IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

- -

RONALD WALSVICK,

Plaintiff,

v.

CUNA MUTUAL INSURANCE SOCIETY,

Defendant.

OPINION AND ORDER

03-C-637-C

- -

Plaintiff Ronald Walsvick filed this civil action against defendant CUNA Mutual Insurance Society seeking monetary and declaratory relief, asserting claims for breach of contract, breach of implied duty of good faith and fair dealing and a violation of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § § 1001-1461. Plaintiff filed his action in the Circuit Court for Dane County, Wisconsin on October 9, 2003. Defendant removed the action to this court on November 12, 2003. Jurisdiction is present under 28 U.S.C. § 1331.

The case is before the court on defendant's motion for summary judgment. Defendant contends that plaintiff's state law claims are preempted by the Employee Retirement Income Security Act (ERISA). In addition, defendant argues that it adequately

reviewed plaintiff's claim for long-term disability benefits and exercised appropriate discretion in denying his claim. Because plaintiff fails to develop any argument against ERISA preemption of his state law claims, I will grant defendant's motion for summary judgment as to that claims. In addition, I will grant defendant's motion for summary judgment as to plaintiff's claim under ERISA because plaintiff's claim for disability was based upon his cardiac condition, not on stress. Therefore, it was reasonable for defendant to deny plaintiff's claim for benefits after each of the medical experts agreed that plaintiff's cardiac condition did not prevent him from returning to work.

From the proposed findings of fact submitted by the parties and the record, I find the following facts to be material and undisputed.

UNDISPUTED FACTS

A. The Parties

Plaintiff Ronald Walsvick is an adult resident of McFarland, Wisconsin. He has a history of coronary artery disease. Defendant CUNA Mutual Insurance Society is a Wisconsin mutual insurance corporation, with its principal office located in Madison, Wisconsin. CUNA Mutual provides a broad range of financial products and services to credit unions and their members.

Plaintiff worked for defendant from October 16, 1972, until his retirement on March

30, 2002. Plaintiff suffered his first heart attack in 1992 and underwent coronary angioplasty. At the time of his first heart attack, plaintiff worked as a property and casualty specialist, a low-stress position with no decision-making authority. On May 26, 1997, plaintiff began work as a senior underwriter. Plaintiff held this position until his retirement in 2002.

B. The Disability Plan

Effective January 1, 1994, defendant adopted the CUNA Mutual FlexBenefits Plan, a master employee benefit plan that includes the CUNA Mutual Long-Term Disability Plan. Plaintiff became eligible to participate in this plan on that date. The long-term disability plan provides benefits in the event of a disability. The plan administrator for the plan is defendant's Employee Benefit Plan Administration Committee. From January 1, 1994 to the present, Section 6 of the long-term disability plan has contained the following language: "The Plan Administrator shall have full authority to control and manage the operation and administration of the Plan." On January 1, 2000, defendant amended Section 6 of the long-term disability plan by adding the following language: "Initial and continuing eligibility to participate in the Plan or to receive benefits or the amount of benefits available under this Plan are determined at the discretion of the Plan Administrator." Section 5.1 of the FlexBenefits Plan provided that:

> The Plan Administrator will have the full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:
>
> * * *
>
> > (4) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and
> >
> > (5) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Defendant's long-term disability plan is funded through a group disability income insurance policy it issued to itself. The long-term disability insurance policy gives defendant discretionary authority "[e]xcept for functions specifically reserved to the Policyholder or Employer in the insurance Policy or Certificate." Defendant has the "sole authority to manage the Policy, to administer insurance claims, to interpret Policy provisions, and to resolve insurance questions arising under the Policy." This authority includes determining employee eligibility for insurance and insurance benefits, deciding what information it requires for making such decisions and resolving "all matters" when a claim review is requested. The policy makes clear that defendant's decisions in this regard are "conclusive and binding."

Under the long-term disability insurance certificate, CUNA Mutual agrees to pay

covered employees a monthly benefit when it receives proof of total or partial disability requiring the regular care of a physician. The physician must be certified to treat the disabling condition and must be aimed at improving the chances of recovery and a return to work, "when possible." The certificate of insurance defines "total disability" as being unable to perform all the material and substantial duties of the employee's own occupation, with reasonable accommodation, because of an injury, sickness, mental or nervous disorder or substance abuse.

With respect to notice and proof of claim, the insurance certificate provides that the insured provide proof of claim no later than 90 days after the end of the elimination period. The initial proof must include, among other things, "objective documentation of the Total Disability or Partial Disability including test results and office and Treatment notes." In addition, the insured must provide proof of continued disability within 30 days after defendant requests the proof. The proof must include a care and treatment plan and a statement of physical capacity as well as objective medical documentation of the insured's inability to participate in work activity, including test results and office and treatment notes.

