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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

BRIAN HAGERTY,)	
)	
Plaintiff(s),)	No. C09-3299 BZ
)	
v.)	ORDER DENYING DEFENDANT'S
)	MOTION FOR SUMMARY JUDGMENT
AMERICAN AIRLINES LONG TERM)	
DISABILITY PLAN,)	
)	
Defendant(s).)	
_____)	

Plaintiff Brian Hagerty filed this action claiming that defendant American Airlines Long Term Disability Plan ("The Plan") violated his rights under ERISA by wrongfully denying him long term disability benefits. The Plan now moves for summary judgment that it did not violate ERISA and that it is entitled to judgment as a matter of law. For the following reasons, The Plan's motion is **DENIED**.¹

Plaintiff worked as a flight attendant for American

¹ All parties have consented to my jurisdiction, including entry of final judgment, pursuant to 28 U.S.C. § 636(c) for all proceedings.

1 Airlines, Inc. for over 30 years.² Around 1984, plaintiff
2 contracted HIV which required him to take several medications.
3 He continued to work as a flight attendant, until November 15,
4 2004. He then filed a claim for long term disability benefits
5 with The Plan, claiming that his HIV, Hepatitis C, and other
6 conditions prevented him from working. Plaintiff has suffered
7 from a number of conditions, with several persisting to this
8 day including chronic hepatitis C, skin lesions, colonic
9 diverticulosis, gastroesophageal reflux disease, recurrent
10 dysphagia, a hiatal hernia, schatzki's ring, a thyroid
11 condition, and a heart murmur.

12 The Plan is administered by MetLife, whose compensation
13 is not tied to the payment or denial of claims. The Plan is
14 funded entirely through employee contributions. Under the
15 terms of The Plan, during the first 24 months of disability,
16 an employee is considered disabled if he or she is unemployed
17 and unable to perform the major and substantial duties of a
18 Flight Attendant because of sickness or injury. After the
19 initial 24 month period, an employee is considered totally
20 disabled if he or she is unemployed and unable to perform the
21 major and substantial duties of any occupation for which the
22 employee has become reasonably qualified.

23 Plaintiff received disability payments from March 15,
24 2005 through April 14, 2008. From January 17, 2007 until
25 April 14, 2008, MetLife determined that plaintiff was disabled

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27 ² The parties did not submit a joint statement of
28 undisputed facts. However, the Court has only relied on facts
which the parties do not dispute, unless otherwise noted.

1 from working in any capacity. AR 189. On April 14, 2008,
2 MetLife terminated Plaintiff's disability benefits based on
3 its on-going review of plaintiff's condition. MetLife found
4 that the medical information it reviewed did not substantiate
5 plaintiff's claim that he was unable to work in any occupation
6 for which he was qualified and that plaintiff would be able to
7 work as a sales attendant, appointment clerk, or cashier.
8 MetLife conducted another review of plaintiff's file which
9 upheld the prior decision. In connection with this review,
10 MetLife had plaintiff's claim reviewed by Medical Consultants
11 Network. Dr. Gerstenblitt of Medical Consultants Network
12 found that plaintiff did not sufficiently establish that he
13 was disabled, in part because he had provided no objective
14 medical evidence of his fatigue claims. Plaintiff then
15 appealed this decision to the Pension Benefits Administration
16 Committee ("PBAC"). In his appeal, plaintiff provided a list
17 of his doctors, health care providers, and prior
18 correspondence with MetLife. He did not enclose any
19 additional medical reports, diagnosis, or test results. The
20 PBAC analyst requested an independent review, which was
21 performed by Network Medical Review. Network had a
22 Gastroenterologist, a Cardiologist, and an Endocrinologist
23 review plaintiff's file and render an opinion whether
24 plaintiff was totally disabled from performing the major job
25 duties of any occupation for which he was qualified as of
26 April 11, 2008. The reviewing doctors all concluded that from
27 their standpoints, plaintiff had not submitted sufficient
28 proof that he was disabled. Plaintiff filed this lawsuit

1 following the final review of his file by Network.

2 The Plan first argues that this case should be subject to
3 an abuse of discretion standard, which plaintiff does not
4 contest. The Plan next argues that there are no triable
5 issues of material fact regarding the disposition of
6 plaintiff's claims and that The Plan did not abuse its
7 discretion.

