IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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BEVERLY JOHNSON,

ORDER

Plaintiff,

98-C-0750-C

v.

PRUDENTIAL INSURANCE
COMPANY OF AMERICA,

Defendant.

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Contending that she is a prevailing party in this litigation, plaintiff Beverly Johnson has moved for an award of attorney fees and costs pursuant to 29 U.S.C. § 1132(g)(1) and for interest pursuant to Fed. R. Civ. P. 54(d). Defendant Prudential Insurance Company of America contests the motion, arguing both that it was substantially justified in opposing plaintiff's lawsuit and that interest is not available on the past due benefits it paid plaintiff because the plan under which the benefits were paid does not authorize interest payments.

Some background is necessary to put plaintiff's motion into context. From February 1994 until January 6, 1997, plaintiff Beverly Johnson worked for TDS Computing Services, which provided her benefits under a long term disability plan administered by defendant

Prudential Insurance. Plaintiff was diagnosed with fibromyalgia in 1987, before she began work with TDS. In January 1997, she left TDS because she believed she was unable to work. She applied for disability benefits from defendant in July 1997. Her claim was rejected in August because, according to defendant, "[t]he medical evidence does not provide objective evidence of a significant pathology that would prevent you from performing your occupation." Defendant advised plaintiff that she could submit additional evidence but did not tell her that this evidence should focus on the specific way in which her condition made it impossible for her to perform the duties and tasks of her former occupation.

Plaintiff appealed the denial of her claim without submitting any additional medical records. Defendant's medical consultant re-examined plaintiff's medical records from the University of Wisconsin Hospitals and Clinics that included reports from two doctors who had seen plaintiff in late 1996. The first had found plaintiff's systems and blood pressure to be normal, no lymph node enlargement and no changes in her bowel habits. The second doctor found that plaintiff's liver function had improved; she was experiencing fatigue and joint discomfort but tolerating it well; she had no swelling of the extremities; and her physical examination was within normal limits. Defendant denied plaintiff's appeal, saying that "[t]he medical information reviewed states that you experienced many of these symptoms [that you think prevent you from working now] prior to going out of work, yet you continued to work.

However, the medical information reviewed does not support Total Disability as defined in 1a above."

In January 1998, plaintiff submitted a report from her treating physician, a rheumatologist. Dr. Malone wrote that plaintiff was "totally and unequivocally" disabled because of her fibromyalgia, that she could not hold full time or part-time employment and that she had one of the worst cases he had seen in twenty years of practice. Defendant arranged for plaintiff to have an independent medical evaluation. The doctor who performed it found plaintiff capable of performing sedentary work for eight hours a day. He found that she did not appear extraordinarily exhausted and that her cognitive functioning seemed quite relevant. He reported that she had no difficulty walking, no signs of drowsiness, no evidence of muscle atrophy and a "give way weakness" on strength testing, which he said was a sign of symptom magnification.

On February 23, 1998, defendant reaffirmed its denial of plaintiff's claim, basing its decision on Dr. Malone's report, which provided "no evidence of impairment and no specific restrictions on activity." Plaintiff appealed a third time. Defendant's appeals committee reviewed the claim, adjourned to obtain additional medical information and reconvened for review of the new materials before deciding to uphold defendant's earlier decisions on the basis of its conclusion that plaintiff had not provided evidence that her functional capacity was so

diminished that she could not perform her job duties.

Plaintiff began this lawsuit promptly after learning of defendant's adverse decision. She alleged breach of contract and violation of 29 U.S.C. § 1132 et seq. (ERISA). Defendant moved for summary judgment on the ground that its decision to deny long term disability benefits to plaintiff should be reviewed under an arbitrary and capricious standard and that the decision was reasonable. In opposition to the motion, plaintiff argued that the standard of review should be de novo and, alternatively, if the standard were arbitrary and capricious, the court should find the denial erroneous under that standard. In addition, plaintiff raised a new claim: that defendant had erred in denying benefits because it had failed to satisfy the specificity requirement for the notification of denial of benefits required under 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503(1)(f).