C. Plaintiff's Claim for Benefits

On July 1, 2001, plaintiff suffered a mild heart attack. The next day, he had a successful angioplasty and was discharged from the hospital on the following day. Dr. Orest

Kostelyna was plaintiff's internal medicine physician following his second heart attack.

Kostelyna's August 1, 2001 treatment note stated:

> Ron presents today for follow-up.
>
> He is doing okay. He is going through cardiac rehab, and things are going okay. He is not back to where he wants to be, but certainly is going in the right direction. No nausea or vomiting. He is down to three cigarettes a day, and he expects by at least September he will be off.
>
> He is on the Zocor religiously and we will be checking a coronary profile on him when we see him again in September. He still has not gone back to work, and he is looking to discuss the option and the possibility of long-term disability.
>
> * * *
>
> PLAN: As above. If the family does decide to go on disability in the interim, they will call me and we will pursue accordingly.

Plaintiff completed his cardiac rehabilitation successfully on September 12, 2001.

Dr. Kostelyna's September 18, 2001 treatment note stated:

> S: Ronald presents today for an evaluation. He is doing well. He has had no angina. He is almost off cigarettes, down to about 2 per day. He has finished cardiac rehab and continues to exercise at home. He denies any chest pain or breathing difficulties. He is going to be applying for disability, because of his stressful job, in an attempt to try to eliminate the stressors, which have typically prompted him to increase his cigarettes intake, and exacerbate his angina.
>
> * * *
>
> His most recent coronary risk panel, has been improved on the continual usage of Zocor at 40 mg, so I think we are going to give him a couple more

months to see if we can't get his numbers down appropriately.

Follow-up with me will be in a month to recheck his blood pressure, will do another coronary risk panel on him in November, and obviously will call sooner for problems. I will fill out his disability forms, and will see how far this gets him.

Plaintiff submitted a claim for benefits under the long-term disability plan on September 19, 2001. Kostelyna signed the physician certification on plaintiff's claim, certifying that plaintiff's cardiac functional capacity was a "Class 1 (No limitation)" and his physical status was a "Class 1 - No limitation on functional capacity; capable of heavy work. No restrictions." In addition, Kostelyna wrote that plaintiff had a mental impairment, "Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations.)" Kostelyna noted that "stress situations excarbate [sic] cardiac condition." Kostelyna stated that July 2, 2001 was the first date that plaintiff was medically unable to work and that he did not expect a fundamental change in plaintiff's condition. Kostelyna did not say whether he had released plaintiff to return to work but listed "current job" as a specific work restriction and indicated that plaintiff was not a suitable candidate for occupational rehabilitation with respect to his job.

Defendant's Employee Benefits Administration and Claims Department is responsible for reviewing claims for long-term disability benefits under the long-term disability insurance policy and claims specialists review initial claims. On September 26, 2001, Stacy Hoven,

a claims specialist in the department and the employee assigned to review plaintiff's claim, faxed Kostelyna a request for additional medical information. On the same day, Hoven wrote plaintiff, informing him that defendant was evaluating his claim, that it had requested additional information from his treating physician and that if plaintiff had additional information he would like to submit he should do so. Kostelyna faxed Hoven answers to her questions on September 27, 2001. In addition, he faxed his treatment notes from August 1, 2001, September 18, 2001 and September 21, 2001. Kostelyna's fax did not include any of the hospital records related to plaintiff's heart attack or any information from plaintiff's cardiologist. In the September 27, 2001 fax, Kostelyna stated that plaintiff's primary disabling condition was atherosclerotic heart disease and his current care and treatment plan included monthly visits, cardiac rehabilitation and smoking cessation. Kostelyna listed the limitation that precluded plaintiff from returning to work as a "less stressful work environment."

On October 4, 2001, Hoven had a telephone conversation with plaintiff, in which she informed him that defendant needed additional medical information, including plaintiff's hospital records related to his July 2001 heart attack and records from his cardiologist. On October 5, 2001, Kostelyna faxed Hoven copies of documents he had sent previously to Hoven on September 27, 2001 and a letter dated October 2, 2001, in which he stated: "Because of the stress level at his workplace environment, which clearly exacerbates his

symptomatology, I have recommended that he continue on full disability leave, on this basis."