8 The Plan contends that it appropriately determined
9 plaintiff's eligibility for two reasons. First, plaintiff
10 made several comments that he was retired and that he had no
11 interest in returning to work. Second, The Plan contends that
12 the final review conducted by Network was accurately and
13 fairly carried out. In response, plaintiff contends that the
14 plan abused its discretion by denying his first appeal,
15 conducting the final appeal without the necessary records,
16 failing to determine the limiting effects of plaintiff's HIV
17 status, and failing to consider plaintiff's SSDI benefits.

18 ***Bias***

19 As an initial matter, plaintiff claims that Dr.
20 Gerstenblitt and Network were biased and did not render
21 independent opinions. In support, he cites to a number of
22 rulings in other cases which found that evidence presented in
23 those cases supported a charge of bias. No such evidence was
24 developed in this case. The Court will only examine
25 National's and Dr. Gerstenblitt's behavior as documented
26 within the administrative record in determining whether they
27 acted appropriately in determining that plaintiff was not
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1 disabled.³ Administrative Record ("AR") 134-38. However,
2 given that MetLife owes the plan participants a "special
3 standard of care," its decision to continue to use Dr.
4 Gerstenblitt and Network in light of the opinions cited by
5 plaintiff is curious.

6 **First Appeal/Failure to Document Fatigue**

7 Plaintiff complains Dr. Gerstenblitt committed error by
8 requiring objective proof or documentation of plaintiff's
9 complaints of fatigue. Plaintiff cited several cases where
10 courts found it error to require objective medical evidence of
11 complaints that are inherently subjective in nature. See e.g.
12 Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 635
13 (9th Cir. 2009) ("unreasonable for Hartford to require Montour
14 to produce objective proof of his pain level"); Cook v.
15 Liberty Life Assur. Co. of Boston, 320 F.3d 11, 21 (1st Cir.
16 2003) (requiring objective documentation of Chronic Fatigue
17 Syndrome is unreasonable); Mitchell v. Eastman Kodak Co., 113
18 F.3d 433 (3rd Cir. 1997) (same). Since defendant did not
19 respond to this argument and the cited cases, I find that
20 requiring objective medical evidence of fatigue, when The Plan
21 documents do not expressly require such proof, is a factor
22 suggesting The Plan abused its discretion.

23 Further, Dr. Gerstenblitt declined to analyze the
24 objective medical effects of the myriad medications plaintiff
25 took which caused drowsiness or fatigue. For example, during

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27 ³ Defendant's objections to plaintiff's evidence of
28 bias against Dr. Gerstenblitt and Network (Reply p. 7) are well
taken. However, plaintiff's bias allegations play no role in
the disposition of this motion.

1 the time surrounding Dr. Gerstenblitt's review, plaintiff
2 regularly took Lexiva, Ziagen, and Lisinopril, all of which
3 are known to cause fatigue.⁴ AR 108. Dr. Gerstenblitt opined
4 that there was no medical documentation of fatigue, yet he
5 ignored the medications which commonly cause fatigue.

6 Failure to Obtain Records

7 Plaintiff contends that Network's failure to obtain
8 medical records referenced, but not attached to plaintiff's
9 second level appeal constituted an abuse of discretion. In
10 support, plaintiff cited Booton v. Lockheed Medical Ben. Plan,
11 110 F.3d 1461, 1465 (9th Cir. 1997) which states that "to deny
12 the claim without explanation and without obtaining relevant
13 information is an abuse of discretion." Booton is based on
14 the numerous requirements in ERISA that a Plan provide a
15 claimant with detailed information of why a claim was denied,
16 including: "iii) A description of any additional material or
17 information necessary for the claimant to perfect the claim
18 and an explanation of why such material or information is
19 necessary" 29 C.F.R. § 2560.503-1. Once again, The
20 Plan declined to respond to this authority which seems to be
21 fairly applicable to this case. In Booton, as here,
22 "[l]acking necessary-and easily obtainable-information, [the
23 defendant] made its decision blindfolded." See Kunin v.
24 Benefit Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990)

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26 ⁴ The Court takes judicial notice of information posted
27 on websites such as that of the Department of Veteran Affairs,
28 <http://www.va.gov/>, and <http://www.drugs.com>, regarding the most
common side effects of medications. Further, defendant does
not dispute plaintiff's assertion that these medications
commonly cause fatigue.

