No. _____

In The

Supreme Court of the United States

SUSAN NUGENT,

Petitioner,

versus

AETNA LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The Fifth Circuit Court Of Appeals

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

This Court has previously held in *Metropolitan Life Insurance Company v. Glenn*, 554 U.S. 105 (2008) that a long-term disability plan administrator under an ERISA plan must consider the impact of a favorable decision of the Social Security Administration awarding disability insurance benefits in determining a claimant's eligibility for long-term disability benefits. Here, the lower courts held that the plan administrator was not required to assign any weight to the favorable decision of the Social Security Administration.

The questions presented is:

Is it "procedurally unreasonable" to assign no weight to the decision of the Social Security Administration finding disability where the disability standards employed by Social Security and the long-term disability insurer are functionally equivalent?

LIST OF ALL PARTIES TO THE PROCEEDING

Susan Nugent

Aetna Life Insurance Company

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The decision of the Fifth Circuit Court of Appeals in this matter is found at the following citation: *Nugent v. Aetna Life Insurance Co.,* 540 Fed.Appx. 743 (5th Cir. 2014).

This action was filed in the United States District Court for the Eastern District of Louisiana. The Court granted the defendant's Motion for Summary Judgment and denied petitioner's Motion for Summary Judgment. Petitioner timely appealed to the United States Court of Appeals Fifth Circuit. The Fifth Circuit Court of Appeals rendered its opinion on January 3, 2014.

BASIS FOR JURISDICTION IN THIS COURT

This petition is timely filed under Supreme Court Rule 13(1) and this Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

Pursuant to Supreme Court Rule 14(e), petitioner provides the following specific information:

- Date the Judgment Order sought to be reviewed: January 3, 2014 by the United States Court of Appeals Fifth Circuit.
- Date of any order respecting rehearing as far as extension of time: not applicable to this petition.
- Rule 12.5 considerations: not applicable to this petition.

- Statutory provision conferring jurisdiction: 28 U.S.C. § 1254(1).
- Rule 29.4 statement: not applicable to this petition.

STATUTES INVOLVED

42 U.S.C. § 423(D)(2)(A)

(d) "Disability" defined

(1) The term "disability" means –

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A) –

(A) An individual shall be determined to be under a disability only if his physical or

> mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

STATEMENT OF THE CASE

The petitioner, Susan Nugent, was employed by Total Safety USA, Inc. and pursuant to her employment purchased a policy of long-term disability insurance with the defendant Aetna Life Insurance Company. Ms. Nugent filed a claim for long-term disability benefits with Aetna based upon colorectal cancer and residual effects of the disease and surgery. Benefits were initially approved on April 30, 2009. Benefits were terminated as of May 20, 2011 based upon the determination by Aetna Life Insurance Company that plaintiff was no longer disabled as defined in the plan. Ms. Nugent has exhausted all administrative appeals of that decision.

On February 19, 2010, the Social Security Administration determined Ms. Nugent to be disabled and awarded disability insurance benefits. The defendant, Aetna, not only encouraged Ms. Nugent to apply for Social Security Disability insurance benefits, it provided counsel to assist her in doing so. The reason that Aetna was so anxious for Ms. Nugent to receive Social Security Disability insurance benefits was that it could take a credit for those benefits against long-term disability benefits owed to her. Paradoxically, while taking advantage of the decision of the Social Security Administration, Aetna has willfully ignored the import of that decision in its continued denial of benefits to Ms. Nugent.

After the filing of suit in this matter, it was noticed that the entire decision of the Social Security Administration awarding disability benefits was not in the record. This matter was then remanded in order for Aetna to consider the entire decision and, to reconsider its decision to terminate benefits. On November 5, 2012, Aetna issued a supplemental decision affirming its prior determination to terminate and deny further benefits. (Supplemental Administrative record, Rec. Doc. 42-1, pp. 10-13) In doing so, Aetna attempted to distinguish its definition of disability from that of the Social Security Administration.

After Aetna issued its Supplemental Decision affirming its prior determination to terminate benefits, the parties jointly moved to place the matter back on the docket. (Rec. Doc. 39) The Court then

scheduled cross-motions for summary judgment, a brief was filed and the Court issued its opinion on July 6, 2013 upholding Aetna's decision to terminate benefits. (Rec. Doc. 48) The trial court found that Aetna's decision to terminate benefits was not arbitrary and capricious. This appeal followed.

REASONS FOR GRANTING THE WRIT

In *Schexnayder v. Hartford Life and Accident Insurance*, 63 F.3d 465 (5th Cir. 2010), the Fifth Circuit Court of Appeals reviewed the impact of this Court's pronouncement in *Metropolitan Life Insurance Company v. Glenn*, 128 S.Ct. 2343 (2008).

While it gave lip service to this Court's holding that an ERISA evaluation is procedurally unreasonable in the event that the evaluator fails to address the Social Security disability decision as a factor in its own right, the Fifth Circuit only required that the evaluator acknowledge the Social Security decision but did not require that any weight be assigned to that decision. In *Schexnayder*, the Fifth Circuit stated:

> We do not require Hartford to give any particular weight to the contrary of findings; indeed, Hartford could have simply acknowledged the award and concluded that, based on the medical evidence before it, the evidence supporting denial was more credible.

> It is the lack of *any* acknowledgements which leads us to conclude that Hartford's decision was procedurally unreasonable and suggests that it failed to consider all relevant evidence. 63 F.3d at 472.