On October 5, 2001, Hoven spoke with plaintiff regarding the status of his claim and reiterated defendant's need for plaintiff's hospital and cardiologist records. During that conversation, plaintiff demanded that defendant make a determination regarding his claim based on the information in his record and that it do so no later than noon on October 8, 2001. In response, Hoven sent plaintiff an email on October 8, 2001 denying his claim and stating:

> Under other circumstances, we would have pursued additional documentation before making a claim decision. However, when we advised you that we needed more information to determine if you meet the definition of disability, you stated you wanted a decision, in writing, no later than 12:00 PM on October 8, 2001. Unfortunately, since you require a decision before we are able to get all relevant information, we have no choice but to deny your claim, as the medical information we have received to date does not support total disability from [your] own occupation.
>
> In order to perfect your claim, you will need to provide us with all the medical records from your cardiologist, your hospital stay in July, and cardiac rehab notes.

Following the October 8, 2001 denial of his claim, plaintiff sent defendant a letter on October 10, 2001, appealing the denial and enclosing information relating to his July 2001 hospital stay, cardiac rehab notes and information from his cardiologist. Upon plaintiff's appeal, defendant referred his claim to the ERISA Committee, which consists of either the

disability manager or claims trainer in the Employee Benefits Administration and Claims Department and at least one claims specialist employed in that department. The committee decided to have plaintiff's claim reviewed by John Hewitt & Associates, Inc., a medical consultant and underwriting manager for defendant's reinsurer. Hoven informed plaintiff of this decision in an October 16, 2001 letter. Russell Stogsdill, a physician assistant and medical consultant employed by John Hewitt & Associates, Inc., provided Hoven with a report on October 18, 2001 regarding plaintiff's medical status. Relying on the medical records plaintiff had provided, Stogsdill concluded that: 1) claimant's class I cardiac status and class I physical status were accurate and supported by the objective data in the file; 2) the class IV stress impairment was not supported by the documentation in the file; 3) no subjective or objective documentation supported plaintiff's claim that his self-reported job stress exacerbated his cardiac condition; and 4) a restriction and limitation from working for the purposes of stress avoidance was neither reasonable nor supported by the objective data in the file.

On October 23, 2001, Hoven sent Stogsdill's October 18, 2001 report to Kostelyna, asking him to review and comment on the conclusions in the report. Hoven informed plaintiff of this action. Plaintiff responded on October 31, 2001, enclosing an October 24, 2001 letter from Kostelyna in which Kostelyna stated:

> I did receive your report dated October 23, 2001. With regards to your

> conclusions, I am neither arguing his cardiac status (he is, in fact, Class 1) nor am I arguing his physical status (he is, in fact, a Class 1 physical status, as well). Mr. Walsvick's impairment is that his symptoms are, in fact, stress induced. Mr. Walsvick does have a personality which clearly causes him to internalize his stressors which thereby exacerbates his underlying disease. There are no tests to prove this, but clearly this is his situation and his personality.
>
> In the many years that I have known Mr. Walsvick, it has been clear to me that his workplace environment is very stressful for him, seemingly contributes to his inability to maintain a healthy lifestyle and, I feel, exacerbates his underlying illnesses. The literature is replete with evidence that clearly states stress does exacerbate underlying coronary disease. It is because of this and because of the underlying stress the patient experiences at his workplace environment that he has applied for disability and that I have supported his application.
>
> My opinion has not changed. I still feel he has stress induced symptomatology that is exacerbated at his workplace environment and, as such, he is disabled because of this . . .

Hoven forwarded plaintiff's October 31, 2001 letter and enclosures to John Hewitt & Associates, Inc. for review. On November 8, 2001, Hoven wrote plaintiff to tell him that the ERISA Committee had denied his appeal of the denial of his claim.

> In a letter from Dr. Kostelyna, dated October 24, 2001, he states, "I am neither arguing his cardiac status (he is, in fact, Class 1) nor am I arguing his physical status (he is, in fact, a Class 1 physical status, as well)." Being a Class 1 for both cardiac and physical status indicates there are no physical restrictions or limitations that would prevent you from performing your job duties as a Senior Underwriter. Dr. Kostelyna does support your disability status but with no real reason other than the stressful job "which seemingly contributes to his inability to maintain a healthy lifestyle." While Dr. Kostelyna is clearly concerned about the stressors effecting [sic] your cardiac

> condition, it does not appear that he has recommended any type of stress management programs for you, and you are not receiving any care and treatment for the management of your stress.
>
> In order to perfect your claim you will need to provide medical evidence that supports your inability to perform your occupation as a Senior Underwriter.