While the parties were briefing the motion for summary judgment, plaintiff's attorneys arranged for her to have a vocational evaluation by Dr. Ross Lynch, a rehabilitation psychologist, to determine plaintiff's ability to perform substantial gainful work activity on a sustained basis in the competitive labor market. In undertaking the evaluation, Dr. Lynch considered the duties and demands of her job with TDS and he administered a General Aptitude test to plaintiff. He concluded that plaintiff's fibromyalgia was a significant vocational handicap and that her level of disability was such that it was unlikely she could

perform substantial gainful activity on a sustained and reliable basis in the competitive labor market. In particular, he found that her pain, discomfort, fatigue, memory and concentration deficits and diminished problem solving skills prevented her from handling either the physical or the nonphysical aspects of her customary job. This evidence was not part of the record before the court on summary judgment or on appeal.

I granted defendant's motion for summary judgment, finding that applicable standard of review to be applied under the law of this circuit was the arbitrary and capricious standard and that plaintiff had not shown that defendant's decision was either arbitrary nor capricious. I found also that although defendant's first letter had been inadequate, the letters it sent subsequently would have conveyed to plaintiff the need to explain with specificity how her fibromyalgia interfered with her ability to work. On appeal, the Court of Appeals for the Seventh Circuit used this case and another to clarify its rulings on the standard of review to be applied to the decisions of ERISA plan administrators. See Herzberger v. Standard Insurance Co., 205 F.3d 327 (7th Cir. 2000). The court held that the language of the TDS plan did not reserve determinations of eligibility to the plan administrator's discretion. Rather, it said, the language was unclear and uncertain language should be construed to favor plenary review.

The court remanded the case to this court for plenary, or de novo, review of the denial of benefits, noting that attention should be given to the adequacy of the letters denying benefits

under 29 C.F.R. § 2560.503-1(f)(3). However, before either issue could be addressed, defendant offered to treat plaintiff as disabled for purposes of the claim and to pay her all past due benefits from July 6, 1997 through July 6, 2000. The parties settled the case on that basis, reserving the questions of attorney fees and interest on the past due benefits.

29 U.S.C. § 1132(g)(1) gives the courts discretion to allow a reasonable attorney fee to either party. Plaintiff argues that she is entitled to such an award because she is the prevailing party and because defendant was not substantially justified in litigating this case. The first issue is easy. Although defendant disagrees that plaintiff prevailed, arguing that it agreed to pay benefits to plaintiff simply to avoid additional litigation costs, the fact is that plaintiff obtained exactly what she sued for: the benefits due her under TDS's long term disability plan. Clearly, the lawsuit was the catalyst in obtaining this result. Had plaintiff not sued, she would not now be receiving benefits.

The second issue is more difficult. Although plaintiff maintains that a reasonable administrator in defendant's position would not have opposed her position, I am inclined to disagree. As I found and as the court of appeals acknowledged, when defendant chose to litigate this suit rather than grant plaintiff's application for benefits, many courts and lawyers believed that in this circuit the arbitrary and capricious standard of review applied to any plan that reserved to the administrator the discretion to determine what proof was satisfactory to

it. Until the court of appeals ruled otherwise, it was not unreasonable for defendant to take the position that the de novo standard of review did not apply. As to the benefits decision, it was neither arbitrary nor capricious for defendant to deny benefits in light of the evidence from all the doctors other than plaintiff's treating physician that plaintiff's fibromyalgia would not prevent her from working at a sedentary job for eight hours a day and no indication in the medical records that her condition had worsened since she began working in February 1994.