1 (burden is on plan to obtain adequate information to make
2 decision). Here, three physicians rendered an opinion without
3 consulting with plaintiff's treating physicians or reviewing
4 at least some of plaintiff's relevant medical files.

5 Plaintiff listed his medical care providers in his appeal to
6 the PBAC and had provided at least some authorization to
7 obtain records. Nevertheless, Network did not contact
8 plaintiff's cardiologist, gastroenterologist, or his
9 endocrinologist despite reviewing plaintiff's file for
10 cardiac, gastroenterologic, and endocrine related disability.

11 Defendant's sole response to this argument is that the
12 appeals process required plaintiff to submit all appropriate
13 documentation and plaintiff's failure to do so should
14 countenance the review of an otherwise incomplete file.
15 However, under ERISA, if defendant believed that plaintiff had
16 not attached adequate information, it should have informed
17 plaintiff that his submission was inadequate. Deciding this
18 case on an admittedly incomplete file without notifying
19 plaintiff of what additional records it needed is another fact
20 suggesting an abuse of discretion.

21 Moreover, plaintiff asserted at argument and defendant
22 did not dispute, that The Plan's practice was to require a
23 claimant to initiate a claim by completing a form and signing
24 a medical authorization so The Plan could get the records
25 necessary to review a claim. Because of this practice
26 plaintiff believed he had done all that was necessary when he
27 updated his long list of doctors.

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1 **Failure to Determine HIV effects**

2 Plaintiff also argues that Network should have evaluated
3 whether plaintiff's HIV status affected his ability to perform
4 any occupation. None of the Network doctors ever evaluated
5 whether plaintiff's HIV status affected his ability to work.
6 Defendant does not contest this statement or the import of it.

7 **SSDI**

8 While it is true that there are differences between
9 disability determinations in Social Security and ERISA
10 settings, "complete disregard for a contrary conclusion
11 without so much as an explanation raises questions about
12 whether an adverse benefits determination was the product of a
13 principled and deliberative reasoning process." Montour v.
14 Hartford Life & Acc. Ins. Co., 588 F.3d 623, 635 (9th Cir.
15 2009). Here, The Plan never obtained plaintiff's Social
16 Security file, and never addressed the different results it
17 found by drawing an opposite conclusion, even though it
18 encouraged him to apply for Social Security.

19 **Plaintiff's Remarks**

20 Defendant heavily relies on several statements that
21 plaintiff made which purportedly show that plaintiff willingly
22 chose not to work despite being physically capable. In 2006,
23 plaintiff said "I could be considered well enough to take on
24 new training for another job." AR 74. In 2006, plaintiff
25 also stated "I can't return to airline or union work, and I am
26 too OLD to retrain." AR 81. Dr. Ollife, plaintiff's
27 attending physician, stated that "patient [plaintiff] has
28 chosen to retire due to intermittent fatigue & physical


1 limitations" and that plaintiff could work a few hours per
2 day. AR 102. Defendant contends that these statements prove
3 that plaintiff was not physically disabled and instead simply
4 chose not to return to work.

5 However, considering the full context of plaintiff's
6 comments, they do not prove that plaintiff was physically able
7 to return to work. Plaintiff also stated that "I retired
8 early due to my interferon treatments" for HIV and that "I
9 can't & won't return to work." AR 109. Plaintiff further
10 stated that "I had hopes of returning to work after the
11 [interferon] treatment was over, but during the course of the
12 year it became apparent that I was getting older and was
13 becoming fatigued very easily, and that didn't stop after my
14 treatment ended in 2006 My decision [to retire] was
15 made at least in part, due to my physical disability to do
16 that job." AR 132. When read in context, plaintiff's
17 comments demonstrate his subjective belief that he was unable
18 to work at least in part due to disability.

19 Conclusion

20 There are a number of factors present here that prevent
21 me from finding that The Plan did not abuse its discretion in
22 determining plaintiff's eligibility for long term disability
23 benefits. Therefore, **IT IS ORDERED** that defendant's motion
24 for summary judgment is **DENIED**.

25 Dated: September 3, 2010

26 
27 Bernard Zimmerman
United States Magistrate Judge