Plaintiff wrote Hoven on November 15, 2001, stating that he had participated in a cardiac rehabilitation program and a nutritional program, was currently involved in a non-smoking program, was exercising daily and was complying with all of Kostelyna's recommendations. In addition, plaintiff wrote that "it should be extremely obvious to you in the various correspondences with Dr. Kostelyna, that he feels it is my workplace that is creating the stress, and that by eliminating that, I am eliminating another of my risk factors."

On November 20, 2001, Hoven wrote plaintiff informing him that a cardiologist was going to review his claim. Dr. Paul Minton submitted a report on December 4, 2001, in which he stated:

> **Discussion:**
> The issue is whether Mr. Walsvick is precluded from returning to his usual occupation as an insurance underwriter because of the potential adverse effect of stress on his documented coronary atherosclerotic heart disease.
>
> Dr. Kostelyna's comments have some merit. However, the data are thoroughly and accurately represented in Mr. Stogsdill's November 21, 2001 report and as corrected in his November 26, 2001 supplemental report.
>
> There have been no psychological evaluations to assess the degree and role of stress in Mr. Walsvick's life and work situations, nor has Mr. Walsvick been

referred to any smoking cessation or stress management programs.

I have studied the effect of psychosocial and work stress on the cardiovascular system for three decades, and concur that the medical literature supports the concept that psychosocial stress has a deleterious effect on coronary atherosclerotic heart disease. If stress is an important element in an individual's illness, one or more of the following are generally present:

- Lost work due to stress.
- Referral for psychological and/or psychiatric evaluations.
- Referral for stress management.
- Drug treatment for stress and/or stress related symptoms.

Opinion:
The records I have reviewed, and have correlated with the known and acceptable effects of work stress on coronary atherosclerotic heart disease, do not support evidence of, or potential for, sufficient work stress to affect the claimant's coronary atherosclerotic heart disease. Therefore Mr. Walsvick is not medically precluded from returning to his job as an underwriter because of the potential deleterious effect of stress.

On December 11, 2001, Hoven wrote plaintiff to tell him that the ERISA Committee had upheld the previous denial of plaintiff's claim. Hoven provided plaintiff with copies of Stogsdill's and Minton's reports. Hoven stated that plaintiff's file did not contain sufficient medical evidence to support plaintiff's claim that stress would be a totally disabling factor in his condition. In addition, she advised plaintiff that he would need to submit evidence that would: 1) demonstrate lost time due attributable to stress prior to his last date present at work by providing time and attendance records indicating the lost time was caused by stress; 2) indicate that he was referred for psychological or psychiatric evaluations regarding

stress prior to or following his last date at work; 3) indicate that he had been referred to a stress management program; and 4) indicate that he had been receiving drug treatment for stress or stress related symptoms in the form of pharmacy records. Hoven informed plaintiff that Dr. Kostelyna would need to dispute the information from Dr. Minton's report that indicates that plaintiff is not medically precluded from returning to his job as an underwriter because of the potentially deleterious effect of stress.

By letter dated February 7, 2002, plaintiff appealed the December 11, 2001 denial of his claim. Plaintiff's letter included a letter from his psychiatrist, Dr. Ladan Mostaghimi, who stated that plaintiff "is suffering from generalized anxiety and depressive disorders. He has had a recent myocardial infarction. Considering his physical and mental health Mr. Walsvick needs a low stress work environment." In plaintiff's own letter, he noted a number of medical journal articles that indicated a causal relationship between work stress and coronary heart disease. Plaintiff did not begin any psychiatric treatment until January 28, 2002.

On March 13, 2002, Hoven wrote plaintiff stating that the ERISA Committee had upheld the previous denial of his claim. Hoven stated that "stress avoidance is not a medical treatment" and that although the letter from Dr. Ladan Mostaghimi had verified plaintiff's visit to a psychiatrist, this visit came six months after plaintiff had left work and he had not received regular care for stress before that visit.

On May 10, 2002, plaintiff, through his attorney Douglas Phebus, appealed the denial of the claim and provided Hoven with additional medical information. In response, Hoven wrote plaintiff on May 24, 2002, stating:

> The ERISA Committee has reviewed your recent appeal of the denial of your request for Long-Term disability benefits. At this time, a decision has been deferred.
>
> In the appeal that was submitted on your behalf, your attorney makes reference to a May 2, 2002 note from Ladan Mostaghimi, MD that indicates "he reported that at times he had to leave his job earlier due to being stressed out." Your attorney indicates that this statement from Dr. Mostaghimi outlines that you lost work due to stress. However, you must provide proof of the lost time from work. Therefore, you will need to summit [sic] your time and attendance records from 2000-2001 that would document the missed time from work.
>
> Your attorney also submitted an office note dated March 22, 2000 from William Jones, MD. This note indicated that Dr. Jones recommended that you see a psychiatrist for evaluation for the possibility of depression. The ERISA Committee would like a copy of the actual evaluation.
>
> Once the above documentation is received, the ERISA Committee will continue to review your appeal.