Next, in *Hamilton v. Standard Insurance Company*, 404 Fed.Appx. 895 (5th Cir. 2010), the Fifth Circuit held:

> An ERISA administrator's failure to consider a SSA disability determination is a factor a court ought to consider when determining whether a denial of benefits was an abuse of discretion. (citations omitted) However, because the eligibility criteria for SSA disability benefits differs from that of ERISA plans, while an ERISA plan administrator should consider a SSA determination, it is not bound by it. *Hamilton, supra*, 404 Fed.Appx. at 898.

Thus, in two cases analyzing the import of this Court's holding in *Glenn, supra*, the Fifth Circuit Court of Appeals held that an ERISA evaluator need not give any weight whatsoever to a finding of the Social Security Administration that a long-term disability claimant was disabled. (*Schexnayder, supra*) and further made the blanket holding that the eligibility criteria for SSA disability benefits always differ from those of ERISA plans and are therefore not binding in the ERISA evaluation (*Hamilton, supra*). Neither of those propositions is consistent with this Court's holding in *Glenn* that failure to consider an

award of Social Security Disability benefits by an ERISA evaluator is procedurally unreasonable.

It was against this historical backdrop that the trial court ruled in the instant case regarding consideration of the Social Security Disability award in favor of Ms. Nugent. The trial court summarized the jurisprudence as follows:

> Although a plan administrator should consider an SSA determination, it is not required to concur "because the eligibility criteria for SSA disability benefits differs from that of ERISA plans." *Hamilton v. Stand. Ins. Co.,* 404 Fed. Appx. 895, 898 (5 Cir. 2010) (citing *Schexnayder,* 600 F.3d at 471 n. 3 (5 Cir. 2010). *But see Raybourne v. CIGNA Life Insurance Company of New York,* 700 F.3d 1076, 1083, 1085 (7 Cir. 2012) (declaring "functionally equivalent" the SSA's definition of disability and the definition, "he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified). (Rec. Doc. 48, p. 10 of 13)

A close look at the definitions of disability in the Aetna plan demonstrates that the Social Security disability regulations under which Ms. Nugent was found to be disabled are actually more restrictive than the definition of disability posited by Aetna. Therefore, the finding of disability is highly probative as to Ms. Nugent's eligibility for long-term disability benefits.

Since Ms. Nugent has received 24 months of benefits, the Aetna long-term disability definition of disability as applies to her is: "If you are not able to work at any reasonable occupation solely because of: disease; or injury." Aetna argues that there is some significant difference between this and the Social Security definition of disability which is:

> Inability to engage in any substantial gainful activity by reason of any medical, determinable, physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period but not less than twelve months.

It is apparent that the SSA definition, requiring that the disabling condition last or be expected to last a year or result in death, is stricter than the Aetna definition.

Given the fact that the definition of disability used by Social Security is stricter than that of Aetna, it was procedurally unreasonable for Aetna to conclude that its policy required a higher degree of disability than that of Social Security.

While this Court has not heretofore assigned any particular weight that a long-term disability insurer must give to his Social Security disability award, surely the comparison of the long-term disability definition with that of Social Security must at least be accurate and not mischaracterize which has the higher burden of proof, as occurred here.

The Seventh Circuit Court of Appeals in *Raybourne v. CIGNA Life Insurance Company of New York*, 700 F.3d 1076 (7th Cir. 2012) in a case almost entirely on point with this one, held that the definitions of disability involved in this case – that is to say the definition of disability provided by the Social Security Administration and the very similar definition of disability provided by Aetna – concluded that the definitions are "functionally equivalent". 700 F.3d at 1085. In *Raybourne*, the applicable definition after 24 months was that "a person is considered disabled if he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified based on education, training or experience." 700 F.3d at 1086. It is respectfully submitted that the CIGNA definition of disability is substantially the same as that of Aetna and since Ms. Nugent has received 24 months of benefits, the Aetna long-term disability definition of disability as applies to her is: "If you are not able to work at any reasonable occupation solely because of: disease; or injury."

The court in *Raybourne*, while talking about CIGNA, describes the same cynical attitude displayed by Aetna in this case in hiring representatives to argue that Ms. Nugent is totally disabled before the Social Security Administration in an effort to reduce its liability but refusing to accept that determination in assessing her entitlement to long-term disability benefits:

> The specific situation presented in *Glenn* is remarkably similar to the facts and circumstances to Raybourne's claims experience with CIGNA. In *Glenn*, the court ultimately found that the insurer's conflict led to an arbitrary and capricious denial of benefits. The insurer initially encouraged Glenn to argue to the SSA that she was totally disabled, and recommended a lawyer to assist her in pursuing her claim before the SSA. The insurer then reaped the benefits of Glenn's success before the SSA by receiving the bulk of her back benefits as reimbursement for amounts the insurer had paid out, with the remainder of back benefits going to the lawyer the insurer recommended. Yet the insurer then ignored the SSA's finding of total disability when it concluded that Glenn could perform sedentary work. The insurer also emphasized the medical report that favored the denial of benefits, de-emphasized reports to the contrary and failed to provide its own vocational and medical experts with all the relevant records. The court found that, in these circumstances, there was nothing improper in concluding that the insurer's conflict of interest tipped the balance in favor of finding that the denial of benefits was arbitrary and capricious. 700 F.3d at 1082.

