*, 389 F.3d 288 (2d Cir. 2004).

[15] Dr. Hymowitz also observed that there was "some stabilizing" of plaintiff's condition in the "spring of 2003" but that, "[m]ost recently, a five week bout of flulike symptoms and adverse reaction to antibiotic medication has contributed to a further worsening of his depression, somatic preoccupations and severe anxiety." (R. 98.)

is, the six doctors who actually treated plaintiff opined that plaintiff's condition rendered him disabled from working for at least some significant period of time. In reaching this conclusion in the Reviews, Dr. Abramson arbitrarily refused to credit the views of plaintiff's treating physicians by failing to address much of the evidence in the record and by misstating the record in this case.

For instance, in the Report, Dr. Abramson observed that plaintiff's "activities of daily living" — including taking "care of himself," walking his dog, going to meetings "daily," attending appointments, maintaining his grooming habits and arriving at Dr. Barnes' office on time for his appoints — "remain[ed] quite robust . . . ." (*See* R. 128; R. 182.) According to Dr. Abramson, the fact that plaintiff participated in such "activities of daily living" was an indication that, notwithstanding the fact that he suffered from, *inter alia*, depression, dysthymia, and polysubstance dependence, plaintiff's "ability to function occupationally in 'any occupation' appear[ed] to be intact." (R. 182.)

However, in reaching this conclusion, Dr. Abramson mistakenly discounted medical evidence indicating that plaintiff was "virtually bedridden" during the relevant period. (*See* R. 151.) Specifically, in her submissions, Dr. Barnes indicated that, in the winter of 2002, soon after plaintiff allegedly became disabled, she observed that plaintiff was "virtually bedridden by symptoms of anxiety and depression" and "*only*" left his home to attend group meetings and medical appointments" (R. 152 (emphasis added).) Yet, in the Addendum, Dr. Abramson discounted Dr. Barnes' observation that plaintiff was "virtually bedridden" in the winter of 2002 by erroneously indicating that this condition had occurred *prior to* June 2002, and, therefore, was not relevant to the resolution of plaintiff's application. (*See* R. 130.) In truth, however, Dr. Barnes' submission unambiguously indicated that plaintiff's condition rendered him "virtually bedridden" during the winter extending from 2002 to 2003.[16] (*See* R. 151.) As such, Dr. Barnes' observation is plainly relevant to the issue of whether plaintiff was disabled during the period at issue.[17]

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[16] Indeed, plaintiff did not commence treatment with Dr. Barnes until May 9, 2002 — *after* the winter of 2001-2002.

[17] Defendants argue that Dr. Barnes' assertion that plaintiff was "virtually bedridden" is simply "implausib[le]" because, *inter alia*, Dr. Barnes "could not ethically permit a patient . . . to remain in a near vegetative state," and "[a] patient suffering from substance abuse who was virtually bedridden would not have had Zoller's success at achieving and maintaining sobriety." (*See* CIGNA's Opp. Mem. at 13.) These arguments are entirely unsupported by citations to the record, case authority, or even medical literature. Therefore, it is inappropriate, for a number of reasons, for this Court to consider such arguments in reviewing the denial of plaintiff's benefits claim. *See, e.g.*, *Miller*, 72 F.3d at 1071 ("[A] district court's review under the arbitrary and capricious standard is limited to the administrative record."). In this regard, the Court notes that, while Dr. Abramson observed that plaintiff continued to attend medical appointments and twelve-step meetings, and maintained his sobriety during the time he was purportedly "virtually bedridden," Dr. Abramson did not reject the "virtually bedridden" observation as implausible but, rather, as irrelevant based on his erroneous view of the timing of that observation. (*See* R. 130.) Indeed, at the conclusion of the initial report, Dr. Abramson specifically indicated that "[t]his review was performed on the basis of medical records provided with the assumption that the material is true and correct." (R. 130.) Thus, although Dr. Abramson certainly differed as to the conclusions

Thus, because Dr. Abramson operated under this mistaken view of the facts, it is clear that he failed to consider Dr. Barnes's observation and its bearing upon plaintiff's claim for benefits. Moreover, it appears that, if Dr. Barnes' assertion had been correctly viewed, it may have altered Dr. Abramson's view of the case: in the Addendum, Dr. Abramson observed that "[i]f we accept Dr. Barnes' assertions as correct and complete then Mr. Zoller would likely have been unable to function in a work environment from June 17, 2002 to June 30, 2003." (R. 130.)