On May 15, 2002, plaintiff's attorney submitted a further report from Kostelyna, dated May 3, 2002, in which Kostelyna stated:

> Over the years, because of Mr. Walsvick's highly stressful workplace environment, this has had a deleterious effect on not only his overall health, but specifically on his cardiac condition.
>
> I believe that, with a reasonable degree of medical certainty, Mr. Walsvick's

> workplace environment has played a negative role and has had a deleterious [sic] on the progression of his coronary ASHD, in the time that I have taken care of him.
>
> I would expect that if he would return to his former occupation at CUNA that he would once again be placed at risk.

Because Hoven had not received any of the additional information from plaintiff that she had requested in her May 24, 2002 letter, she wrote plaintiff on July 30, 2002, stating:

> To date we have not received a response to the above requested documentation. Please submit the requested information within 30 days of the date of this letter so the ERISA Committee may continue with the review of your appeal. If the requested information is not received within 30 days, the ERISA Committee will make a final determination based on the information that is presently contained in your file.

On August 27, 2002, plaintiff's attorney wrote Hoven, stating:

> Enclosed please find a statement by Jim Rosenberger which shows that Mr. Walsvick had to leave early two days per month in 2000 and 2001. This statement is in lieu of the attendance records you requested because, per Mr. Rosenberger's statement, no such records were kept of these partial sick days.
>
> As to your request for medical records relating to prior treatment for depression, Mr. Walsvick did not have a formal evaluation performed back in 2000.

On September 6, 2002, Hoven wrote plaintiff, stating that the ERISA Committee was deferring a decision on his appeal so that a medical specialist could reevaluate his claim. That same day she sent Minton the additional information submitted by plaintiff and requested that Minton update his prior opinion. Minton updated his report on September

30, 2002. He concluded that upon reviewing the additional records submitted by plaintiff, "Mr. Walsvick's return to his usual occupation as an insurance underwriter is medically contraindicated at this time."

The ERISA Committee disagreed with Minton's updated report because it believed that Minton made certain invalid assumptions relating to whether plaintiff had missed work because of stress or had been treated for stress before his July 2001 heart attack. On November 1, 2002, Hoven wrote plaintiff informing him that the ERISA Committee had upheld the previous denial of his claim. Hoven stated:

> The reasons this claim has again been denied are outlined below.
>
> 1) Your attorney, Douglas Phebus, submitted the statement from Jim Rosenberger that indicated that "during the year 2000 through June of 2001, Mr. Walsvick would request and be granted permission to leave early approximately two (2) days per month pursuant to this sick leave policy." I have contacted CUNA Mutual Group's Human Resource's [sic] department and they were not able to provide me with any documentation that validates Mr. Rosenberger's statement of your lost time from work. In addition, there is no documentation that can support that the [alleged] time off missed from work was solely due to stress. As stated previously, there is not sufficient medical evidence to support that stress would be a Totally Disabling factor in your condition as defined in Section 2.1 of your Long-Term disability contract . . .
>
> * * *
>
> 2) Medical records contained in your file document that your first visit to a psychiatrist was six months after you left work and you did not receive regular care prior to your date of disability for this condition.

* * *

> If you wish further consideration of your claim, you and your physician must provide:
>
> - A care and treatment plan as outlined in section 4.1 [of the long-term disability certificate]. The information submitted should clearly document that you have been receiving care and treatment by a physician certified to treat your specific condition and is aimed at maximizing recovery and return to work. This information must also document that this care and treatment began prior to the end of your 90 day elimination period.
> - Time & Attendance records demonstrating lost time prior to your last date present at work and documentation that the time missed was due to stress.

As a result of Minton's September 30, 2002 report, plaintiff appealed defendant's denial of his claim. On March 5, 2003, Hoven sent Minton an email, seeking clarification of his September 30, 2002 opinion. On March 31, 2003, Hoven wrote Minton, outlining the issues the ERISA Committee wanted addressed, such as the absence of human resource records showing plaintiff's lost time from work on a regular basis before his date of disability and the absence of a psychiatric evaluation before January 2002. Minton revised his report on April 28, 2003, concluding:

> The medical records do not document work related stress or evaluation and/or treatment for at work related stress before January, 2002. Therefore, there is no documentation that work stress played a role in the non-Q wave anterior myocardial infarction.