In its appeal denial letter of December 8, 2011, Aetna made the following statement regarding the weight given to the Social Security Disability determination:

> We understand that your client was approved for Social Security Disability (SSD) benefits in 2008 [sic]. However, our disability determination and the SSD determination are made independently and are not always the same. The difference between our determination and the SSD determination may be driven by the Social Security Administration (SSA) regulations. For example, SSA regulations require that certain disease/diagnoses or certain education or age levels be given heavier or even controlling weight in determining whether an individual is entitled to SSD benefits. Or, it may be driven by the fact that we have information that is different from what SSA considered. Therefore, even though you are receiving SSD benefits, we are unable to give it significant weight in our determination. (Rec. Doc. 29-2, p. 24)

It is clear from the foregoing statement, which appears to be boilerplate, that Aetna could not have given real consideration to the specifics of the Social Security Disability decision because it did not have it.

In its November 5, 2012 letter upholding its previous decision to terminate benefits, after considering the entire decision of the Social Security Administration, Aetna again refused to give significant weight to the decision of the Social Security Administration, stating as follows:

> The 2/19/2010 SSA determination letter does not provide any new additional medical information or cite medical records beyond

> 2/19/2010 to change our original disability determination. Furthermore, the SSA vocational evaluation is not relevant to our determination as the SSA criteria for residual functional capacity is not consistent with the definition of disability under the LTD Policy.
>
> We have taken into consideration the additional information from the SSA. There is no new objective evidence to support disability as defined by the Policy beyond 5/10/2011. (Rec. Doc. 42-1, p. 13 of 13)

As the following will demonstrate, Aetna's conclusion that the SSA criteria for residual functional capacity is not consistent with the definition of disability under its policy is patently incorrect. Aetna fails to provide any specifics as to why it believes the standards are inconsistent. As is also pointed out below, the Social Security standard for disability is more stringent than that of Aetna.

The Administrative Law Judge considering Ms. Nugent's Social Security Disability claim found that she had the following residual functional capacity:

> The claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) and 416.967(a) limited by the ability to sit for 6 hours out of an eight-hour workday; and stand for less than 1 hour out of an 8-hour workday. In addition, the claimant has a limited ability to walk and must be allowed to alternate sitting and standing options at her own volition. Moreover, the claimant's employment

> must not require lifting more than 20 pounds occasionally and 10 pounds frequently; as well as no more than occasionally climbing, stooping, kneeling, crouching, and crawling. Furthermore, the claimant can only have occasional exposure to heat and cold environments. (Rec. Doc. 42-1, p. 6)

The Administrative Law Judge went on in the decision to analyze the medical evidence. In reviewing that analysis, it appears that the Administrative Law Judge considered essentially the same medical evidence as was considered by Aetna. (Rec. Doc. 42-1, p. 7) Also, the Administrative Law Judge found Ms. Nugent to be credible. (See SSA decision, Rec. Doc. 42-1, p. 7)

In order to determine whether there were any jobs available to Ms. Nugent in the national economy, the Administrative Law Judge requested the testimony of a vocational expert. In the decision, the Administrative Law Judge described the reason for the consultation with a vocational expert and the vocational expert's conclusion that given all of the relevant factors, there are no jobs in the national economy that Ms. Nugent can perform:

> If the claimant had the residual functional capacity to perform the full range of sedentary work, considering the claimants age, education and work experience, a finding of 'not disabled' would be directed by Medical-Vocational Rule 201.28. To determine the extent to which the claimant's additional limitations erode the unskilled sedentary

> occupational base, the Administrative Law Judge asked the vocational expert whether jobs exist in the national economy for an individual with the claimant's age, education, work experience and residual functional capacity. The vocational expert testified that given all these factors there are no jobs in the national economy that the individual could perform.
>
> Based on the testimony of the vocational expert, the undersigned concludes that, considering the claimant's age, education, work experience, and residual functional capacity, a finding of 'disabled' is appropriate under the framework of the above-cited rule. (Rec. Doc. 42-1, p. 8)

Aetna dismisses the testimony of the vocational expert as "irrelevant" yet Aetna did not provide any similar vocational evaluation based upon Ms. Nugent's residual functional capacity. Given the similarity of the definitions of disability of the Social Security Administration and of Aetna, it would have been appropriate for Aetna to obtain a vocational opinion, however it chose not to do so. The opinion of the vocational expert consulted by the Social Security Administration stands unrefuted.

While Ms. Nugent's cancer may be in remission, there is no medical evidence directly supporting the proposition that her residual functional capacity – the basis for the Social Security Disability decision – has improved in the slightest.

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DENIAL OF BENEFITS WAS ARBITRARY AND CAPRICIOUS

Under almost exactly the same circumstances, the court in *Raybourne, supra*, found that the insurer's denial of benefits was arbitrary and capricious. As in *Metropolitan Life Insurance Company v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343 (2008) the court found in *Rayboune* that the scenario that we see in this case – the inconsistent positions taken by Aetna regarding the Social Security Disability decision, was financially advantageous to Aetna in this case in that it not only received a credit for benefits previously paid but it used the artificial distinction in disability standards to justify denial of future benefits.

In *Glenn*, this Court described the situation as "procedural unreasonableness". The *Glenn* court also concluded that this scenario justified the reviewing court in giving more weight to the conflict because the seemingly inconsistent positions taken by the insurer were both financially advantageous to the insurer. *Glenn*, 554 U.S. at 118. A court may use a structural conflict of interest to break a tie in a close case "where circumstances suggest a higher likelihood that it affected the benefits decision." *Glenn, supra*, 554 U.S. at 117. The evidence in the instant case preponderates in favor of the conclusion that Aetna's denial of benefits was not supported by substantial medical evidence but instead was the result of a conflict of interest.