Moreover, other than Dr. Abramson's erroneous statement that Dr. Barnes' observation was "not germain [sic] to the dates in question," the sole basis for his refusal to credit the treatment records submitted by Dr. Barnes was his view that "[t]he extent of [plaintiff's] depression is not documented in the medical record to be of adequate severity to preclude full time occupational functioning from June 17, 2002 onward." (R. 130.) However, as discussed *supra*, this conclusion is not supported by substantial evidence in the record.

In regard to the remaining observations and diagnoses offered by plaintiff's physicians, Dr. Abramson appears either to have overlooked that evidence or rejected it in whole for an unspecified reason. As such, his conclusion regarding plaintiff's ability to engage in "full time occupational functioning" was an arbitrary rejection of what appears to be reliable medical evidence.

Moreover, the Court has serious concerns regarding the accuracy of Dr. Abramson's account of his May 12, 2003 telephone conversation with Dr. Barnes. In the initial report, Dr. Abramson indicated that, in a telephone conversation with Dr. Barnes on May 12, 2003, she stated her opinion that plaintiff "could function at 'any occupation' at this time." (R. 181.)

Subsequently, Dr. Barnes asserted that she never made that statement. (R. 152.) Moreover, Dr. Barnes' purported statement, as recounted by Dr. Abramson in the Report, is directly contrary to her written observations regarding plaintiff's condition that were recorded around the time of her conversation with Dr. Abramson. For instance, on March 13, 2003, Dr. Barnes observed that plaintiff was "[a]nxious and depressed most days if not all and fears that he won't be able to work if disability [benefits] end[]" (R. 214); on March 30, 2003, she indicated that plaintiff was "totally disabled from [his] regular work" and "all other work" (R. 258); and, on November 12, 2003, she observed that plaintiff "has only just now begun to respond to treatment" but that he was nevertheless "only capable of working part time in a low stress job with little responsibility" (R. 152). This Court finds it highly unlikely that Dr. Barnes would, in a telephone conversation

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to be drawn from the treatment records, he did not *explicitly* challenge the accuracy of Dr. Barnes' observation that plaintiff was "virtually bedridden" in the winter of 2002. (*Id.*) Moreover, the Court notes that defendants' entirely unsupported assertion that "[a] patient suffering from substance abuse who was virtually bedridden would not have had Zoller's success at achieving and maintaining sobriety" (*see* CIGNA's Opp. Mem. at 13), is flatly contradicted by the medical evidence in the record: several of plaintiff's treating physicians observed that plaintiff's depressive symptoms and feelings of lethargy grew *more severe* during the period in which he attained sobriety (*see* R. 84-85, 195-229.)

with Dr. Abramson, flatly contradict her prior written statements that she had already submitted to CIGNA in support of plaintiff's claim for disability benefits, especially where she was aware that plaintiff's ability to function in his then-occupation was the central issue in the benefits proceeding.

Thus, Dr. Abramson's Report failed (1) "to adequately and credibly rebut the findings of [plaintiff's] treating physicians," *Rappa*, 2007 WL 4373949, at *11, (2) to consider relevant evidence of plaintiff's lack of "robust" daily activity during the relevant period, and, (3) it appears, to accurately recite portions of his telephone conversation with Dr. Barnes regarding plaintiff's ability to work at "any occupation." Therefore, the Court finds that the Report, by itself, does not constitute evidence that a reasonable mind might accept as adequate to support the rejection of plaintiff's benefits claim. *See Celardo*, 318 F.3d at 146.

Indeed, in their submissions regarding the instant cross-motions, defendants have struggled to offer a colorable defense of Dr. Abramson's Report. Their principal arguments in support of the Reviews is that Dr. Abramson's conclusions were buttressed by the fact that plaintiff had a "colorful history of drug usage," which defendants recounted at length in their papers, and that plaintiff's persistent "self-grooming" establishes that he was not disabled during the relevant period. (*See* CIGNA's Opp. Mem. at 10.) In presenting these arguments to the Court, counsel for CIGNA asserted that

> People who have substance abuse problems, they can go to work. They can deal with these things — they can go to meetings at night. They can go to therapy at night. . . . [W]e are not dealing with a situation where the medicals show a disabling condition preventing him from doing work. From the get-go, . . . there is nothing from a physical point of view, when you look to the treating records, you see functional abilities to take care of himself and to do work.