* * *

> Based on all of the information currently available to me, my opinions, with a reasonable degree of medical certainty, are as follows:
>
> * * *
>
> 2. Psychiatric evaluations and drug treatment for anxiety and depression subsequent to January, 2002 are documented. There is medically accepted evidence that psychosocial stress, such as work stress, has a deleterious effect on individuals with coronary atherosclerotic heart disease.
>
> 3. Whether Mr. Walsvick will experience significant, disabling work stress on returning to his usual position as an underwriter in [sic] not a cardiac issue. This is a psychiatric and/or psychologic issue. Further psychiatric and/or psychologic evaluations are needed to assess the potential for work stress and to determine whether or not treatment with counseling and/or psycho tropic drugs will minimize or control work stress.
>
> 4. Even though work stress is not documented as playing a role in the myocardial infarction of July, 2001, uncontrolled work stress, whether treated or untreated, more likely than not, will be deleterious to Mr. Walsvick's documented coronary atherosclerotic heart disease.

On May 2, 2003, Hoven wrote plaintiff, informing him that the ERISA Committee had upheld the previous denial of his claim and advising him that 1) defendant's human resources department did not have any records supporting the allegation that plaintiff missed work time because of stress; 2) plaintiff had failed to follow up with treatment for stress/depression before January 2002; and 3) plaintiff's file did not clearly demonstrate that at the end of his 90-day elimination period he was totally or partially disabled because of stress.

Plaintiff appealed the denial of his claim in a June 26, 2003 letter from his attorney that included updated medical information. The letter read as follows:

> I would note that the decision is that Mr. Walsvick has not proven that he was disabled by stress. Mr. Walsvick has not made a claim that he is disabled by stress. His claim relates to his cardiac condition and resulting impairment.
>
> I would request that you issue a final decision on Mr. Walsvick's claim and address whether you will accept your expert's opinion that Mr. Walsvick is disabled as a result of his cardiac condition, [and] if not, why not.
>
> Finally, I would request that your decision indicate that it is a final determination and that Mr. Walsvick has exhausted all of his administrative remedies.

After considering Minton's April 28, 2003 report, stating that there was no medical documentation of stress having been a factor in plaintiff's heart attack and that plaintiff's ability to return to work was not a cardiac issue but a psychiatric or psychologic one and the June 26, 2003 letter from plaintiff's attorney asserting that plaintiff's claim was disability resulting from his cardiac condition, not stress, the ERISA Committee decided to send plaintiff's file to another cardiologist for review.

On July 11, 2003, Hoven forwarded plaintiff's file to Behavioral Management, Inc., a medical consulting firm. Dr. Irvin Goldenberg, a cardiologist with Behavioral Management, Inc., sent a report to Hoven on August 5, 2003, in which he concluded:

> I see no reason why [Walsvick] cannot return to work. I am not convinced at all that the stress of work is any greater than the stress he relays in regards to

> his present family situation that he faces daily because he is not working. Also his financial problems and stress would be less if he were working. In the total scope of things there is no convincing evidence that long-term occupational stress would be a significant risk factor for progression of cardiac disease in this patient. Personally I think it would be good for this patient to go back to work, it is likely to help his self-esteem, his family situation, his financial situation and his overall quality of life. Clearly in my opinion, he has no contraindications to return to work from a cardiac standpoint.

Defendant's ERISA Appeals Review Committee considered Goldenberg's report along with plaintiff's claim and related documentation. That committee consisted of defendant's Vice President of Employee Benefits and the Assistant Vice President of Operations for Employee Benefits. On August 28, 2003, Hoven wrote plaintiff's attorney, stating that the ERISA Committee had upheld the previous denial of plaintiff's claim.

> Since CUNA Mutual Group had conflicting information from Mr. Walsvick's treating physician and Dr. Minton, a third review by an independent cardiologist was completed (Attachment I). Dr. Irwin Goldenberg, MD FACC, states, "Clearly in my opinion, he has no contraindications to return to work from a cardiac standpoint."
>
> As previously mentioned, Mr. Phebus stated that Mr. Walsvick has not made a claim his [sic] is disabled by stress. However, the medical documentation that has been supplied has been reviewed by two independent cardiologists and neither concluded that Mr. Walsvick was totally disabled from his own occupation as a Senior Underwriter from a cardiac condition.
>
> The Committee has also determined that Mr. Walsvick has exhausted his administrative appeals for his claim, and that further administrative appeals will not be accepted.

Defendant's long-term disability plan administrator never reviewed plaintiff's claim for long-term disability benefits.