The Fifth Circuit Court of Appeals in the instant case held as follows regarding Aetna's consideration of the Social Security decision:

> On appeal, Nugent challenges the plan administrator's treatment of the SSA's February 2010 determination that she is disabled. Specifically, she argues that the administrator should have given more deference to the SSA's determination since the definition of "disability" applied by the SSA is arguably more stringent than the definition employed by Aetna. However, Nugent's argument contains two fatal flaws. First, we only require that a claim administrator address a contrary decision as a factor. Nugent urges us to give the SSA's decision more weight because of her belief that its definition of disability is arguably harder to meet. Without opining on whether the SSA's definition is more or less stringent than the definition of disability in Nugent's plan, Nugent's proposed treatment of the SSA determination is contrary to this circuit's clear requirement that the plan administrator need not afford the agency's findings and conclusions any special deference. *Id.* The ultimate weight afforded the determination is case-specific and depends on the balancing of the competing factors. Aetna discussed the SSA determination, so its decision is not procedurally unreasonable. 540 Fed.Appx. 475-476.

The Court of Appeals woodenly applied its precedent that no particular weight – or any weight at all – be given a Social Security finding of disability. Moreover, the court refused to even analyze whether the Social Security and long-term disability standards were "functionally equivalent" as found by the *Raybourne* court or whether the Social Security standard was even more stringent. Procedural reasonableness would dictate that the standards at least be compared.

CONCLUSION

This Court's previous jurisprudence has indicated that long-term disability evaluators must consider Social Security disability determinations, but has provided no guidance on the amount of weight to give to such decisions. This case presents a situation in which the standards of disability applied by the Social Security Administration and the long-term disability insurer Aetna are not only similar, but the Social Security definition of disability is stricter than that of the long-term disability insurer. It is urged that ERISA plan administrators should be required to afford significant weight to the decisions of the Social Security Administration in cases in which the Social Security standards are more stringent than or are functionally equivalent to long-term disability plan definitions of disability. This case

presents an opportunity for this Court to provide guidance regarding this important issue.

Respectfully submitted,

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IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 13-30795
Summary Calendar

SUSAN NUGENT,

Plaintiff-Appellant

v.

AETNA LIFE INSURANCE COMPANY,

Defendant-Appellee

Appeals from the United States District Court
for the Eastern District of Louisiana
USDC No. 2:12-CV-65

(Filed Jan. 3, 2014)

Before KING, DAVIS, and ELROD, Circuit Judges.

PER CURIAM:*

Plaintiff-Appellant Susan Nugent brought this lawsuit against Defendant-Appellee Aetna Life Insurance Company alleging that she was denied long-term

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* Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the *limited* circumstances set forth in 5TH CIR. R. 47.5.4.

disability benefits in violation of provisions of the Employee Retirement Income Security Act. The district court granted summary judgment in Aetna's favor, holding that the plan administrator did not abuse its discretion in determining that Nugent was not eligible for benefits. Nugent appeals on the grounds that the plan administrator did not afford sufficient weight to the Social Security Administration's earlier determination that she is disabled and that it failed to fully evaluate some of the medical evidence. Because we find that the plan administrator's decision is supported by substantial evidence and is neither arbitrary nor capricious, we AFFIRM the judgment of the district court.

I. Factual and Procedural Background

While working as a bookkeeper for Total Safety USA, Inc., Susan Nugent purchased a long-term disability insurance policy through her employer with Aetna Life Insurance Company. Nugent was later diagnosed with colorectal cancer, and she left her position to undergo treatment, including chemotherapy, which lasted until October 2009. Nugent filed a claim for long-term disability benefits with Aetna based on her cancer and related side-effects, including chemotherapy-induced neuropathy. Aetna's plan administrator approved her application for benefits on April 30, 2009.

After approving her application, Aetna assisted Nugent in applying for disability insurance benefits through the Social Security Administration ("SSA").

On February 19, 2010, the SSA determined that Nugent was disabled within the meaning of the Social Security Act as a result of the physical limitations resulting from her cancer and its treatment, and it granted her application for benefits.

Nugent's cancer treatment was successful. In December 2009 and March 2010, PET scans confirmed that her cancer was in remission. However, Nugent believed that she could not work due to residual side effects of her treatment, including the pain from her neuropathy and incontinence issues. As time passed, though, medical testing revealed that many of her side effects diminished. On May 10, 2011, Aetna notified Nugent that her long-term disability benefits would be terminated because the plan administrator found that she was no longer disabled as defined by her insurance plan. The plan administrator relied on medical records evincing the improvement in her condition after the SSA awarded her benefits.

Nugent appealed Aetna's denial of benefits, but Aetna upheld its determination. Nugent filed this lawsuit against Aetna in federal court on January 10, 2012. The parties discovered that due to a technical error, Aetna had not received the complete SSA determination, so the parties jointly moved to resubmit the claim to Aetna. The district court granted the motion, and Aetna reconsidered the claim in light of the full SSA opinion. It issued a supplemental determination on November 5, 2012, in which it again determined that it would terminate Nugent's benefits

because she was no longer disabled under the terms of the policy.