On the other hand, defendant cannot maintain that it had substantial justification for its failure to send plaintiff an adequate explanation of its denial of her application for benefits or for its defense of that failure. As the court of appeals suggested in Herzberger, 205 F.3d at 333, none of the three letters sent on October 14, 1997, February 23, 1998 and May 7, 1998, were sufficiently specific to convey to plaintiff what information she needed to perfect her claim and why that information was necessary. See 29 C.F.R. § 2560.503-1(f)(3). Although it was my initial opinion that the second two letters made up for the deficiencies in the first letter, I see now that none of the letters conveyed to plaintiff the need for her to show exactly how her fibromyalgia and associated problems interfered with her ability to perform the specific tasks required of her in her job. Thus, defendant was in violation of the regulation. Had the letters conveyed the requisite information, it is probable that plaintiff's attorneys would have arranged promptly for her to have the vocational assessment she obtained a year later. The results of this

assessment supply the kind of specific information that was lacking in plaintiff's applications and requests for reconsideration.

I conclude, therefore, that plaintiff is entitled to an award of reasonable attorney fees and costs. The remaining question is plaintiff's entitlement to interest on the past due benefits award.

In this circuit, a plaintiff is presumptively entitled to an award of prejudgment interest when the plaintiff is a plan beneficiary and benefits have been withheld wrongfully or erroneously. See, e.g., Lorenzen v. Employees Retirement Plan of Sperry and Hutchinson Co., 896 F.2d 228, 236 (7th Cir. 1990); Hizer v. General Motors Corp., 888 F. Supp. 1453 (S.D. Ind. 1995); see also Fotta v. Trustees of the United Mine Workers of America, Health and Retirement Fund of 1974, 165 F.3d 209, 212 (3d Cir. 1998). Defendant argues both that these cases are inapplicable to plaintiff's situation because there has been no determination of wrongfulness in this instance and that Clair v. Harris Trust & Savings Bank, 190 F.3d 495, 497 (7th Cir. 1999), holds that awards of interest for ERISA violations are inappropriate unless the plan provides for interest.

As to defendant's first point, I have decided that defendant did violate ERISA when it failed to provide plaintiff an explanation for the denial of her application for benefits that specified precisely what was wrong with her application and what she needed to submit to

improve her chances of success. Therefore, the presumption applies. As to defendant's second point, Clair does not hold to the contrary; the plaintiffs in that case were not seeking unpaid benefits but were complaining about the time the administrator took to pay out their benefits. Defendant raises a third point, suggesting that bad faith should be a criterion in determining whether to award interest and arguing that plaintiff has not shown that it acted in bad faith when it wrote the inadequate denial letters. In fact, an award of interest is simply giving plaintiff the interest defendant earned on the money to which plaintiff was entitled and preventing defendant from being unjustly enriched. See Lorenzen, 896 F.2d at 236. The presence or absence of bad faith may play a role in a district court's determination to grant or withhold prejudgment interest, but it is not a necessary element. Therefore, I conclude that plaintiff is entitled to prejudgment interest.

For some unexplainable reason, plaintiff's counsel refrained from submitting an itemized accounting of plaintiff's claim for attorney fees and costs, making it necessary to order a new round of submissions. In the future, plaintiff's counsel should submit such an itemization with a request for attorney fees so that opposing counsel and the court do not have to take the matter up in two separate stages.

ORDER

IT IS ORDERED that plaintiff Beverly Johnson's motion for an award of attorney fees, costs and prejudgment interest is GRANTED; plaintiff may have until August 21, 2000, in which to submit an itemized accounting of the time expended on plaintiff's case, with identification of the tasks performed, together with an itemization of the costs plaintiff reasonably incurred in prosecuting this suit, and any argument plaintiff wishes to make on the questions whether her success in this suit entitles her to a full or partial award of all the fees she requests and for what period of time the award of prejudgment interest should run; defendant may have until August 31, 2000, in which to respond to plaintiff's submission. There will be no reply brief.

Entered this 9th day of August, 2000.

BY THE COURT:

BARBARA B. CRABB
District Judge