OPINION

A. Standard of Review

The denial of benefits under an employee benefit plan governed by ERISA may be challenged pursuant to 29 U.S.C. § 1132(a)(1)(B). The standard of review a court applies when reviewing a plan administrator's decision to deny benefits is controlled by Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), in which the Supreme Court held that a plan administrator's denial of benefits must be reviewed de novo unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id. at 115. If the plan gives the administrator or fiduciary such discretionary authority, the court reviews the denial of benefits under the arbitrary and capricious standard. Id. This standard was clarified by the Court of Appeals for the Seventh Circuit in Herzberger v. Standard Insurance Co., 205 F.3d 327 (7th Cir. 2000). The court upheld the presumption of plenary review, except where the language of the policy "indicates with the requisite if minimum clarity that a discretionary determination is envisaged" or where the "nature of the benefits or the conditions upon it will make reasonably clear that the plan administrator is to exercise discretion." Id. at 331.

Thus, in order to determine whether defendant's denial of plaintiff's long-term disability benefits was proper, a court must first determine whether the plan grants defendant sufficient discretionary authority to invoke the arbitrary and capricious standard, see Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 379 (7th Cir. 1994), under which a plan administrator's decision will not be overturned unless it is "downright unreasonable," Fuller v. CBT Corp., 905 F.2d 1055, 1058 (7th Cir. 1990). Although in Herzberger the court was reluctant to announce the "magic words" that would establish that an administrator had the requisite discretionary authority, the court concluded that "the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof of the applicant's claim, or requires both a determination and proof (or satisfactory proof), does not give the employee adequate notice that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary." Herzberger, 205 F.3d at 332. "[E]mployees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." Id. at 333.

Plaintiff agrees that the language of the long-term disability plan, as amended on January 1, 2000, grants the plan administrator discretionary authority over plan decisions "such that its decisions would be reviewed under an arbitrary and capricious standard."

Plt.'s Br., dkt. #16, at 13. Nevertheless, plaintiff argues, the court should use the de novo standard of review because the discretionary plan language was not in effect when he bargained for long-term disability benefits. Id. at 14. When the amendment went into effect in January 2000 to allow for discretionary authority, plaintiff had no bargaining power other than to quit his job.

Plaintiff's argument is reasonable but ultimately unavailing, because plan participants do not have an unalterable right to benefits that do not vest, Hackett v. Xerox Corporation Long-Term Disability Income Plan, 315 F.3d 771, 774 (7th Cir. 2003), and plaintiff has not shown that his long-term disability benefits vested. Plaintiff gets no help from ERISA; it does not include disability benefits in its vesting requirements. 29 U.S.C. § 1051(1) (excluding "employee welfare benefit plans" from participation and vesting requirements). When long-term disability benefits are not vested, the employer may change the plan and benefits. Hackett, 315 F.3d at 774. "Since the employer can change the plan, then it must follow that the controlling plan will be the plan that is in effect at the time a claim for benefits accrues." Id. The plan in effect at the time plaintiff applied for long-term disability benefits contained the proper discretionary language to apply an arbitrary and capricious standard of review to defendant's decision, I will use that standard to review defendant's decision to deny plaintiff's claim for benefits.

B. Defendant's Denial

Plaintiff has two challenges to defendant's denial of his claim for benefits: 1) the plan administrator (the Employee Benefit Plan Administration Committee) never reviewed plaintiff's claim despite plan language that requires the administrator to review appeals of negative coverage decisions; and 2) defendant denied plaintiff's claim in bad faith when it used medical experts with a conflict of interest and "doctor shopped" until it found a doctor who supported its decision to deny.

1. Review by plan administrator

ERISA allows plan administrators to allocate fiduciary responsibilities among named fiduciaries or other designated persons. 29 U.S.C. § 1105(c). Plaintiff argues that defendant's plan does not provide expressly for such procedures and therefore, defendant's plan administrator had no right to ignore plaintiff's appeal of the denial of his claim. Plt.'s Br., dkt. #16, at 16.

First, despite plaintiff's argument that the plan document requires the plan administrator to review appeals of a negative coverage decision, plaintiff points to no language in the plan imposing such a requirement. Second, it is undisputed that the long-term disability plan is part of the master employee benefit plan, which contains language that allows the plan administrator to allocate and delegate its responsibilities under the plan

and to designate other persons to carry out any of its responsibilities under the plan, so long as such allocation, delegation or designation is in writing. It is undisputed also that the long-term disability plan gives defendant authority to determine employees' eligibility for insurance and entitlement to insurance benefits. Defendant's ERISA Appeals Review Committee conducted the final review of plaintiff's claim for benefits. That committee consisted of the Vice President of Employee Benefits and the Assistant Vice President of Operations for Employee Benefits. This method of review was properly within defendant's authority under the terms of the long-term disability plan.