The matter returned to district court, and the parties filed cross-motions for summary judgment. The district court denied Nugent's motion, granted Aetna's motion, and entered judgment in Aetna's favor. It held that: the plan administrator's denial of benefits was supported by substantial medical evidence; a conflict of interest existed in the case, but there were no facts showing that this conflict should be given additional weight in reviewing the decision; and that the plan administrator properly considered the SSA award in making its determination. The district court explained that some of the medical evidence showed that Nugent's condition had improved after the SSA made its determination. Based on this evidence, the plan administrator's decision was neither arbitrary nor capricious. Nugent timely appealed.

II. Standard of Review

We review de novo the district court's conclusion that an Employee Retirement Income Security Act ("ERISA") plan administrator did not abuse its discretion in denying disability benefits. *Crowell v. Shell Oil Co.,* 541 F.3d 295, 312 (5th Cir. 2008). Under this approach, we review the plan administrator's decision from the same perspective and with the same standard of review as the district court. *Anderson v. Cytec Indus.,* 619 F.3d 505, 512 (5th Cir. 2010). When a

benefits plan's terms grant the plan administrator discretionary authority to determine eligibility for benefits or construe the terms of the plan, which it does here, we review the determination to deny benefits for abuse of discretion. *Id.* We will affirm a plan administrator's determination to deny benefits if it is "supported by substantial evidence and is not arbitrary or capricious[.]" *Ellis v. Liberty Life Assurance Co. of Boston,* 394 F.3d 262, 273 (5th Cir. 2004). "The fact that the evidence is disputable will not invalidate the decision; the evidence need only assure that the administrator's decision fall somewhere on the continuum of reasonableness – even if on the low end." *Porter v. Lowe's Cos., Inc.'s Business Travel Accident Ins. Plan,* 731 F.3d 360, 363-64 (5th Cir. 2013) (internal quotation marks and footnote omitted).

III. Discussion

In reviewing Aetna's decision to terminate Nugent's long-term disability benefits, we weigh several case-specific factors. *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105, 117 (2008). Any one factor may serve "as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance." *Id.* Factors may include the medical evidence, structural conflicts of interest, and whether the SSA has awarded benefits. *Schexnayder v. Hartford Life & Accident Ins. Co.,* 600 F.3d 465, 469-71 (5th Cir. 2010). When one of the factors is an

existing SSA determination finding that a claimant is disabled, the plan administrator must address the SSA's decision in its determination; failure to do so renders a determination procedurally unreasonable. *Id.* at 471. However, the duty to acknowledge a contrary SSA determination is not a duty to afford the determination any specific weight. A plan administrator need only consider the SSA's determination, but it may conclude that the medical evidence supporting denial is more credible. *Id.* at 471 n.3.

On appeal, Nugent challenges the plan administrator's treatment of the SSA's February 2010 determination that she is disabled. Specifically, she argues that the administrator should have given more deference to the SSA's determination since the definition of "disability" applied by the SSA is arguably more stringent than the definition employed by Aetna. However, Nugent's argument contains two fatal flaws. First, we only require that a claim administrator address a contrary decision as a factor. Nugent urges us to give the SSA's decision more weight because of her belief that its definition of disability is arguably harder to meet. Without opining on whether the SSA's definition is more or less stringent than the definition of disability in Nugent's plan, Nugent's proposed treatment of the SSA determination is contrary to this circuit's clear requirement that the plan administrator need not afford the agency's findings and conclusions any special deference. *Id.* The ultimate weight afforded the determination is case-specific and depends on the balancing of the

competing factors. Aetna discussed the SSA determination, so its decision is not procedurally unreasonable.

Second, Nugent's fixation on the meaning of "disability" suggests that Aetna ultimately afforded the SSA determination little weight because of the technical differences between Aetna's and the SSA's definitions. This characterization is incorrect. Aetna's decision not to give the SSA's determination weight stemmed largely from the fact that it was based on outdated medical records. According to Aetna, medical evaluations of Nugent following the SSA's determination in February 2010 revealed that Nugent's cancer was in remission and her neurological symptoms had lessened. Nugent argues that Aetna has not pointed to any medical records that would support this conclusion, but the record contains PET scans from 2009 and 2010, which reveal that her cancer was in remission; several "benign" and "normal" neurological exams between February 2010 and May 2011; an EMG study from December 2010 that was "normal" and revealed no evidence of neuropathy, plexopathy or radiculopathy; and numerous "normal" examinations by her primary care physician. Furthermore, in April 11, 2011, a neurologist performed a peer review of the medical record and opined that there was no objective evidence that Nugent had any functional impairments that would preclude work. Thus, Nugent's suggestion that the plan administrator dismissed the SSA's determination solely based on the difference in the definitions of "disability" ignores

the fact that there was ample evidence in the record to show that the SSA's determination no longer reflected Nugent's physical limitations as of May 2011. Given the change in Nugent's condition, we find no error in the plan administrator's evaluation and consideration of the SSA opinion.

Nugent only vaguely challenges Aetna's determination that the record demonstrates an improvement in her medical condition between February 2010 and May 2011. She argues that Aetna failed to fully consider three documents that support her claim that she experiences neuropathy and cannot work. However, Nugent does not claim that this evidence is so persuasive as to overwhelm the contrary medical evidence and render the plan administrator's decision unreasonable. As the district court correctly noted, these medical documents make Aetna's determination debatable but not arbitrary and capricious. Since Nugent does not expressly challenge the sufficiency of the medical evidence supporting the plan administrator's decision to terminate her benefits, we will not consider it here.