(July 18, 2008 Tr. at 32.) Put simply, these are bad arguments. Plaintiff asserts that his depression and other mental health issues — some of which are related to his prior substance abuse — rendered him disabled during the relevant period. He does not assert that some physical condition limited his ability to work, or that the fact that he previously abused controlled substances, by itself, prevented him from working. Thus, the Court finds that defense counsel's arguments in this regard do not provide any basis to find that Dr. Abramson's conclusions in the Reviews were supported by substantial evidence.

2. The Denial Letters Did Not Present Substantial Evidence In Support of CIGNA's Determination

The Court further finds that the Denial Letters issued by CIGNA did not present substantial evidence in support of the rejection of plaintiff's claim for benefits.

While CIGNA indicated in the Denial Letters that it relied on its claims examiners' independent review of plaintiff's "complete file" *in addition* to the results of Dr. Abramson's "peer review," the Denial Letters merely reiterate the flawed findings and

conclusions of Dr. Abramson, and otherwise contain merely conclusory statements indicating that CIGNA has reviewed the "entirety" of the file and found that it did not support plaintiff's claim of disability. For instance, in the First Denial Letter, CIGNA specifically noted (1) Dr. Abramson's conclusion that plaintiff was able to "function occupationally in any occupation on a full time basis," and (2) Dr. Barnes' purported statement — directly contradicted by the other evidence submitted by Dr. Barnes — that plaintiff "could function at any occupation at this time." (R. 170.) CIGNA thus determined, without offering any analysis beyond its recitation of Dr. Abramson's findings, that "the clinical evidence provided does not show the presence of severe exam findings/observations that would significantly impair your functionality," and that the "medical evidence provided does not support your inability to perform any job for any employer for which you are qualified, or may reasonably become qualified by training, education or experience." (R. 170-71.)

Similarly, in the Second Denial Letter, CIGNA noted that Dr. Abramson had "indicated that the extent of [plaintiff's] depression is not documented in the medical record to be of adequate severity to preclude full time occupation functioning from June 17, 2002 to present time" and, therefore, concluded that plaintiff's claim was "denied for [the] reasons detailed in this letter and our previous letter . . . ." (R. 117-18.) Finally, in the Third Denial Letter, CIGNA denied plaintiff's claim for the "reasons detailed in our previous letters." (R. 75.)

Moreover, even assuming *arguendo* that CIGNA's conclusion was based solely on its claims examiner's independent review of the record presented by plaintiff, CIGNA's rejection of plaintiff's claim is not supported by substantial evidence. The overwhelming weight of the evidence in the record — recited herein — indicated that plaintiff's condition had resulted in significant impairments to his "functionality" in the workplace. In the Denial Letters, CIGNA failed to offer any basis for rejecting this evidence — that is, other than conclusory statements to the effect that the "evidence provided does not support" plaintiff's claims (R. 171) and its recitation of the findings contained in Dr. Abramson's flawed Reviews. Moreover, CIGNA failed to offer any analysis regarding plaintiff's ability to function in a job, or even to identify the particular jobs for which plaintiff was purportedly "qualified" or for which he "may reasonably become qualified." (*See* R. 171.)

Accordingly, the Court finds that, even under the deferential standard applied here, CIGNA's conclusion was not supported by substantial evidence. Indeed, in the Denial Letters, CIGNA failed to address any of the inconsistencies between Dr. Abramson's submissions and the voluminous medical evidence submitted by plaintiff and his treating physicians, or to correct the clear factual errors in the Report regarding the relevance of plaintiff purportedly being "virtually bedridden" in the "winter of 2002," even though Dr. Barnes raised the issue in her submissions to CIGNA in support of plaintiff's second appeal.[18] Therefore,

[18] As noted, the Supreme Court has advised courts to avoid imposing a "a discrete burden of explanation [on plan administrators] when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker*, 538 U.S. at 834. To be clear, the

because CIGNA relied largely, if not exclusively, on the Reviews — which contained factual errors and was not supported by substantial evidence — and because the conclusions advanced in the Denial Letters themselves were not supported by substantial evidence, the Court finds that the denial of plaintiff's application was arbitrary and capricious. *Rappa*, 2007 WL 4373949, at *10 (finding the claims administrator's decision not supported by substantial evidence where its conclusion was "inconsistent with the rest of the record").