2. Bad faith

Plaintiff argues that defendant acted in bad faith by using medical experts who had conflicts of interest and by "doctor shopping." Plaintiff alleges that the physician assistant who performed the initial review of his claim was employed by a company that also functioned as defendant's reinsurer. Plt.'s Br., dkt. #16, at 17. However, defendant did not limit its final decision to the physician assistant's report, but sought the opinions from two cardiologists. One of those cardiologists, Minton, eventually agreed with plaintiff's physician, Kostelyna, that plaintiff should not return to work because of his medical condition. Although plaintiff argues that defendant manipulated Minton's final report by asking Minton to revise his opinion, Minton held to his original statement that

"uncontrolled work stress, whether treated or untreated, more likely than not, will be deleterious to Mr. Walsvick's documented coronary atherosclerotic heart disease." This statement supports plaintiff's contention that avoiding work stress would help his cardiac condition. However, Minton concluded that there was no documentation to show stress had played a role in plaintiff's July 2001 heart attack, the condition for which plaintiff was seeking long-term disability benefits, as his attorney emphasized in his June 26, 2003 letter to defendant. ("[Plaintiff] has not made a claim that he is disabled by stress.") Plaintiff did not begin seeking treatment for stress until after he had made his claim for long-term disability benefits. Plaintiff's own physician stated that plaintiff's cardiac and physical status was "Class 1 - No limitation on functional capacity." To the extent that plaintiff is arguing that defendant should give greater weight to the opinions of Minton and his own physician about the effects of stress on his cardiac condition, defendant is not obligated to do so. E.g., Leipzig v. AIG Life Insurance Co., 362 F.3d 406, 409 (7th Cir. 2004) (on deferential review, insurer's decision prevailed when it rejected the opinions of several physicians who concluded that plaintiff should not hold a high stress job and adopted position of physician who concluded that although claimant suffered from serious heart condition, he could return to his high stress job with no restrictions). Because plaintiff's claim for disability was based upon his cardiac condition, not stress, it was reasonable for defendant to deny plaintiff's claim for benefits when each of the medical experts agreed that plaintiff's cardiac condition

would not prevent him from returning to work. I will grant defendant's motion for summary judgment as to plaintiff's claim under ERISA.

C. Preemption of Plaintiff's State Law Claims

In a two-sentence paragraph, plaintiff concedes that, as presently interpreted by the Court of Appeals for the Seventh Circuit, ERISA preempts his state law claims but avers that the current law is wrong and asks to preserve the issue for appeal. Plt.'s Br., dkt. #16, at 22. I note that plaintiff has preserved this issue for appeal and I will grant defendant's motion for summary judgment as to plaintiff's state law claims.

D. Costs

In its motion for summary judgment, defendant asks for an award of its costs incurred in litigating this case. 29 U.S.C. § 1132(g)(1) authorizes a court to award reasonable attorney fees and costs to either party in any action brought by a plan participant or beneficiary. The Court of Appeals for the Seventh Circuit recognizes two methods for analyzing whether attorney fees should be awarded to a party in an ERISA case after it has attained "prevailing party" status. Quinn v. Blue Cross and Blue Shield Association, 161 F.3d 472, 478 (7th Cir. 1998). "[B]oth tests essentially ask the same question: 'was the losing party's position substantially justified and taken in good faith, or was that party

simply out to harass its opponent?'" Id. Defendant has not submitted any argument in support of its motion for an award of attorney fees or costs incurred in this litigation. Because defendant's argument on this issue is undeveloped, it is deemed waived. Central States, Southeast and Southwest Areas Pension Fund, 181 F.3d 799, 808 (7th Cir. 1999) ("Arguments not developed in any meaningful way are waived."). Defendant's request for an award of attorney fees and costs will be denied.

ORDER

IT IS ORDERED that

1. Defendant CUNA Mutual Insurance Society's motion for summary judgment is GRANTED as to plaintiff Ronald Walsvick's claims under the Employee Retirement Income Security Act, 29 U.S.C. § § 1001-1461;

2. Defendant's motion for summary judgment is GRANTED as to plaintiff's state law claims;

3. Defendant's request for attorney fees and costs is DENIED; and

4. The clerk of court is directed to enter judgment for defendant and close this case.

Entered this 14th day of June, 2004.

BY THE COURT:

BARBARA B. CRABB
District Judge