IV. Conclusion

For the aforementioned reasons, we AFFIRM the judgment of the district court.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

SUSAN NUGENT	**CIVIL ACTION**
VERSUS	**NO. 12-0065**
AETNA LIFE INSURANCE COMPANY	**SECTION "B" (5)**

ORDER AND REASONS

Before the Court are Plaintiff, Susan Nugent's ("Nugent"), and Defendant, Aetna Life Insurance Company's ("Aetna"), Cross-Motions for Summary Judgment. (Rec. Doc. Nos. 43 & 44). In response, each party submitted a Memorandum in Opposition to the other party's Motion for Summary Judgment. (Rec. Doc. Nos. 46 & 47). Accordingly, and for the reasons articulated below,

IT IS ORDERED that Aetna's Motion for Summary Judgment is **GRANTED** and Nugent's claim is **DISMISSED**. Nugent's Motion for Summary Judgment is **DENIED**.[1]

PROCEDURAL AND FACTUAL HISTORY

Nugent was employed as a bookkeeper by Total Safety USA, Inc. and pursuant to her employment purchased a policy of long-term disability insurance

[1] We are grateful for the work on this case by Matt S. Landry, a Tulane University Law School extern with our Chambers.

with the defendant, Aetna. (Rec. Doc. No. 43-1 at 1; Rec. Doc. No. 44-1 at 2). After purchasing this policy, Nugent was diagnosed with colorectal cancer for which she received chemotherapy treatment until October 2009. (Rec. Doc. No. 44-1 at 2). Nugent filed a claim for long-term disability benefits with Aetna based upon colorectal cancer and residual effects of the disease and surgery, *id.,* including neuropathy, *See* (Rec. Doc. No. 44-1 at 3). Benefits were initially approved on April 30, 2009. (Rec. Doc. No. 43-1 at 1; Rec. Doc. No. 44-1 at 2).

Some time afterwards, Aetna encouraged Nugent to apply for disability insurance benefits with the Social Security Administration, and provided counsel to assist her in doing so. (Rec. Doc. No. 43-1 at 1). On February 19, 2010, the Social Security Administration ("SSA") determined Nugent to be disabled, because a vocational expert testified that there are no jobs in the national economy that Nugent could perform. (Rec. Doc. No, 44-1 at 4; Rec. Doc. No. 44-2 at 5). As a result, Aetna received a credit for those benefits it paid Nugent. (Rec. Doc. No. 43-1 at 1).

On October 6, 2009, Nugent's oncologist, Dr. Satti, discontinued Nugent's chemotherapy. (Rec. Doc. No. 44-2 at 5). In December 2009 and March 2010, PET scans confirmed that Nugent's cancer was in remission. (Rec. Doc. No. 44-1 at 3).

On February 8, 2011, Nugent reported to Aetna that she still could not work.[2] (Rec. Doc. No. 44-2 at 8-9).

Nonetheless, on May 10, 2011, Aetna notified Nugent that her long-term disability ("LTD") benefits would be terminated effective May 9, 2011, (Rec. Doc. No. 44-1 at 4), reasoning that she was no longer disabled as defined in her plan, as evidenced by medical records of Nugent's condition after Nugent was awarded disability by the SSA. (Rec. Doc. No. 43-1 at 1; Rec. Doc. No. 44-2 at 11; Rec. Doc. No. 46 at 3). Aetna concluded that Nugent was no longer disabled under its policy because medical records no longer contained evidence of functional impairment that would preclude Nugent from performing her occupation as a bookkeeper. (Rec. Doc. No. 44-1 at 3).

Nugent appealed Aetna's denial on June 21, 2011. (Rec. Doc. No. 44-1 at 4). Aetna upheld the termination of benefits on December 8, 2011, reasoning that medical evidence did not support Nugent's claimed inability to perform her bookkeeper occupation. *Id.*

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[2] Nugent claimed that she had severe neuropathy in her legs, that she was never without pain, does not have control of her bowels and cannot go far from her house for that reason, has pain with walking or sitting too long, and did not think she could ever return to work and could not do her job due to her problems with sitting and standing and being in the bathroom all the time. (Rec. Doc. No. 44-2 at 8-9).

Nugent filed suit against Aetna in this Court on January 10, 2012. *Id.* After Nugent's counsel discovered that a technical glitch resulted in the failure to submit the full SSA decision to Aetna, the parties agreed to resubmit the claim to Aetna. *Id.* Upon review, Aetna upheld its termination of Nugent's disability benefits on November 5, 2012, and the case came back to this Court. *Id.* Advising the Court that no general issues of material fact remain, the parties agreed to submit the instant motions for summary judgment to resolve the case. (Rec. Doc. No. 41 at 1).

LAW AND ANALYSIS

I. Standard of Review

Summary judgment is proper if the pleadings, depositions, interrogatory answers, and admissions, together with any affidavits, 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); *see also Celotex Corp. v. Catrett,* 477 U.S. 317, 327 (1986).