III. REMEDY

"[A] remand of an ERISA action seeking benefits is inappropriate where the difficulty is not that the administrative record was incomplete but that a denial of benefits based on the record was unreasonable." *Zervos*, 277 F.3d at 648 (internal quotation marks and citation omitted). Moreover, the Second Circuit has observed that remand is inappropriate where the parties failed to identify anything "that might have been gained by the District Court's remanding the matter to the plan administrator." *Frommert v. Conkright*, — F.3d — , 2008 WL 2837783 (2d Cir. July 24, 2008) (citing *Krauss*, 517 F.3d at 630 (stating that plaintiffs were not entitled to administrative remand where doing so would have been "futile") and *Miller*, 72 F.3d at 1071 (stating that remand to a plan administrator is not required where such additional proceedings would be a "useless formality")). Here, "the administrative record did not contain substantial evidence supporting a denial of benefits and in fact could only be read to support granting" plaintiff's claim for benefits. *See Zervos*, 277 F.3d at 648. Moreover, neither party asserts that there is additional evidence to be adduced upon remand or that the record before the Court is otherwise incomplete. Finally, the Court notes that plaintiff filed the underlying claim for benefits on June 17 2002, and, therefore, has been improperly denied such benefits for over six years. Therefore, under the circumstances of the instant case, the Court finds that a remand for further proceedings on the merits of plaintiff's benefits claims is an inappropriate remedy.[19] Instead, the Court grants plaintiff's motion for summary judgment, finds that he is entitled to disability benefits, and remands this case for the limited purpose of determining the amount of disability benefits owed to plaintiff.

IV. CONCLUSION

For the foregoing reasons, plaintiff's motion for summary judgment is granted, and

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Court does not impose such a burden here; rather, it finds that CIGNA's decision to credit Dr. Abramson's entirely unsupported conclusions regarding plaintiff's condition rather than the overwhelming amount of evidence in the record to the contrary was arbitrary and capricious.

[19] Plaintiff also asserts that defendants failed to afford him a "full and fair" review pursuant to ERISA. However, the Court declines to resolve plaintiff's claims in this regard, as it has already found, for the foregoing reasons, that CIGNA's rejection of his claim was not supported by substantial evidence. Moreover, even assuming *arguendo* that CIGNA had failed to afford plaintiff a full and fair review the outcome in this case would be the same: additional proceedings in this case would constitute a "useless formality" given that the administrative record before the Court is complete and only allows for the conclusion that CIGNA's determination was not supported by substantial evidence and that plaintiff is entitled to benefits. *Miller*, 72 F.3d at 1071

defendants' respective cross-motions for summary judgment are denied. The determination by the claims administrator is vacated, and plaintiff's claim is remanded to the claims administrator for the sole purpose of determining the amount of disability benefits owed to plaintiffs. The parties shall submit a joint letter within 45 days of this decision apprising the Court of the progress of the benefits determination, and every 45 days thereafter, unless otherwise directed by this Court.

The Clerk of the Court shall terminate the motions docketed as document numbers 30, 44, and 52.

SO ORDERED.

RICHARD J. SULLIVAN
United States District Judge

Dated: August 25, 2008
New York, New York

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Plaintiff is represented Scott M. Riemer, Esq., 60 East 42nd Street, 47th Floor, New York, New York 10165. Defendant INA Life Insurance Company of New York is represented by Kevin Gerard Horbatiuk, Esq., Russo, Keane & Toner LLP, 26 Broadway, 28th Floor, New York, New York 10004. Defendant Lucent is represented by Allen B. Roberts, Esq., John Houston Pope, Esq., and Amy J. Traub, Esq., Epstein, Becker & Green, P.C., 250 Park Avenue, New York, New York 10177.