A deferential standard of review is appropriate for an Employee Retired Income Security Act of 1974 ("ERISA") claim appealing denial of plan benefits if the ERISA plan "grant[s] 'the administrator or fiduciary discretionary authority to determine eligibility for benefits.'" *Metropolitan Life Insurance Company v. Glenn,* 554 U.S. 105, 111 (2008) (citing *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989)); *Schexnayder v. Hartford Life and Acc. Ins. Co.,* 600

F.3d 465, 468 (5th Cir. 2010) (citing *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan,* 493 F.3d 533, 537 (5th Cir. 2007))

Under a deferential standard of review, a plan administrator's decision will be upheld if it "is supported by substantial evidence[3] and is not arbitrary and capricious." *Schexnayder,* 600 F.3d at 468 (citing *Ellis v. Liberty Life Assur. Co. of Boston,* 394 F.3d 262, 273 (5th Cir. 2004)). "The court's 'review of the administrator's decision need not be particularly complex or technical; it need only assure that the administrator's decision fall somewhere on a continuum of reasonableness-even if on the low end.'" *Holland v. International Paper Co. Retirement Plan,* 576 F.3d 240, 246 (5th Cir. 2009) (citing *Corry v. Liberty Life Assurance Co. of Boston,* 499 F.3d 389, 398 (5th Cir. 2007).

II. Plan Administrator's Denial of an LTD Award

To determine whether a plan administrator's decision to deny disability benefits is arbitrary and capricious or reasonable and supported by substantial evidence, the Fifth Circuit conducts a balancing analysis which examines multiple factors, including

[3] Substantial evidence is "more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Ellis,* 394 F.3d at 273 (quoting *Deters v. Secretary of Health, Educ. & Welfare,* 789 F.2d 1181, 1185 (5th Cir. 1986) (citing *Richardson v. Perales,* 402 U.S. 389, 401 (1971))).

medical evidence, structural conflicts of interest, and the SSA's award. *See Schexnayder,* 600 F.3d at 469-71.

A. Medical Evidence

The Supreme Court has held that in reviewing medical evidence, plan administrators need not "accord special weight to the opinions of a claimant's physician"; however, *a plan administrator may not arbitrarily refuse to include the opinions of treating physicians. Schexnayder,* 600 F.3d at 469 (citing *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 834 (2003)) (emphasis added). If reliable medical evidence contradicts a plaintiff 's treating physician's opinions, plan administrators are "not required to give special deference to the treating physicians," as long all evidence submitted by the plaintiff is taken into account. *Hamilton v. Stand. Ins. Co.* No. 08B1717, 2010 WL 686399 (W.D. Louisiana February 23, 2010) (citing *Nord,* 538 U.S 822(2003); *Love v. Dell, Inc.,* 551 F.3d 333 (5th Cir. 2008)); *aff'd by Hamilton v. Stand. Ins. Co.* 404 Fed. Appx. 895, 898 (5th Cir. 2010). For example, in *Hamilton v. Stand. Ins. Co.,* the court held that a plan administrator's decision to deny disability benefits was not arbitrary and capricious when it based its decision on the fact that four of its consulting physicians opined that the records did not support a diagnosis of fibromyalgia, in contrast to two out of plaintiff 's three treating physician's' opinions that she was suffering from fibromyalgia. *Hamilton,* 404 Fed. Appx. at 896-898.

Here, Aetna's decision was supported by substantial medical evidence. Prior to the SSA's February 2010 decision to award Nugent disability benefits, Nugent had multiple normal neurological examinations, but one of her treating physicians stated that Nugent "had no ability to work until sometime after her surgery scheduled for April 4, 2009" (Rec. Doc. No. 44-2 at 3-5). Between February 2010 and when Aetna made its determination in May 2011, Nugent saw several doctors who reported normal neurological examinations. *See* (Rec. Doc. No. 44-2 at 6-13). Six treating physicians opined about Nugent's neuropathy, *See* (Rec. Doc. No. 44-1 at 6-7; Rec. Doc. No. 44-2 at 3-16). Aetna's peer medical reviews, which determined that Nugent could return to work, only conflicted with two of these physicians' opinions, *See* (Rec. Doc. No. 44-1 at 6-7; Rec. Doc. No. 44-2 at 9-13). One of these physicians declared that his opinion that Nugent could not perform her job was outside his "area of knowledge." (Rec. Doc. No. 44-2 at 9-13). The other merely stated that he suspected it would be difficult for Nugent to return to work, based on a normal neurological evaluation. *Id.* at 10. Because plan administrators are permitted to disagree with a plaintiff 's treating physicians, *see Hamilton,* 404 Fed. Appx. at 898, and Aetna only disagreed with one of several treating physician's suspicion that Nugent could go to work, *see* (Rec. Doc. No. 44-1 at 6-7; Rec. Doc. No. 44-2 at 10), Aetna's conclusion about Nugent's ability to return to work was based on substantial medical evidence.

B. Conflict of Interest

The Supreme Court has held that conflicts of interest should be weighed in determining whether a plan administrator's decision is arbitrary and capricious. *Schexnayder,* 600 F.3d at 470 (citing *Metropolitan Life Insurance Company v. Glenn,* 554 U.S. 105, 115 (2008)). A conflict of interest occurs when an entity that administers an employee benefit plan "both determines whether an employee is eligible for benefits and pays benefits out of its own pocket." *Glenn,* 554 U.S. at 108. This includes insurance companies. *Id.* at 114-15.

A conflict of interest's significance relative to other factors "depend[s] upon the circumstances of the particular case." *Glenn* 554 U.S. at 108 (citing *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989)); *see also Holland v. International Paper Co. Retirement Plan,* 576 F.3d 240, 247 (2009) ("[T]he specific facts of the conflict will dictate its importance.") For example, a conflict of interest

> should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. (Omitted citation) It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy.

Metropolitan, 554 U.S. at 117. A conflict of interest should be given more weight if the plan administrator evidences "procedural unreasonableness." *See Schexnayder,* 600 F.3d at 471 (citing *Glenn,* 554 U.S. at 118). One way in which a plan administrator demonstrates procedural unreasonableness is by failing to address a contrary SSA award. *Id.* (citing *Glenn,* 554 U.S. at 118). Indeed, failure to address an SSA award of disability suggests financial bias may have affected a plan administrator's decision. *See id.*

A conflict of interest exists in this case because Aetna both determined whether Nugent was eligible for benefits and paid her benefits. *See Glenn,* 554 U.S. at 108, 114-15. However, the only claim made by either party as to whether this conflict of interest should be given more or less weight is Nugent's claims that Aetna made its decision in a "procedurally unreasonable" manner by insufficiently considering the SSA's award. *See* (Rec. Doc. 43-1 at 8). Because Aetna sufficiently considered the SSA's award, as discussed below, *see infra,* no facts in this case indicate that Aetna's conflict of interest should be given more, rather than less, weight.

C. SSA Award

In addition to exacerbating or alleviating a conflict of interest factor, failure to address an SSA award is "a factor in its own right," and should therefore be considered as a third factor, in addition to medical evidence and conflicts of interest. *Schexnayder,* 600 F.3d at 471. Nevertheless, this factor will

only "tip the balance" for "borderline cases." *Raybourne v. Cigna Life Ins. Co. of New York,* 576 F.3d 444, 450 (7th Cir. 2009) (citing *Glenn,* 554 U.S. at 117).

Although a plan administrator should consider an SSA determination, it is not required to concur "because the eligibility criteria for SSA disability benefits differs from that of ERISA plans." *Hamilton v. Stand. Ins. Co.,* 404 Fed. Appx. 895, 898 (5th Cir. 2010) (citing *Schexnayder,* 600 F.3d at 471 n. 3 (5th Cir. 2010)). *But see Raybourne v. CIGNA Life Insurance Company of New York,* 700 F.3d 1076, 1083, 1085 (7th Cir. 2012) (declaring "functionally equivalent" the SSA's definition of disability and the definition, "he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified").

Nugent points to *Schexnayder* to support the proposition that failure to "really consider the rationale or make any meaningful distinction between its decision and that of the Social Security Administration" amounts to "procedural unreasonableness." *See* (Rec. Doc. No. 43-1 at 5). Although the *Schexnayder* Court held that a claim administrator made a decision in a procedurally unreasonable manner, the claim administrator in that case failed to consider the SSA award entirely. *See Schexnayder,* 600 F.3d at 471 (explaining that "Hartford did not address the SSA award in any of its denial letters"). Unlike the claim administrator in *Schexnayder,* Aetna considered the

SSA award. *See* (Rec. Doc. 42-1 at 10-13). In a November 5, 2012 letter to Nugent, Aetna explained that it denied Nugent's disability benefits, because (1) the SSA and Aetna's definitions differ in that a higher degree of disability is required to meet Aetna's threshold; and (2) Aetna considered Nugent's ability to return to work over one year later than the SSA, much further removed from when Nugent's chemotherapy concluded. *See id.* Because Aetna considered the SSA award, *Schexnayder* does not support Nugent's claim that Aetna's decision was procedurally unreasonable.[4]

Nugent also points to a recent Seventh Circuit case, *Raybourne v. CIGNA Life Insurance Company of New York,* 700 F.3d 1076 (7th Cir. 2012), to support its claim that Aetna insufficiently considered SSA's award by dismissing the similarity of SSA and Aetna's definition of disability requirements. *See* (Rec. Doc. No. 43-1 at 2-4). Although the Fifth Circuit has held that "the eligibility criteria for SSA disability benefits differs from that of ERISA plans," *Hamilton v. Stand. Ins. Co.,* 404 Fed. Appx. 895, 898 (2010) (citing *Schexnayder,* 600 F.3d at 471, n. 3), the Seventh

[4] To support its assertion that Aetna insufficiently considered the SSA's award, Nugent points to another case, *Moller v. El Campo Aluminum Company,* 973 F.3d 85 (5th Cir. 1996), in which the court reversed because a decision-maker failed to consider an SSA award. (Rec. Doc. No. 43-1 at 5). However, in *Moller,* like in *Schexnayder,* and unlike Aetna in the instant matter, (Rec. Doc. 42-1 at 10-13), the decision-maker completely neglected a contrary SSA award, *See Moller,* 973 F.3d at 87-89.

Circuit, in *Raybourne,* held that "the definitions are functionally equivalent," *Raybourne,* 700 F.3d at 1085. Nevertheless, Aetna's decision to treat the definitions as different is not arbitrary, because a rational administrator could find that the definitions had different meaning, not only because of their textual dissimilarity, *see* (Rec. Doc. No. 43-2 at 1), but also because the Fifth Circuit has held they are different, *Hamilton,* 404 Fed. Appx. at 898 (citing *Schexnayder,* 600 F.3d at 471 n. 3). Thus, Aetna's decision to deny Nugent disability benefits was not procedurally unreasonable.

Balancing these three factors: (1) medical evidence; (2) the relatively slight weight given to Aetna's conflict of interests; and (3) sufficient consideration of the SSA's award; Aetna's decision was rational, and supported by substantial evidence, as the latter term is legally defined. While contrary medical evidence makes Aetna's denial of benefits debatable, in the Court's opinion, it does not thereby show the decision to be arbitrary and capricious.

New Orleans, Louisiana, this 16th day of July, 2013.

/s/ Ivan L.R. Lemelle
UNITED STATES
DISTRICT JUDGE